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COMMUNITY-DRIVEN INCLUSIVE, EQUITABLE, MENTAL HEALTHCARE ACCESS

D2.1. Innovative solutions in mental health services for people in vulnerable situations in Europe

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1. Introduction

1.1 Role of the deliverable in the project

The overarching aim of EQUICARES is to promote inclusive, equitable, and resilient access to mental health and care services for people in vulnerable situations across Europe. The project recognises that despite increasing attention to mental health across the WHO European Region, people in vulnerable situations, including migrants, refugees, asylum seekers, ethnic and religious minorities, LGBTQIA+ individuals, people with disabilities, homeless populations, older adults, children and adolescents, and socioeconomically disadvantaged groups, continue to face disproportionate barriers to timely, appropriate, and culturally relevant care (WHO, 2022; Priebe et al., 2012).

EQUICARES addresses these challenges through a structured programme of work: generating robust evidence on barriers and facilitators to mental health service access (WP1); identifying and mapping innovative solutions (WP2); co-designing and piloting community-driven interventions in eight pilot sites across seven countries (WP3,4); and developing policy recommendations and evaluation frameworks (WP5).

This deliverable (D2.1) responds to Task 2.1 under Work Package 2 (Innovative Solutions), which requires desk research-based mapping of existing services, policies, programmes, and initiatives that address mental health access barriers for people in vulnerable situations across the WHO European Region. Although the task specification initially focused on identifying services across the EU-27, the review was extended to include all countries within the WHO European Region. This broader scope was pursued in consultation with project partners, as we believed that restricting the review to the EU-27 alone would risk overlooking relevant insights from countries with comparable mental health systems. This approach also aligns with the methodology used in an earlier WP1 deliverable. The task specification calls for identification of services across public, civil society, private, and social economy sectors; primary, secondary, tertiary, and integrated service levels; and multiple implementation levels (macro, meso, micro).

The findings of this deliverable feed directly into the **Atlas on Mental Health and Care Innovative Solutions (T2.5)**, which will provide a searchable, interactive resource for policymakers, service planners, and practitioners seeking evidence-informed approaches to improving mental health access. The mapping also informs subsequent tasks: T2.2 (fieldwork in pilot countries), T2.3 (benchmarking), and T2.4 (co-design workshops), ensuring that EQUICARES interventions at the eight pilot sites are grounded in existing evidence on what has been implemented and reported to work.

1.2 Relationship to Deliverable 1.1

This deliverable builds directly on the findings of **Deliverable 1.1** (Identifying barriers and facilitators to access to mental health for vulnerable groups in European countries), which

conducted two scoping umbrella reviews synthesising evidence on: (a) the prevalence of mental health conditions among people in vulnerable situations in the WHO European Region; and (b) barriers and facilitators to mental health care access for these populations.

D1.1 identified key barriers operating at multiple levels:

- **Supply-side barriers:** workforce shortages, lack of culturally competent providers, service fragmentation, geographic maldistribution, long waiting times, and inadequate funding.
- **Demand-side barriers:** stigma, cultural beliefs about mental health, language barriers, lack of awareness of services, mistrust of institutions, and competing priorities (housing, employment, legal status).
- **System-level barriers:** restrictive eligibility criteria, lack of policy frameworks for vulnerable populations, poor coordination between health and social services, and inadequate data collection on access inequities.

Where D1.1 focused on *identifying and characterising barriers*, this deliverable (D2.1) focuses on *identifying and characterising solutions*—the services, programmes, and interventions that have been implemented to address these barriers. Together, D1.1 and D2.1 provide the evidence foundation for EQUICARES: understanding what prevents access (D1.1) and what has been tried to improve it (D2.1).

1.3 Conceptual framework

This review is informed by the **Levesque framework for healthcare access** (Levesque et al., 2013), which EQUICARES is adapting for mental health services (WP1, T1.2). The Levesque framework conceptualises access as the interaction between supply-side factors (characteristics of services and providers) and demand-side factors (characteristics of populations and individuals), operating across five dimensions: approachability, acceptability, availability/accommodation, affordability, and appropriateness.

Consistent with this framework, and with Horizon Europe's conceptualisation of system determinants, this review examines solutions operating at three implementation levels:

- **Macro level** (policy and system architecture): national policies, financing mechanisms, workforce strategies, digital infrastructure, and legal frameworks that shape what services exist and who can access them.
- **Meso level** (organisational and service structures): regional commissioning, service integration mechanisms, inter-sectoral partnerships, and organisational practices that determine how services are configured and delivered.
- **Micro level** (individual and community): clinical practices, therapeutic relationships, cultural competence, interpreter provision, peer support, outreach activities, and community engagement that shape how individuals experience and engage with services.

This multi-level framework enables the review to map not only what solutions exist, but where in the system they operate, what barriers they address, and what levels of coordination are required for effective implementation.

1.4 Populations in scope

Aligned with the EQUICARES project framework and D1.1, this review focuses on nine categories of populations in vulnerable situations:

- Migrants, refugees, asylum seekers, and unaccompanied minors
- Ethnic and religious minorities (including Roma communities)
- Children, adolescents, youth, and transitional age populations
- LGBTQIA+, transgender, and non-binary people
- Older adults
- People with disabilities (physical and neurodevelopmental)
- Socioeconomically disadvantaged populations, including rural communities
- Homeless individuals
- Disaster-affected populations

The term **"people in vulnerable situations"** is used throughout this report, acknowledging that vulnerability is typically situational and contextual - created by discrimination, exclusion, service gaps, and systemic barriers - rather than inherent to individuals or groups (see D1.1, Section 1). Where vulnerability is intrinsic (e.g., children's developmental stage), the term 'vulnerable groups' may be used. This framing aligns with the structural and equity-oriented perspective of EQUICARES.

We recognise that these categories are not mutually exclusive; many individuals experience intersecting vulnerabilities (e.g., refugee youth, LGBTQ+ older adults, ethnic minority people with disabilities). The review captures this intersectionality through multi-category coding of studies addressing populations with overlapping characteristics.

1.5 Objectives of this deliverable

In line with Task 2.1 requirements, this deliverable aims to:

1. Identify and map implemented solutions — services, programmes, and interventions that have been implemented to address mental health access barriers for people in vulnerable situations across the WHO European Region, with particular attention to the nine population categories defined in the EQUICARES framework (Section 1.4).

2. Characterise solutions in terms of: (a) target populations served; (b) geographic coverage and context; (c) service sectors and settings; (d) implementation levels (macro, meso, micro); (e) access barriers addressed (linked to D1.1 barrier categories); and (f) solution mechanisms and delivery features.

3. Analyse solution approaches and reported outcomes — examining how solutions are designed and delivered, what implementation features are associated with reported success, and what outcomes (access, engagement, clinical, acceptability) have been reported. This analysis does not constitute formal effectiveness evaluation; rather, it synthesises what has been reported in the literature to inform Atlas development and pilot site planning.

4. Develop a typology of solution categories to support structured organisation and navigation in the Atlas on Mental Health and Care Innovative Solutions (T2.5).

5. Identify gaps in coverage — populations, geographic regions, and solution types that are underrepresented in the literature — to highlight priorities for subsequent EQUICARES work packages (T2.2–T2.4) and future research.

6. Assess transferability considerations — factors that may support or limit the replication of solutions across countries, health system contexts, and population groups — to inform adaptation for the eight EQUICARES pilot sites.

7. Meet the project Key Performance Indicator (KPI) to identify at least 50 services with documented solutions addressing access barriers.

1.6 Structure of this report

The remainder of this report is organised as follows:

Chapter 2 (Methodology) describes the structured literature review approach, including search strategy, screening and selection procedures, prioritisation criteria, data extraction framework, and analytical methods.

Chapter 3 (Results) presents findings in three sections: an overview of the evidence base (3.1), solutions organised by population category (3.2), and a cross-cutting synthesis by solution category (3.3).

Chapter 4 (Discussion) interprets the findings in relation to project objectives, discusses implications for policy, practice and the Atlas, acknowledges limitations, and outlines connections to subsequent EQUICARES work packages.

Chapter 5 (Conclusions) summarises key findings and their significance for the project.

Appendices provide summary tables of all included studies.

2. Methodology

2.1 Methodological approach

This deliverable reports a **structured literature review** to identify existing services, policies, programmes and initiatives addressing mental health access barriers for people in vulnerable situations across the WHO European Region. The review responds to Task 2.1's requirement for desk research-based mapping of services, policies, programmes, and initiatives, with findings structured to inform the Atlas on Mental Health and Care Innovative Solutions (T2.5).

The review employed a systematic search strategy across multiple databases, structured screening against predefined eligibility criteria, and in-depth data extraction using a standardised 14-field framework. The focus was on implemented or piloted solutions that have been reported to address access barriers, rather than on formal evaluation of evidence quality. A tiered analysis approach was adopted: 55 high-priority studies were selected for comprehensive full-text analysis based on explicit prioritisation criteria (KPI:≥ 50), while the remaining 160 eligible studies were catalogued at abstract level to document the broader scope of existing evidence.

2.2 Search strategy

A structured literature search was conducted across four electronic databases in [November 2025]:

Database	Records Retrieved
Scopus	452
PsycINFO	308
Embase	605
PubMed	561
Total	1,926

The search strategy combined controlled vocabulary (e.g., MeSH terms in PubMed) and free-text terms covering: (a) mental health services and service delivery; (b) access, equity, and barriers to care; (c) populations in vulnerable situations; (d) implemented programmes, interventions, or service models; and (e) countries within the WHO European Region.

2.3 Screening and selection

2.3.1 Reference management and deduplication

All records were imported into Rayyan.ai[1] for collaborative screening. A manual deduplication process removed 851 duplicates, resulting in 1,075 unique records for eligibility screening.

2.3.2 Eligibility criteria

Inclusion was limited to studies published between 2015 and 2025, with no restrictions on study design, type of study, or language, to ensure comprehensive capture of relevant literature. Studies were assessed against the following criteria:

Criterion	Included	Excluded
Publication year	Published between 2015–2025	Published before 2015
Geographic scope	Conducted in one or more countries of the WHO European Region	Conducted outside the WHO European Region
Target population	Targets at least one of the nine population categories in vulnerable situations	Does not address any population in vulnerable situations
Intervention focus	Describes an implemented or piloted mental health service, programme, or intervention aimed at tackling access barriers	No implemented or piloted intervention described; focuses only on barriers without linking to a specific intervention
Service linkage	Intervention is embedded in or linked to mental health services	School-based awareness or community programmes that address mental health but not access to mental health care
Type of study	Describes an implemented or piloted service, programme, or intervention	Theoretical, conceptual, protocol, or opinion papers with no implemented intervention described

2.3.3 Screening process

Screening proceeded in two rounds:

First round: A researcher screened all 1,075 abstracts in Rayyan against the eligibility criteria. This round excluded 793 studies, retaining 282 for rescreening.

[1] Rayyan.ai is a free web-based application designed to facilitate systematic reviews and other knowledge synthesis projects. It streamlines the screening process by allowing multiple reviewers to independently include or exclude records, resolve conflicts, and apply labels or reasons for decisions. In this review, all retrieved records were imported into Rayyan.ai, where the review team conducted title and abstract screening collaboratively.

Second round: A researcher independently assessed the 282 retained studies for consistency. Disagreements were resolved through discussion. This round led to the exclusion of a further 66 studies that did not meet eligibility criteria on closer inspection.

Final screened dataset: 215 eligible studies.

2.4 Prioritisation for in-depth analysis

Task 2.1 requires desk research-based mapping of services, policies, programmes, and initiatives that "address service access equality barriers in mental health, and effectively integrate people in vulnerable situations in the care and health system," with results feeding into the Atlas on Mental Health and Care Innovative Solutions (T2.5). The associated Key Performance Indicator specifies identification of ≥50 services through desk research.

To meet these objectives, a prioritisation step was introduced to identify studies most likely to yield detailed, transferable descriptions of service delivery models suitable for inclusion in the Atlas. The aim was to surface entries offering comprehensive insight into: (a) how services address access barriers; (b) mechanisms for integrating people in vulnerable situations; and (c) features enabling benchmarking and potential replication across contexts.

A structured scoring system was applied to all 215 eligible abstracts:

Criterion	Score Range	Description
Service description clarity	0–2	Apparent comprehensiveness of the solution described
Benchmark/ transferability potential	0–2	Likelihood of offering transferable models for benchmarking across contexts
Access mechanism detail	0–2	Articulation of access mechanisms (e.g., entry points, eligibility thresholds, referral pathways, outreach strategies)
Innovation signal	0–2	Presence of distinctive or innovative features

Each criterion was scored as 0 (absent), 1 (some detail), or 2 (comprehensive detail). Studies scoring ≥4 were prioritised for full-text retrieval.

Studies scoring ≥4 were prioritised for full-text retrieval. Considerations of geographic and population balance informed the final selection to ensure diverse representation across the WHO European Region and population categories, consistent with the project's EU-27 scope. This process yielded 73 prioritised studies. Of these, 55 full texts were successfully retrieved; 4 were inaccessible due to publisher paywalls, and 14 were conference abstracts without available full-text publications.

The 55 analysed studies exceed the KPI target (≥50 services identified) and provide the detailed characterisation required for Atlas development. The remaining 160 eligible studies (142 below the prioritisation threshold, plus the 18 prioritised studies without accessible full texts) were retained for abstract-level cataloguing (see Section 2.7.3).

2.5 Data extraction framework

A standardised 14-field extraction framework was developed to capture comprehensive information on each included study. The framework was designed to align with project objectives, the Levesque access framework (WP1), and Atlas requirements (T2.5). Fields 1–8 capture descriptive and contextual information; Fields 9–14 focus on solutions, outcomes, and transferability.

Field	Content
F1: Short Reference	Author et al., Year
F2: Full Reference	Complete APA7 citation with DOI
F3: Population Category	Primary and secondary category from the nine a priori categories; sample characteristics
F4: Country/Cluster	Geographic location using six regional clusters; urban/rural setting
F5: Study Design	Study type, methods, sample, analysis approach
F6: Type of Service	Service sector category (standardised types); service description
F7: Implementation Level	Macro (policy/system), Meso (organisational), Micro (individual), or Multiple
F8: Access Barriers	Primary and secondary barriers addressed; supply-side vs demand-side classification
F9: Solutions Identified	Formal and informal supports; design features; authors' recommendations
F10: Reported Outcomes	Significant and non-significant findings; engagement rates; qualitative findings
F11: Access Mechanisms	Referral pathways; entry points; eligibility; outreach strategies
F12: Innovation Features	Novel elements; distinctive approaches
F13: Implementation Insights	Success factors; challenges; study limitations
F14: Transferability	Factors supporting/limiting transfer; scale-up needs; research gaps

2.6 Data analysis

2.6.1 Categorisation framework

A standardised categorisation framework was applied to all included studies, drawing on established project frameworks and standard research classifications. Categories were assigned during data extraction based on explicit study characteristics.

Population categories. Studies were coded against nine *a priori* population categories defined in the EQUICARES project framework and aligned with D1.1:

1. Migrants, refugees, asylum seekers, unaccompanied minors;

2. Ethnic and religious minorities;
3. Children, adolescents, youth, transitional age;
4. LGBTQIA+, transgender, non-binary people;
5. Older adults;
6. People with disabilities (physical and neurodevelopmental);
7. Socioeconomically disadvantaged populations, including rural communities;
8. Homeless individuals;
9. Disaster-affected populations.

Primary and secondary category membership was recorded to capture intersecting vulnerabilities. The **primary category** reflects the intervention's stated design focus; **secondary categories** capture additional vulnerabilities present in the study population.

For quantitative summaries, each study is counted once according to its primary classification, ensuring mutually exclusive totals. Secondary classifications are discussed narratively in Section 3.2 to capture the full scope of populations addressed.

Geographic clustering. Studies were assigned to six regional clusters within the WHO European Region:

- Cluster 1: Northern and Western Europe (Austria, Belgium, Denmark, Finland, Germany, Ireland, Luxembourg, Netherlands, Norway, Sweden, Iceland, Switzerland, United Kingdom, and Israel[2]);
- Cluster 2: Southern Europe (Cyprus, France, Greece, Italy, Malta, Portugal, Spain);
- Cluster 3: Central and Eastern Europe (EU Member States) (Croatia, Czechia, Bulgaria, Estonia, Hungary, Romania, Latvia, Lithuania, Poland, Slovakia, Slovenia);
- Cluster 4: Western Balkans/South-East Europe and Türkiye (Albania, Bosnia and Herzegovina, Kosovo[3], Montenegro, North Macedonia, Serbia and Türkiye);
- Cluster 5: Eastern Europe and Central Asia (EECA) (Eastern Europe (non-EU): Armenia, Azerbaijan, Belarus, Georgia, Moldova, Russian Federation, Ukraine; Central Asia: Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan);
- Cluster 6: Multi-country/pan-European studies.

Study design classification. Studies were classified by research design using standard methodological categories: randomised controlled trials; qualitative studies; pilot and feasibility studies; cohort and observational studies; mixed methods studies; cross-sectional surveys; systematic and scoping reviews; service evaluations and other designs.

Service sector classification. Services were categorised across sector types aligned with health system structures: primary care; specialist/secondary services (including CAMHS); digital mental health interventions; tertiary care; integrated/multi-sector services; long-term care; and community-based services. Within these broad categories, more granular classifications (e.g., digital services, peer-delivered services, educational settings) were applied where relevant to capture the specific delivery modalities reported in the literature.

[2] Israel was grouped with Northern and Western Europe due to similarities in health system organisation, service delivery models, and mental health care infrastructure, consistent with its frequent inclusion in WHO European Region health system analyses.
[3] The designation “Western Balkans” follows European Commission usage, while “South-East Europe and Türkiye” reflects common regional groupings in WHO European health system analyses.

Implementation level. Following the Levesque framework for healthcare access (Levesque et al., 2013) and Equicares project conceptualisation of system determinants, studies were classified by implementation level:

- **Macro** (policy and system architecture): national policies, financing mechanisms, workforce strategies, legal frameworks;
- **Meso** (organisational and service structures): regional commissioning, service integration, inter-sectoral partnerships, organisational practices;
- **Micro** (individual and community): clinical practices, therapeutic relationships, cultural competence, peer support, outreach;
- **Multiple**: solutions operating across two or more levels simultaneously.

Access barriers classification. Barriers addressed by solutions were categorised using a framework derived from D1.1 (*Identifying barriers and facilitators to access to mental health for vulnerable groups in European countries*), which synthesised evidence on barriers facing people in vulnerable situations across the WHO European Region. Consistent with D1.1 and the Levesque framework, barriers were classified as **supply-side** (service/system factors) or **demand-side** (individual/population factors). Ten barrier categories were applied:

Barrier Category	Side
Stigma, trust, and acceptability	Demand
Cultural and linguistic barriers to help-seeking	Demand
Structural/systemic barriers (capacity, waiting times, fragmentation)	Supply
Workforce gaps and training needs	Supply
Transition gaps (between services or life stages)	Supply
Geographic and rural access barriers	Supply
Affordability and financial barriers	Supply
Language/cultural barriers in service provision	Supply
Digital exclusion	Supply
Legal status and eligibility barriers	Supply

2.6.2 Thematic synthesis of solutions

Solution descriptions extracted in Field 9 (Solutions Identified) were analysed using **inductive thematic analysis** to develop a typology of solution mechanisms. The process followed three stages: (1) solution descriptions were read iteratively to identify recurring mechanisms by which services aimed to improve access; (2) initial codes were grouped into candidate categories based on shared operational logic; (3) categories were refined through constant comparison across studies until a stable typology emerged.

This process yielded **six categories of service delivery solutions** representing the dominant mechanisms of action through which services addressed access barriers:

1. **Integrated and Coordinated Care Models** — service integration, stepped care, care pathways, transition support;
2. **Culturally and Linguistically Adapted Services** — cultural adaptation, interpreter provision, ethnic matching, transcultural approaches;
3. **Outreach and Low-Threshold Access Models** — walk-in services, self-referral, proactive outreach, youth-friendly design;
4. **Digital and e-Mental Health Interventions** — online platforms, apps, video therapy, digital referral systems;
5. **Peer Workers, Community Mediators, and Lay Health Agents** — task-shifting, peer support, community health workers, lived experience involvement;
6. **Organisational Redesign and Capacity Building** — workforce training, policy development, system-level change.

These categories are not mutually exclusive; most studies employed solutions spanning multiple categories. Each study was assigned a **primary solution category** based on its core mechanism of action, with secondary categories documented to capture the full solution profile.

2.6.3 Analysis of supplementary dataset

In addition to the 55 studies selected for in-depth analysis, the remaining 160 eligible studies were catalogued to document the broader scope of existing evidence on mental health access solutions. This supplementary dataset comprised:

- 142 studies that met eligibility criteria but scored below the prioritisation threshold (< 4) for full-text analysis;
- 14 studies initially prioritised but available only as conference abstracts without accessible full-text publications;
- 4 studies for which full texts could not be retrieved despite meeting prioritisation criteria.

For these 160 studies, **abstract-level data extraction** was conducted using a condensed framework capturing: short reference; country; geographic cluster; primary population category; primary barrier addressed; primary and secondary solution categories; and a brief narrative description synthesised from the abstract. This cataloguing enables comprehensive documentation of existing evidence while acknowledging that abstract-level data provides less detail than full-text analysis. Findings from the supplementary dataset are presented separately in Section 3.4, and the full catalogue is provided in Appendix B.

2.7 Presentation of findings

Results are presented in four sections:

- **Section 3.1** provides an overview of the 55 studies selected for in-depth analysis, including study characteristics, geographic distribution, population coverage, service sectors, implementation levels, and access barriers addressed.
- **Section 3.2** presents findings organised by **primary population category**, enabling coherent narrative synthesis of solutions for each population in vulnerable situations.
- **Section 3.3** provides a **cross-cutting synthesis by solution category**, examining patterns across populations and implementation contexts.

- **Section 3.4** summarises findings from the **supplementary dataset** of 160 studies catalogued at abstract level.

This structure supports both population-specific and solution-oriented entry points for the Atlas, while ensuring comprehensive documentation of the evidence base.

Complete data extraction tables for all 55 analysed studies are provided in Appendix A. The full catalogue of 160 supplementary studies is provided in Appendix B.

3. Results

3.1 Overview of the studies selected for in-depth analysis

3.1.1 Study characteristics and designs

The 55 analysed studies were published between 2017 and 2025, with the majority (n=45, 82%) published from 2020 onwards, reflecting growing attention to mental health access for people in vulnerable situations. The full list of included studies can be found in the Appendix A. The temporal distribution shows acceleration in recent years: 2024 alone contributed 14 studies (25%), followed by 2023 and 2025 with 7 studies each. The earlier studies (n=10) were published between 2017 and 2019 (Adriaenssens, 2019; Edge, 2018; Elbert, 2017; Gire, 2017; King & Said, 2019; Notredame, 2018; Price, 2019; Schoenmakers, 2017; Trilesnik, 2019; Wilson, 2018).

Of the 55 studies, 50 were primary studies describing implemented solutions, and 5 were systematic or scoping reviews synthesising evidence on interventions for specific populations or modalities. Both types contribute valuable evidence: primary studies provide detailed descriptions of specific implemented solutions, while reviews synthesise patterns across multiple interventions.

Table 1 summarises the distribution of study designs.

Table 1. *Study designs of included studies (n=55)*

Study Design	n	%
Primary studies of implemented solutions	**50**	**91%**
— Service description/evaluation	13	24%
— RCT/Quasi-experimental	10	18%
— Qualitative	10	18%
— Mixed methods	9	16%
— Cohort/observational	5	9%
— Policy analysis	3	5%
Reviews of interventions	**5**	**9%**

Study design classifications were based on primary methodology reported. Service description/evaluation includes feasibility studies, service evaluations, realist evaluations, and case studies describing implemented services. RCT/Quasi-experimental includes randomised controlled trials, cluster RCTs, wait-list controlled trials, and pre-post studies with control groups. Cohort/observational includes retrospective cohort studies using routine data or electronic health records. Mixed methods studies were classified separately from purely qualitative or quantitative designs. Reviews synthesise evidence across multiple studies rather than describing a single implemented solution, but provide valuable evidence on intervention patterns and effectiveness.

The predominance of service descriptions and evaluations (24%) reflects the review's focus on implemented solutions rather than solely efficacy evidence. The substantial proportion of RCTs and quasi-experimental studies (18%) indicates growing attention to rigorous evaluation of mental health access interventions. Mixed methods approaches (16%) were commonly employed to capture both

implementation processes and outcomes, while qualitative studies (18%) provided insight into user experiences and implementation contexts.

Studies by design category:

- *Service description/evaluation (n=13):* Bajbouj et al., 2021; Bechdolf et al., 2024; Baleige et al., 2022; Burbach & Stiles, 2021; Elbert et al., 2017; Gee et al., 2024; Notredame et al., 2018; Porter et al., 2022; Saillant et al., 2020; Schmidt et al., 2023; Trilesnik et al., 2019; Venkataraman et al., 2024; Wilson et al., 2018.
- *RCT/Quasi-experimental (n=10):* Aeschlimann et al., 2025; Alfayumi-Zeadna et al., 2025; de Graaff et al., 2023; Freţian et al., 2023; Lelutiu-Weinberger et al., 2023; Nieder et al., 2024; Reich et al., 2024; Smith et al., 2024; Spaaij et al., 2022; Surkan et al., 2024.
- *Qualitative (n=10):* Hassan et al., 2020; Holmen et al., 2023; Keogh et al., 2020; King & Said, 2019; Lamotte d'Incamps & Rizzi, 2024; Leijdesdorff et al., 2021; Price et al., 2019; Santa et al., 2024; Schoenmakers et al., 2017; Spaas et al., 2022.
- *Mixed methods (n=9):* Carey et al., 2025; Crombach et al., 2025; Edge et al., 2018; Karaoğlan Kahiloğulları et al., 2020; McDermott et al., 2024; Meurling et al., 2023; Pryjmachuk et al., 2024; Smith et al., 2025; Van Everdingen et al., 2021.
- *Cohort/observational (n=5):* Ganga et al., 2024; Gilmour et al., 2022; Harty et al., 2023; Koet et al., 2024; Marchini et al., 2021.
- *Policy analysis (n=3):* Adriaenssens et al., 2019; Michaud et al., 2020; Parr et al., 2024.
- *Systematic/scoping/narrative review (n=5):* Bechdolf et al., 2025; Carballeira Carrera et al., 2020; Eilert et al., 2022; Gire et al., 2017; Stockwell et al., 2025.

Mapping to project framework categories

Task 2.1 specifies mapping of "services, policies, programmes and initiatives" addressing mental health access barriers. In the published literature, these terms are often used flexibly, with considerable overlap—for example, a youth mental health hub may be described as a "service," "programme," or "initiative" depending on the source. We therefore adopted a pragmatic grouping as presented in Table 2.

Table 2. *Study mapping - services, policies, programmes and initiatives (n=55)*

Category	n	Description
Services, programmes, interventions, initiatives	52	Primary studies and reviews describing or evaluating implemented solutions
Policies	3	Policy analyses examining system-level frameworks

The six solution categories developed through thematic analysis (Section 3.3) provide a more granular classification of *how* these services, programmes, and interventions address access barriers—enabling navigation in the Atlas by mechanism of action.

3.1.2 Geographic distribution

Studies were assigned to six regional clusters within the WHO European Region. Table 3 presents the distribution, revealing significant geographic concentration.

Table 3. *Geographic distribution by regional cluster (n=55)*

Regional Cluster	n	%
Cluster 1: Northern/Western Europe	42	76%
Cluster 6: Multi-country/Pan-European	7	13%
Cluster 2: Southern Europe	4	7%
Cluster 3: Central/Eastern Europe	1	2%
Cluster 4: Western Balkans / South-East Europe and Türkiye	1	2%
Cluster 5: Eastern Europe and Central Asia (EECA)	0	0%

The evidence base is heavily concentrated in Northern/Western Europe (76%; Aeschlimann et al., 2025, Carey et al., 2025, Crombach et al., 2025, Nieder et al., 2024, Reich et al., 2024, Ganga et al., 2024, Smith et al., 2025, Van Everdingen et al., 2021, Venkataraman et al., 2024, Price et al., 2019, Parr et al., 2024, McDermott et al., 2024, Edge et al., 2018, Alfayumi-Zeadna et al., 2025, Keogh et al., 2020, Hassan et al., 2020, Saillant et al., 2020, Burbach & Stiles, 2021, Leijdesdorff et al., 2021, King & Said, 2019, Spaas et al., 2022, Schoenmakers et al., 2017, Freţian et al., 2023, Pryjmachuk et al., 2024, Smith et al., 2024, Gilmour et al., 2022, Wilson et al., 2018, Marchini et al., 2021, Holmen et al., 2023, Porter et al., 2022, Bajbouj et al., 2021, de Graaff et al., 2023, Spaaij et al., 2022, Meurling et al., 2023, Elbert et al., 2017, Trilesnik et al., 2019, Schmidt et al., 2023, Harty et al., 2023, Gee et al., 2024, Koet et al., 2024, Santa et al., 2024, Bechdolf et al., 2024), with the United Kingdom contributing the largest share (n=17), followed by Germany(n=8), the Netherlands, (n=6) and France (n=4). Seven studies (13%) were multi-country or pan-European in scope (Stockwell et al., 2025, Carballeira Carrera et al., 2020, Adriaenssens et al., 2019, Gire et al., 2017, Bechdolf et al., 2025, Eilert et al., 2022, Michaud et al., 2020). **Significant geographic gaps** exist in Clusters 3 and 4, with only one study included from Romania (Lelutiu-Weinberger, 2023), one from Türkiye (Karaoğlan Kahiloğulları, 2020), and no studies from the Eastern Europe and Central Asia (EECA) countries.

It should be noted that additional studies from these underrepresented regions were identified in the broader screened literature; however, as described in Section 2.4, they did not meet the prioritisation threshold (scoring ≥4 on service description clarity, transferability potential, access mechanism detail, and innovation signal) required for full-text analysis, and are instead catalogued at abstract level in the supplementary dataset (Appendix B).

3.1.3 Population coverage

Table 4 shows the distribution of studies by population category. Categories are not mutually exclusive, as many studies addressed multiple population groups.

Table 4. *Coverage by population category (n=55; categories not mutually exclusive)*

Population Category	n	%
G3: Children, adolescents, youth, transitional age	25	45%

G1: Migrants, refugees, asylum seekers, unaccompanied minors	16	29%
G4: LGBTQIA+, transgender, non-binary people	4	7%
G2: Ethnic and religious minorities	4	7%
G5: Older adults	3	5%
G7: Socioeconomically disadvantaged populations (incl. rural)	2	4%
G8: Homeless individuals	1	2%
G6: People with disabilities (physical and neurodevelopmental)	0	0%
G9: Disaster-affected populations	0	0%
Multiple (with secondary relevance noted)	2	4%
Total	**55**	**100%**

Notes:
1. Two studies had dual primary classifications and are counted in both relevant categories: McDermott et al. (2024) addressed both LGBTQIA+ young people (G3 & G4); Schoenmakers et al. (2017) addressed elderly migrants (G1 & G5). Column totals therefore exceed 55.
2. Two studies were classified as "Multiple" due to broader clinical or general population focus but with specific relevance to target vulnerability categories: Gire et al. (2017) focused on mHealth for psychosis with explicit relevance to socioeconomically disadvantaged and rural populations (G7); Harty et al. (2023) evaluated a digital mental health service highlighting significant underrepresentation of older adults (G5).

Children, adolescents, and youth were the most frequently studied population as a primary focus (n=25, 45%; Bechdolf et al., 2024; Bechdolf et al., 2025; Burbach & Stiles, 2021; Carey et al., 2025; Crombach et al., 2025; Eilert et al., 2022; Freţian et al., 2023; Ganga et al., 2024; Gee et al., 2024; Gilmour et al., 2022; Holmen et al., 2023; Koet et al., 2024; Leijdesdorff et al., 2021; Marchini et al., 2021; McDermott et al., 2024; Michaud et al., 2020; Notredame et al., 2018; Parr et al., 2024; Porter et al., 2022; Price et al., 2019; Pryjmachuk et al., 2024; Santa et al., 2024; Smith et al., 2024; Smith et al., 2025; Wilson et al., 2018), followed by migrants, refugees, and asylum seekers (n=16, 29%; Aeschlimann et al., 2025; Bajbouj et al., 2021; Carballeira Carrera et al., 2020; de Graaff et al., 2023; Elbert et al., 2017; Karaoğlan Kahiloğulları et al., 2020; King & Said, 2019; Lamotte d'Incamps & Rizzi, 2024; Meurling et al., 2023; Reich et al., 2024; Schmidt et al., 2023; Schoenmakers et al., 2017; Spaaij et al., 2022; Spaas et al., 2022; Surkan et al., 2024; Trilesnik et al., 2019). LGBTQIA+ populations (n=4, 7%; Baleige et al., 2022; Lelutiu-Weinberger et al., 2023; McDermott et al., 2024; Nieder et al., 2024) and ethnic and religious minorities (n=4, 7%; Alfayumi-Zeadna et al., 2025; Edge et al., 2018; Keogh et al., 2020; Stockwell et al., 2025) were each addressed by four studies as their primary focus.

The evidence base for several population groups remains notably limited in terms of primary focus. Older adults were the primary target of only three studies (5%; Adriaenssens et al., 2019; Schoenmakers et al., 2017; Venkataraman et al., 2024), while socioeconomically disadvantaged and rural populations (n=2, 4%; Hassan et al., 2020; Saillant et al., 2020) and homeless individuals (n=1, 2%; Van Everdingen et al., 2021) were rarely prioritised. Two additional studies addressed multiple populations with secondary relevance to underrepresented groups: Gire et al. (2017), a systematic review of mHealth for psychosis explicitly focused on reaching socioeconomically disadvantaged and rural populations; and Harty et al. (2023), which highlighted significant underrepresentation of older adults in digital mental health service uptake.

Notably, no studies primarily targeted people with disabilities (G6) or disaster-affected populations (G9). However, several studies addressed disability-related needs as secondary populations, particularly neurodevelopmental conditions in youth mental health contexts. These included studies examining autism and ADHD diagnostic pathways (Parr et al., 2024; Burbach & Stiles, 2021; Price et al., 2019), services noting neurodivergent young people as an explicitly targeted subgroup (Carey et

al., 2025; Pryjmachuk et al., 2024; Leijdesdorff et al., 2021), and studies addressing cognitive impairments in older adult populations (Adriaenssens et al., 2019; Venkataraman et al., 2024) or among homeless service users (Van Everdingen et al., 2021). Similarly, while no studies primarily addressed disaster-affected populations, two studies had secondary relevance: Burbach & Stiles (2021) described service adaptations during the COVID-19 pandemic, and Reich et al. (2024) noted post-migration stressors among refugees in crisis contexts.

Despite the concentration of primary evidence around youth and migrant populations, the majority of included studies acknowledged intersecting vulnerabilities within their samples. Many youth-focused studies explicitly recruited from socioeconomically deprived areas (Ganga et al., 2024; Gilmour et al., 2022; Koet et al., 2024; Santa et al., 2024), included LGBTQ+ young people as target subgroups (McDermott et al., 2024; Pryjmachuk et al., 2024; Leijdesdorff et al., 2021; Bechdolf et al., 2024; Bechdolf et al., 2025), or addressed ethnic minority youth (Smith et al., 2024; Smith et al., 2025; Gee et al., 2024). Similarly, several migrant-focused studies included children and adolescents (King & Said, 2019; Spaas et al., 2022; Karaoğlan Kahiloğulları et al., 2020; Bajbouj et al., 2021; Schmidt et al., 2023; Elbert et al., 2017) or older migrants (Schoenmakers et al., 2017) as key subpopulations. This pattern of intersectionality suggests that while primary population focus may appear narrow, the actual reach of evidence across vulnerability categories is broader when secondary populations are considered.

3.1.4 Service sectors

Studies addressed mental health services across multiple sectors, with considerable overlap. Table 5 summarises the sectors represented.

Table 5. *Service sectors represented (n=55; categories not mutually exclusive)*

Service Sector	n	%
Specialist mental health services	15	27%
Digital/online services	13	24%
Integrated/Multi-sector services	13	24%
Community-based services	13	24%
Third sector/NGO (Peer-delivered/Lay worker)	9	16%
CAMHS/Youth mental health services	8	15%
Primary care	5	9%
Educational settings	2	4%

Note: Categories are not mutually exclusive; many studies addressed multiple service sectors. For example, Nieder et al. (2024) combined digital mental health with targeted specialist services; Ganga et al. (2024) integrated digital interventions with multi-sector approaches.

Studies addressed mental health services across multiple sectors, with considerable overlap reflecting the complexity of access solutions for vulnerable populations.

Specialist mental health services were addressed by 15 studies (27%; Bajbouj et al., 2021; Carballeira Carrera et al., 2020; Edge et al., 2018; Keogh et al., 2020; King & Said, 2019; Lelutiu-Weinberger et al., 2023; Marchini et al., 2021; McDermott et al., 2024; Nieder et al., 2024; Notredame et al., 2018; Parr et al., 2024; Schmidt et al., 2023; Smith et al., 2025; Van Everdingen et al., 2021; Venkataraman et al., 2024). These included culturally adapted interventions for ethnic minorities (Edge et al., 2018;

Carballeira Carrera et al., 2020), specialist liaison services for Traveller communities (Keogh et al., 2020), targeted services for homeless populations (Van Everdingen et al., 2021), and provider training to improve LGBTQ+ competency in specialist settings (Lelutiu-Weinberger et al., 2023).

Digital and online services featured prominently (n=13, 24%; Aeschlimann et al., 2025; Burbach & Stiles, 2021; Eilert et al., 2022; Ganga et al., 2024; Gee et al., 2024; Gire et al., 2017; Harty et al., 2023; Meurling et al., 2023; Nieder et al., 2024; Porter et al., 2022; Reich et al., 2024; Santa et al., 2024; Venkataraman et al., 2024), reflecting growing interest in technology-enabled access solutions. Digital interventions ranged from culturally adapted self-help apps for refugees (Aeschlimann et al., 2025; Reich et al., 2024) to telehealth models extending specialist care to remote populations (Nieder et al., 2024).

Integrated and multi-sector approaches were equally represented (n=13, 24%; Adriaenssens et al., 2019; Bechdolf et al., 2024; Bechdolf et al., 2025; Carey et al., 2025; Ganga et al., 2024; Hassan et al., 2020; Holmen et al., 2023; Schmidt et al., 2023; Smith et al., 2024; Smith et al., 2025; Spaas et al., 2022; Trilesnik et al., 2019; Wilson et al., 2018), highlighting the importance of cross-sectoral collaboration in addressing complex access barriers. These included youth mental health hubs combining clinical services with social support (Bechdolf et al., 2024; Bechdolf et al., 2025; Wilson et al., 2018), school-based mental health integration for refugee children (Spaas et al., 2022), social prescribing models linking mental health with community resources (Hassan et al., 2020), and stepped-care models connecting psychiatric clinics with psychosocial counselling centres for refugees (Trilesnik et al., 2019).

Community-based services were addressed by 13 studies (24%; Adriaenssens et al., 2019; Alfayumi-Zeadna et al., 2025; Baleige et al., 2022; Crombach et al., 2025; Hassan et al., 2020; Leijdesdorff et al., 2021; McDermott et al., 2024; Pryjmachuk et al., 2024; Saillant et al., 2020; Schoenmakers et al., 2017; Smith et al., 2024; Stockwell et al., 2025; Van Everdingen et al., 2021). These ranged from walk-in youth mental health centres (Crombach et al., 2025; Leijdesdorff et al., 2021) to community suicide prevention programmes for rural populations (Saillant et al., 2020) and voluntary sector LGBTQ+ youth services (Pryjmachuk et al., 2024).

Third sector and peer-delivered services featured in nine studies (16%; Alfayumi-Zeadna et al., 2025; Carey et al., 2025; Crombach et al., 2025; Elbert et al., 2017; Pryjmachuk et al., 2024; Spaaij et al., 2022; Stockwell et al., 2025; Surkan et al., 2024; de Graaff et al., 2023), predominantly in refugee mental health contexts where lay counsellor and peer support models addressed workforce shortages and cultural barriers, as well as in voluntary sector provision for LGBTQ+ youth where NGOs fill gaps in statutory services.

CAMHS and youth-specific mental health services were the focus of eight studies (15%; Burbach & Stiles, 2021; Gilmour et al., 2022; King & Said, 2019; Leijdesdorff et al., 2021; Marchini et al., 2021; Parr et al., 2024; Price et al., 2019; Wilson et al., 2018), addressing service transitions, specialist pathways for unaccompanied minors, and neurodevelopmental assessment services.

Primary care integration featured in five studies (9%; Baleige et al., 2022; Karaoğlan Kahiloğulları et al., 2020; Koet et al., 2024; Lamotte d'Incamps & Rizzi, 2024; Michaud et al., 2020). These included transgender-affirming primary care services (Baleige et al., 2022), mhGAP training for primary care doctors serving refugee populations (Karaoğlan Kahiloğulları et al., 2020), and policy analyses of primary care mental health provision for migrant children (Michaud et al., 2020).

Educational settings were addressed by two studies (4%; Freţian et al., 2023; Spaas et al., 2022), both contributing solutions to improve equitable access to mental health care for children from vulnerable backgrounds. Freţian et al. (2023) evaluated a school-based mental health literacy programme designed to increase help-seeking among socioeconomically disadvantaged youth, while Spaas et al. (2022) examined integrated school-based mental health support for refugee children as a pathway to appropriate care. These studies demonstrate the potential of educational settings as accessible entry points to mental health services for children who might otherwise face barriers to care.

The distribution across service sectors reflects the diversity of approaches required to address mental health access inequities. In terms of the health system structure specified by the project framework, secondary-level care was well represented through specialist mental health services (27%) and CAMHS (15%), and primary care featured in 9% of studies. Integrated services were prominent (24%). Digital, community-based, and third sector services often operate across traditional health system tiers or outside statutory provision entirely. Tertiary care and long-term care settings were not a primary focus of included studies, likely reflecting the review's emphasis on solutions addressing barriers to initial access rather than care within established institutional settings.

3.1.5 Implementation levels

Solutions were classified by their level of implementation within health and social care systems. Table 6 presents the distribution.

Table 6. *Implementation levels (n=55)*

Implementation Level	n	%
Multiple levels (macro, meso, micro)	42	76%
Meso (organisational) only	5	9%
N/A (systematic reviews/qualitative studies)	4	7%
Micro (individual/clinical) only	3	5%
Macro (policy/system) only	1	2%

Note: "Multiple levels" includes studies operating across two or more implementation levels: Macro + Meso + Micro (n=12), Macro + Meso (n=6), and Meso + Micro (n=24). Four studies were classified as N/A as they were systematic reviews or qualitative exploratory studies where implementation level classification was not applicable.

Solutions were classified by their level of implementation within health and social care systems. A key finding is that 76% of studies described solutions operating across multiple implementation levels (n=42), combining different levels of system engagement. The most common pattern was Meso + Micro (n=24, 44%), reflecting solutions that combined organisational-level adaptations with individual clinical interventions. This included culturally adapted services delivered within existing organisational structures (Edge et al., 2018; Keogh et al., 2020), peer-delivered interventions requiring organisational partnerships (Alfayumi-Zeadna et al., 2025; Surkan et al., 2024; de Graaff et al., 2023), and digital service innovations implemented across multiple sites (Nieder et al., 2024; Gee et al., 2024; Santa et al., 2024).

Twelve studies (22%) operated across all three implementation levels (Macro + Meso + Micro), combining policy or system-level engagement with organisational adaptations and individual-level interventions. These comprehensive approaches included national refugee mental health programmes with local service delivery (Trilesnik et al., 2019; Reich et al., 2024; Schmidt et al., 2023),

youth mental health policy initiatives translated into integrated service models (Carey et al., 2025; Harty et al., 2023), and national training programmes aimed at changing both system capacity and individual clinical practice (Lelutiu-Weinberger et al., 2023; Karaoğlan Kahiloğulları et al., 2020).

Six studies (11%) combined Macro and Meso levels, typically describing policy frameworks and their organisational implementation without detailed evaluation of individual-level outcomes. These included national youth mental health service evaluations (Bechdolf et al., 2025; Holmen et al., 2023; Pryjmachuk et al., 2024) and system-wide service mapping studies (Adriaenssens et al., 2019; Notredame et al., 2018).

Studies focused on single implementation levels were less common. Five studies (9%) operated at the Meso level only, describing organisational innovations such as centralised refugee mental health clinics (Bajbouj et al., 2021), service pathway evaluations (Gilmour et al., 2022; Parr et al., 2024), and regional service models (Porter et al., 2022; Saillant et al., 2020). Three studies (5%) focused exclusively on Micro-level interventions, examining individual clinical encounters without broader organisational or system components (Aeschlimann et al., 2025; King & Said, 2019; Lamotte d'Incamps & Rizzi, 2024). Only one study (2%) focused exclusively on the Macro level (Michaud et al., 2020), mapping national policies on primary care mental health for migrant children across 31 European countries.

Four studies (7%) were classified as N/A for implementation level as they were systematic reviews synthesising existing evidence (Gire et al., 2017; Eilert et al., 2022) or qualitative exploratory studies examining stakeholder experiences rather than evaluating specific implementations (Leijdesdorff et al., 2021; Schoenmakers et al., 2017).

This multi-level approach reflects the complexity of addressing access barriers, which typically require coordinated action across different system levels. The predominance of Meso + Micro combinations suggests that many access solutions are being developed and evaluated at the service delivery level, with scope for greater policy integration to support scaling and sustainability.

A key finding is that **80% of studies described solutions operating across multiple implementation levels** (n=44), combining macro-level policy or system changes with meso-level organisational adaptations and micro-level clinical interventions. This multi-level approach reflects the complexity of addressing access barriers, which typically require coordinated action across different system levels.

3.1.6 Access barriers addressed

Studies addressed a range of access barriers, often targeting multiple barriers simultaneously. Table 7 summarises the barriers most frequently addressed.

Table 7. *Primary access barriers addressed by solutions*

Primary Access Barrier	n	%
Structural/Systemic (Supply-side)	26	47%
Stigma/Trust/Acceptability (Demand-side)	12	22%
Language/Cultural barriers	6	11%
Transition gaps (Supply-side)	4	7%
Mixed/Multiple barriers	3	5%

Workforce capacity/training (Supply-side)	2	4%
Geographic/Administrative (Supply-side)	1	2%
Health literacy/Navigational (Demand-side)	1	2%
Total	**55**	**100%**

Note: Table 7 presents the PRIMARY barrier addressed by each study as classified in the data extraction (Appendix A). Many studies addressed multiple barriers; secondary barriers are summarised below.

While Table 7 presents primary barriers, most studies acknowledged and addressed multiple barriers through their solutions. Analysis of the full data extraction (Field 8) identified the secondary barriers addressed across the evidence base (Table 8).

Table 8. *Secondary access barrier addressed by solutions*

Secondary Access Barrier	n	Examples
Stigma/Trust/Acceptability	38+	Walk-in services reducing help-seeking barriers; peer support models; culturally safe spaces
Workforce gaps	33+	Training programmes; task-shifting to lay workers; cultural competency development
Language/Cultural	26+	Interpreter provision; multilingual materials; cultural adaptation of interventions
Geographic/Administrative	18+	Digital/telehealth solutions; outreach services; decentralised delivery
Financial/Affordability	19+	Free-to-access services; removal of eligibility restrictions; funded programmes
Transition gaps	15+	Extended age ranges; flexible boundaries; integrated youth-adult pathways
Digital exclusion	12+	Accessible app design; offline options; device provision; digital literacy support
Legal status/Eligibility	16+	Services regardless of immigration status; navigation support; advocacy

Note: Counts are indicative based on keyword analysis of Field 8 (Access Barriers) in the full data extraction tables. Most studies addressed 3-5 barrier types through their solutions.

Studies addressed a range of access barriers, with classification based on the primary barrier targeted by each solution.

Structural and systemic barriers were the most frequently targeted as a primary focus (n=26, 47%), reflecting the evidence base's emphasis on supply-side system improvements. These studies addressed service capacity constraints, long waiting times, fragmented care pathways, and inadequate resource allocation. Solutions included digital platforms to extend service reach (Ganga et al., 2024; Santa et al., 2024; Gee et al., 2024), integrated service models reducing fragmentation (Holmen et al., 2023; Bechdolf et al., 2025), and system redesign to improve access pathways (Pryjmachuk et al., 2024; Smith et al., 2024).

Stigma, trust, and acceptability barriers were the primary focus of 12 studies (22%), addressing demand-side factors that prevent help-seeking among vulnerable populations. These included culturally adapted interventions building trust with ethnic minority communities (Edge et al., 2018; Keogh et al., 2020), youth-friendly services reducing stigma around mental health (Crombach et al.,

2025; Leijdesdorff et al., 2021), peer support models increasing acceptability (Alfayumi-Zeadna et al., 2025), and provider training to improve LGBTQ+ competency and reduce discrimination (Lelutiu-Weinberger et al., 2023).

Language and cultural barriers were the primary focus of six studies (11%), predominantly addressing refugee and migrant populations. Solutions included multilingual digital interventions (Reich et al., 2024; Meurling et al., 2023), culturally adapted therapy delivery (Surkan et al., 2024), and systematic screening in appropriate languages (Schmidt et al., 2023; Trilesnik et al., 2019).

Transition gaps between child and adult services were the primary barrier addressed by four studies (7%), highlighting the persistent challenge of service discontinuity at age boundaries. These studies examined youth mental health hubs with extended age ranges (Bechdolf et al., 2024; Wilson et al., 2018), transition pathway improvements (Price et al., 2019), and models bridging paediatric and adult care (Marchini et al., 2021).

Three studies (5%) addressed mixed or multiple barriers as their primary focus, recognising the intersecting nature of access challenges. Carballeira Carrera et al. (2020) examined both structural and cultural barriers in transcultural psychiatric consultations; Spaaij et al. (2022) addressed structural barriers alongside stigma in refugee mental health; and Stockwell et al. (2025) reviewed interventions targeting multiple barriers facing Black men.

Workforce capacity and training gaps were the primary focus of two studies (4%), both addressing the shortage of appropriately trained mental health workers for refugee populations through task-shifting models (Elbert et al., 2017; Karaoğlan Kahiloğulları et al., 2020).

Geographic and administrative barriers were the primary focus of one study (Nieder et al., 2024), which used telehealth to extend specialist gender-affirming care to transgender individuals in remote areas. Health literacy and navigational barriers were similarly the primary focus of one study (Schoenmakers et al., 2017), examining how older migrants navigate mental health systems.

While these primary classifications reflect each study's main focus, the majority of included studies acknowledged and addressed multiple barriers through their solutions. Secondary barrier analysis indicates that stigma reduction strategies, workforce development, and language/cultural adaptations featured across studies regardless of primary classification, reflecting the interconnected nature of access barriers facing vulnerable populations.

3.1.7 Summary

The evidence base comprises 55 studies, predominantly from Northern/Western Europe (76%) and multi-country studies (13%), with significant geographic gaps in EU countries in Central and Eastern Europe, Western Balkans / South-East Europe and Türkiye, and the EECA countries. Studies most frequently addressed children and youth (45%) and migrants/refugees (29%) as their primary population focus, with limited evidence for older adults (5%), homeless individuals (2%), and no primary focus on people with disabilities or disaster-affected populations. The majority of solutions (76%) operated across multiple implementation levels, most commonly combining organisational and individual-level components. Structural and systemic barriers were the most common primary focus (47%), followed by stigma, trust, and acceptability factors (22%). Specialist mental health services (27%), digital interventions (24%), integrated/multi-sector approaches (24%), and community-based services (24%) were the most common service sectors, with limited evidence on primary care (9%) and educational settings (4%).

3.2 Solutions by population category

This section presents findings organised by primary population category. Each subsection describes the services, programmes, and interventions identified for that population, the solution mechanisms employed, and key implementation insights. Cross-references are provided where studies have relevance to multiple population categories.

3.2.1 Children, adolescents, youth, and transitional age

Overview

Twenty-five studies (45%) primarily addressed children, adolescents, youth, or transitional age populations (see Section 3.1.3 for full reference list). An additional ten studies addressed youth as a secondary population within broader samples, particularly studies targeting migrants and refugees where refugee children and unaccompanied minors were included (e.g., Carballeira Carrera et al., 2020; King & Said, 2019; Spaas et al., 2022; Bajbouj et al., 2021). Studies were predominantly from the UK, the Netherlands, Germany, and Ireland, with service types spanning digital interventions, integrated youth mental health services, specialist CAMHS, school-based programmes, and LGBTQ+-specific services.

Solution Mechanisms

Solutions for young people drew heavily on outreach and low-threshold access models, digital interventions, integrated care models, and peer involvement strategies. Key mechanisms included:

- **Low-threshold access:** The @ease model (Netherlands) and headspace-inspired services (Germany) provided anonymous, free, walk-in access without referral requirements, addressing young people's preferences for informal, non-stigmatising entry points (Crombach et al., 2025; Leijdesdorff et al., 2021; Bechdolf et al., 2024; Bechdolf et al., 2025; Holmen et al., 2023). Self-referral pathways were a common feature across youth services, including LGBTQ+ voluntary sector provision (Pryjmachuk et al., 2024; McDermott et al., 2024).
- **Extended age ranges:** Several services extended traditional CAMHS boundaries (typically 0–18) to cover ages 12–25, 14–25, or even 10–35, addressing the well-documented 'transition gap' where young people fall between child and adult services (Wilson et al., 2018; Marchini et al., 2021; Bechdolf et al., 2024; Holmen et al., 2023). This reflects international models such as headspace (Australia) and Jigsaw (Ireland).
- **Digital platforms:** Digital solutions included online therapy platforms enabling remote CBT delivery (Burbach & Stiles, 2021; Porter et al., 2022), apps for specific conditions such as Lumi Nova for childhood anxiety (Gee et al., 2024), digital referral systems creating single points of access (Ganga et al., 2024; Santa et al., 2024), and online screening and self-help tools (Eilert et al., 2022). Digital approaches addressed both geographic barriers and young people's preferences for technology-mediated support.
- **Peer involvement:** Youth Advocate programmes (Carey et al., 2025) and peer worker integration in walk-in centres (Crombach et al., 2025) leveraged young people with lived experience to reduce barriers and increase acceptability. The @ease model specifically employs trained peer supporters alongside professionals, creating youth-friendly environments that reduce power imbalances.
- **School-based integration:** Mental health literacy curricula (Freţian et al., 2023) and collaborative care networks linking schools with mental health services (Spaas et al., 2022) addressed access at the point where young people spend most time. School-based

approaches were particularly valuable for reaching refugee children who might not otherwise access care.

- **Culturally adapted and population-specific services:** Several studies described services tailored to specific youth subpopulations, including LGBTQ+ youth services providing affirming spaces and peer support (McDermott et al., 2024; Pryjmachuk et al., 2024), and culturally adapted group interventions for unaccompanied asylum-seeking children (King & Said, 2019).

Key Exemplars

- **@ease walk-in centres (Netherlands):** Free, anonymous walk-in centres for young people aged 12–25, staffed by trained peer supporters and professionals. The model emphasises peer-to-peer support, youth-friendly environments, and immediate access without appointment or referral. Standard @ease centres primarily reach female, higher-educated youth; an adapted outreach version ('Everybody @ease') proactively reaches underrepresented groups including males, lower-educated youth, and those born abroad through community presence at neighbourhood hangouts and community centres. Studies reported high acceptability and successful engagement of previously disengaged youth (Crombach et al., 2025; Leijdesdorff et al., 2021).
- **Integrated Youth Mental Health Services (Germany):** Based on headspace (Australia) principles, German IYMHS pilots provide 'one-stop shop' services for youth aged 15–35 (Bechdolf et al., 2024) with emerging mental health difficulties. Key features include low-threshold walk-in access, multi-disciplinary teams, single point of access, and smooth transitions to specialist care when needed. The model addresses the transition gap by extending beyond traditional CAMHS age limits. Similar Norwegian services ('Rask psykisk helsehjelp') demonstrated comparable approaches for ages 16+ (Holmen et al., 2023). A comparative review identified common features across international youth mental health models including extended age ranges, low-threshold access, integrated care, and youth participation (Bechdolf et al., 2025).
- **CYP as One digital platform (UK):** A web-based digital referral system in Liverpool/Sefton replacing fragmented paper-based pathways, enabling multiple referral routes (self-referral, GP, school, parent) to a single point of access for CAMHS. Implementation reduced waiting times, improved pathway visibility, and enabled real-time demand monitoring. The platform required significant organisational change management and multi-agency collaboration across NHS trusts, schools, and local authorities (Ganga et al., 2024). A similar platform (GIFT-Cloud) in the same region focused specifically on anxiety in children aged 7–12 (Santa et al., 2024).
- **School-based Collaborative Refugee Care (Belgium):** The Consultation team for Collaborative Refugee Care (CCRC) in Leuven provides school-based mental health support for refugee children integrating academic, multilingual, and psychosocial services. The interdisciplinary care network includes transcultural trauma specialists, multilingual development consultants, school counsellors, families, and cultural brokers. Working within schools addresses the barrier that refugee families may not access specialist mental health services independently due to stigma, lack of awareness, or system navigation difficulties (Spaas et al., 2022).
- **LGBTQ+ Youth Services (UK):** A UK-wide mapping identified 111 LGBTQ+ youth mental health services, predominantly in the voluntary sector, offering drop-in, peer support, and counselling. Services valued by young people included self-referral, affirming spaces, peer support, and practitioners with LGBTQ+ competency. The study identified a five-category

service typology and highlighted the critical role of voluntary sector provision in filling gaps in statutory services (McDermott et al., 2024; Pryjmachuk et al., 2024).

- **CBT Skills Group for Unaccompanied Asylum-Seeking Children (UK):** A specialist CAMHS service developed a trauma-informed psychological skills group for unaccompanied minors, integrating elements from DBT, CFT, and ACT with cultural adaptations. Key features included interpreter support, open group format allowing flexible attendance, and content addressing physical health, emotional wellbeing, and resilience. The approach demonstrated high acceptability (92% attendance) and preliminary effectiveness for PTSD symptoms (King & Said, 2019).
- **Youth Advocate Programme (Ireland):** Jigsaw's Youth Advocate programme embeds young people with lived experience within national youth mental health services. Youth Advocates co-facilitate groups, contribute to service design, and provide peer support. The participatory action research approach used COM-B and Lundy models to ensure meaningful youth participation in service development (Carey et al., 2025).

Access Barriers Addressed

Solutions for youth primarily targeted:

- Stigma and confidentiality concerns — via anonymous services, self-referral, youth-friendly environments, and peer involvement;
- Long waiting times — via digital solutions increasing capacity, walk-in models, and streamlined referral pathways;
- Service fragmentation — via single points of access, integrated care models, and multi-agency platforms;
- Transition gaps between child and adult services — via extended age ranges (12–25, 14–25, 10–35);
- Lack of awareness — via school-based programmes, community outreach, and digital presence;
- Cultural and language barriers — via adapted interventions, interpreter provision, and culturally competent practitioners (particularly for refugee youth and LGBTQ+ youth).

Implementation Insights

Key enablers identified were:

- Co-design with young people throughout service development;
- Youth-friendly environments and communication styles;
- Flexible access options (no referral required, walk-in, digital alternatives);
- Peer worker involvement reducing power imbalances;
- Multi-agency partnerships enabling integrated pathways;
- Extended age ranges preventing transition cliff-edges.

Key challenges identified were:

- Sustaining volunteer and peer worker workforces;
- Integrating low-threshold services with statutory provision while maintaining clinical governance;
- Managing demand once low-threshold services become known;
- Ensuring services reach underrepresented groups (males, lower-educated youth, ethnic minorities) — requiring proactive outreach adaptations;

- Balancing informality with appropriate safeguarding - Securing sustainable funding beyond pilot phases.

Finally, we would like to note cross-references:

- Studies addressing youth within migrant/refugee populations are discussed further in Section 3.2.2 (Migrants, refugees, asylum seekers);
- LGBTQ+ youth services are also addressed in Section 3.2.4 (LGBTQIA+ populations).

3.2.2 Migrants, refugees, and asylum seekers

Overview

Sixteen studies (29%) primarily addressed migrants, refugees, asylum seekers, or unaccompanied minors (see Section 3.1.3 for full reference list). An additional three studies addressed migrant populations as secondary within broader samples: Michaud et al. (2020) examined primary care mental health for migrant adolescents; Bechdolf et al. (2024) reported that youth mental health services reached young people with migration backgrounds; and Van Everdingen et al. (2021) found that 39% of homeless service users had non-Western migration backgrounds. Studies were concentrated in Germany (4 studies), the Netherlands (3), Switzerland (2), and France (2), with additional representation from Belgium, Sweden, the UK, and Türkiye. Service types included culturally adapted digital interventions, task-shifting programmes using lay helpers, stepped-care models, screening and assessment services, and capacity building initiatives.

Solution Mechanisms

Solutions for migrants and refugees emphasised cultural and linguistic adaptation, task-shifting to address workforce gaps, integrated care coordination, and digital approaches to extend reach. Key mechanisms included:

- **Language-concordant services:** Native-speaker clinicians (Bajbouj et al., 2021), professional interpreters with mental health training (Carballeira Carrera et al., 2020; Trilesnik et al., 2019), multilingual digital tools (Reich et al., 2024; Aeschlimann et al., 2025; Meurling et al., 2023), and Arabic-speaking lay helpers (de Graaff et al., 2023; Surkan et al., 2024) addressed language barriers as a fundamental prerequisite for effective mental health care.
- **Cultural adaptation of interventions:** Systematic cultural adaptation of evidence-based interventions using established frameworks ensured cultural relevance while maintaining therapeutic fidelity. Examples included the RECAPT framework for adapting a grief app for Syrian refugees (Aeschlimann et al., 2025), culturally adapted Problem Management Plus (PM+) for Arabic speakers (de Graaff et al., 2023; Surkan et al., 2024), and transcultural psychiatric consultation models integrating ethnopsychiatric approaches (Carballeira Carrera et al., 2020).
- **Task-shifting to lay helpers:** Problem Management Plus (PM+) delivered by trained non-specialist helpers demonstrated effectiveness for refugees with psychological distress, addressing workforce shortages while providing culturally concordant support. The model uses community members who share language and cultural background with recipients, with structured training (typically 80 hours) and ongoing supervision by mental health professionals (de Graaff et al., 2023; Spaaij et al., 2022; Surkan et al., 2024). Elbert et al. (2017) proposed a cascade training model with multiple tiers of lay workers for refugee trauma therapy.
- **Stepped-care models:** Tiered systems providing screening, brief intervention, and specialist referral ensured appropriate allocation of scarce specialist resources. The RefuKey model

linked low-threshold psychosocial counselling centres near refugee reception facilities with psychiatric clinics as specialist competence centres (Trilesnik et al., 2019). The Berlin Clearing Clinic provided centralised triage and coordination (Bajbouj et al., 2021).

- **Digital screening and self-help:** Online and app-based tools addressed access barriers by enabling screening in multiple languages (Meurling et al., 2023; Schmidt et al., 2023), providing culturally adapted psychoeducation and self-help (Reich et al., 2024; Aeschlimann et al., 2025), and reaching refugees who might not access in-person services due to stigma, mobility, or geographic barriers.
- **Capacity building at scale:** The mhGAP programme in Türkiye trained 1,468 primary care physicians to deliver basic mental health care to Syrian refugees, demonstrating scalable workforce expansion through brief standardised training (Karaoğlan Kahiloğulları et al., 2020).

Key Exemplars

- **Problem Management Plus (PM+, Netherlands/France)**: A WHO-developed brief psychological intervention (5 weekly 90-minute sessions) delivered by trained non-specialist helpers to refugees with elevated psychological distress. RCT evidence from the Netherlands showed significant reductions in psychological distress compared to care-as-usual, with effects maintained at follow-up (de Graaff et al., 2023). A pilot RCT in France demonstrated feasibility and acceptability among Arabic-speaking refugees in accommodation centres (Surkan et al., 2024). Key success factors included: structured helper training (80 hours), weekly clinical supervision, cultural adaptation of materials, and recruitment of helpers sharing language and cultural background with participants. The programme demonstrates that effective mental health support can be delivered at scale without relying solely on specialist clinicians.
- **Berlin Clearing Clinic (Germany)**: A central access point (‘Clearing Stelle’) for newly arrived refugees providing low-threshold psychiatric assessment by a multidisciplinary team including a native Arabic-speaking psychiatrist. Located centrally in Berlin near former refugee accommodation, the clinic provides same-day assessment, brief stabilisation, on-site medication provision, and coordinated referral to appropriate services. Over 3,000 cases were seen in the initial implementation period. Key innovations included: low-threshold access without appointment, video-based interpreter service covering 36 languages, short-term group psychotherapy, and specialised women’s services with Arabic/Farsi-speaking female providers. The model addressed both language barriers and service navigation challenges (Bajbouj et al., 2021).
- **RefuKey Stepped-Care Model (Germany)**: A need-adapted stepped-care model linking psychosocial counselling centres (PCCs) located near refugee reception facilities with psychiatric clinics as cooperating competence centres. Low-threshold services (open counselling hours, no referral required) in PCCs provide initial support, with clear pathways to specialist psychiatric-psychotherapeutic treatment when needed. Professional interpreters funded by the project addressed language barriers. The model demonstrated successful integration of low-threshold community services with specialist care (Trilesnik et al., 2019).
- **mhGAP Training Programme (Türkiye)**: Adaptation of the WHO Mental Health Gap Action Programme to train primary care physicians serving Syrian refugees. Over 1,468 Turkish and Syrian doctors were trained through standardised 5-day courses covering depression, psychosis, anxiety/stress disorders, suicide, and child/adolescent mental disorders. Post-training assessments showed significant knowledge gains. The programme operated through Refugee Health Training Centres in provinces hosting large refugee populations. This exemplar demonstrates macro-level capacity building to address access gaps at population

scale in a country hosting over 3.6 million Syrian refugees (Karaoğlan Kahiloğulları et al., 2020).

- **iFightDepression Digital Tool (Germany)**: A culturally adapted, guided online self-management programme for refugees with depressive symptoms, available in Arabic, Farsi/Dari, and other languages. The tool provides psychoeducation, behavioural activation exercises, and mood monitoring. Healthcare providers receive training to guide users through the programme. Implementation included targeted outreach through refugee centres, psychosocial centres, and professional networks. The programme was provided free of charge through the European Alliance Against Depression (Reich et al., 2024).
- **Multilingual Online Screening (Sweden)**: A tiered online screening procedure for identifying mental health problems among refugees, available in five languages (Arabic, Swedish, Dari, Farsi, English). The anonymous questionnaire approach addressed stigma barriers, while multilingual delivery addressed language access. The model demonstrated feasibility of reaching refugees through digital channels for mental health screening and triage (Meurling et al., 2023).

Access Barriers Addressed

Solutions primarily targeted:

- Language barriers — via interpreters, language-concordant clinicians and lay helpers, multilingual digital tools, and translated materials;
- Cultural mistrust and unfamiliarity with Western mental health concepts — via cultural adaptation of interventions, community engagement, peer/lay helper delivery, and ethnopsychiatric approaches;
- Workforce shortages — via task-shifting to trained non-specialists, cascade training models, and mhGAP capacity building;
- Service fragmentation and navigational complexity — via central access points, stepped-care coordination, and integrated referral pathways;
- Stigma — via anonymous screening tools, community-based delivery, and normalisation through peer support;
- Geographic barriers and mobility — via digital tools, co-location in refugee accommodation settings, and decentralised service delivery.

Implementation Insights

Key enablers identified were:

- Involvement of community members in design and delivery, including as lay helpers and cultural mediators;
- Adequate time and resources for systematic cultural adaptation;
- Structured training and regular clinical supervision for non-specialists;
- Co-location of services in settings refugees already access (reception centres, accommodation, community venues);
- Multi-language capacity through interpreters, bilingual staff, or digital tools;
- Partnership with refugee community organisations and trusted institutions.

Key challenges identified were:

- High mobility of refugee populations affecting service continuity and follow-up;
- Interpreter availability, quality, and cost (particularly for less common languages);

- Risk of trauma re-activation during assessment, requiring trauma-informed approaches;
- Sustainability of project-funded services beyond initial implementation;
- Balancing fidelity to evidence-based interventions with cultural adaptation;
- Legal and administrative barriers affecting eligibility for services;
- Addressing the mental health needs of undocumented migrants who may avoid formal services.

Finally, we would like to note cross-references:

- Studies addressing refugee children and unaccompanied minors are also discussed in Section 3.2.1 (Children, adolescents, youth);
- Older migrants are addressed in Section 3.2.5 (Older adults), including Schoenmakers et al. (2017) which examined help-seeking among older Turkish and Moroccan migrants.

3.2.3 LGBTQIA+, transgender, and non-binary people

Overview

Four studies (7%) primarily addressed LGBTQIA+, transgender, or non-binary populations (see Section 3.1.3 for full reference list): Baleige et al. (2022) on transgender-affirming primary care in France; Lelutiu-Weinberger et al. (2023) on LGBTQ-affirmative provider training in Romania; McDermott et al. (2024) on LGBTQ+ youth mental health services in the UK; and Nieder et al. (2024) on e-health interventions for transgender individuals in Germany.

Additionally, multiple youth-focused studies (Section 3.2.1) included LGBTQ+ young people as secondary populations or reported on LGBTQ+ subgroups within their samples. These included: Pryjmachuk et al. (2024), whose linked study focused on LGBTQ+ youth; Smith et al. (2024), noting LGBTQ+ young people as a higher-risk group; Bechdolf et al. (2024; 2025), whose youth mental health services explicitly included LGBTQIA+ young people in their target populations; Carey et al. (2025), which included LGBTQI+ young people; and Crombach et al. (2025), whose sample included 8.5% non-binary participants. This overlap reflects that LGBTQ+ youth face compounded barriers at the intersection of age and sexual/gender minority status.

Studies were from the UK, France, Germany, Romania, and the Netherlands. Service types included LGBTQ-affirmative provider training, informed consent models for gender-affirming care, dedicated e-health interventions, community-based LGBTQ+ youth services, and principles-based service design guidance.

Solution Mechanisms

Solutions emphasised provider training, organisational change to create LGBTQ-affirmative environments, and specific adaptations to address minority stress and discrimination-related barriers:

- **LGBTQ-affirmative provider training:** Structured training programmes for mental health providers to develop competence in working with LGBTQ+ populations. The Romanian programme (Lelutiu-Weinberger et al., 2023) provided two-day training covering minority stress theory, LGBTQ-affirmative therapy principles, and integration with cognitive-behavioural approaches, with optional ongoing supervision. Training addressed both knowledge gaps and attitudinal barriers in settings with limited societal LGBTQ+ acceptance.
- **Informed consent models for gender-affirming care:** The Lille model (Baleige et al., 2022) replaced psychiatric gatekeeping with primary care coordination based on free and informed consent. Transgender individuals access transition support through primary care without

mandatory psychiatric diagnosis, supported by a harm reduction perspective. This approach aligns with ICD-11's removal of transgender diagnoses from the mental disorders chapter.

- **Trans-specific e-health interventions:** The i²TransHealth programme (Nieder et al., 2024) provided video consultations with trained therapists for transgender, non-binary, and gender diverse individuals in remote areas, addressing geographic barriers to specialist gender-affirming care. The intervention combined digital delivery with TGD-informed mental health support.
- **LGBTQ+ youth service mapping and principles:** McDermott et al. (2024) mapped 111 LGBTQ+ youth mental health services across the UK and developed 13 evidence-based principles for LGBTQ+ youth mental health services organised around five domains: Time (allowing adequate time), People (who delivers care), Body (physical safety), Space (environment), and additional structural principles. The typology identified five service categories ranging from LGBTQ+-specific youth organisations to NHS services with LGBTQ+ components.
- **Inclusive youth service design**: Pryjmachuk et al. (2024) examined how mainstream youth mental health services can better include LGBTQ+ young people through visible representation, staff training, and tailored pathways. The study emphasised self-referral, voluntary sector partnerships, and service design responsive to LGBTQ+ needs.
- **Community-led and user-involved approaches:** Multiple studies emphasised the involvement of LGBTQ+ community members in service design and delivery. The Lille model included a Trans Users Committee and Trans Health Collective with transgender co-researchers (Baleige et al., 2022). Youth services valued peer support from LGBTQ+ individuals with lived experience (McDermott et al., 2024).

Key Exemplars

- **LGBTQ-Affirmative Provider Training (Romania):** A structured two-day training programme for psychologists and psychiatrists in a context with limited societal LGBTQ+ acceptance. Training covered minority stress theory, affirmative practice principles, appropriate language use, and practical clinical skills, integrating LGBTQ-affirmative approaches with cognitive-behavioural therapy. An optional 8-month supervision component provided ongoing support through monthly online sessions. Evaluation showed improved provider knowledge, attitudes, and self-efficacy. The model demonstrates that provider-level change can improve access even in challenging policy environments where system-level advocacy may be difficult (Lelutiu-Weinberger et al., 2023).
- **Trans Health Collective / Informed Consent Model (France):** A network of four interconnected organisations in Lille providing transgender-affirming care aligned with ICD-11 depsychopathologisation. The model includes: (1) a primary care centre (MDS) providing transition support based on informed consent without psychiatric gatekeeping; (2) a Trans Health Collective (CST) developing experiential knowledge and organising care pathways; (3) a Trans Users Committee (CUT) empowering users through citizen workshops; and (4) an experimental community mental health service at a WHO Collaborating Centre. The approach shifts coordination from tertiary psychiatric services to primary care, with mental health support available but not mandatory. Key innovations include peer support worker integration, participatory research with transgender co-researchers, and alignment with human rights frameworks (Baleige et al., 2022).
- **i²TransHealth E-Health Intervention (Germany):** A telehealth programme providing bi-weekly video consultations with trained therapists for transgender, non-binary, and gender diverse (TGD) individuals. The intervention addressed geographic barriers preventing access

to specialist gender-affirming mental health care, particularly for TGD individuals in remote areas who would otherwise face significant travel burdens. The programme was delivered through a University Medical Centre with a regional physician network across six locations. The model demonstrates how digital delivery can extend specialist care to underserved populations (Nieder et al., 2024).

- **13 Principles for LGBTQ+ Youth Mental Health Services (UK):** Based on UK-wide service mapping (111 services) and qualitative research with LGBTQ+ young people, practitioners, and researchers, McDermott et al. (2024) developed 13 evidence-based principles organised into five domains. Core principles include: providing adequate time for appointments; ensuring practitioners have LGBTQ+ knowledge and create affirming relationships; attending to physical safety and bodily autonomy; creating welcoming spaces with visible LGBTQ+ representation; and addressing structural factors including self-referral access, links with LGBTQ+ community organisations, and explicit anti-discrimination policies. The service typology identified the critical role of voluntary sector LGBTQ+-specific organisations in filling gaps in statutory provision.

Access Barriers Addressed

Solutions targeted barriers such as:

- Provider lack of knowledge and competence — via structured training programmes, supervision, and principles-based guidance;
- Fear of discrimination in services — via visible signals of inclusion, staff training, affirming environments, and LGBTQ+-specific services;
- Pathologisation of LGBTQ+ identities — via informed consent models removing psychiatric gatekeeping, alignment with ICD-11 depsychopathologisation;
- Gatekeeping in gender-affirming care — via primary care coordination replacing mandatory psychiatric assessment;
- Geographic barriers to specialist care — via e-health/telehealth extending reach to remote areas;
- Lack of visible LGBTQ+ inclusion in mainstream services — via representation, dedicated pathways, and community partnerships;
- Minority stress and discrimination-related distress — via affirmative approaches addressing underlying causes of mental health difficulties.

Implementation Insights

Key enablers identified were:

- Involvement of LGBTQ+ community members in service design, delivery, and research (including as co-researchers and peer workers);
- Visible signals of inclusion (signage, materials, representation);
- Staff training covering minority stress, appropriate language, and affirmative practice;
- Self-referral options avoiding disclosure to gatekeepers;
- Partnerships between statutory services and voluntary sector LGBTQ+ organisations;
- Alignment with evolving policy frameworks (ICD-11, human rights principles);
- Dedicated pathways where mainstream services cannot provide affirming care.

Key challenges identified were:

- Hostile policy environments in some countries limiting system-level change (requiring focus on provider-level interventions);
- Provider resistance or discomfort, particularly in settings with limited LGBTQ+ acceptance;
- Balancing mainstream inclusion with need for specialist LGBTQ+-specific provision;
- Sustainability of voluntary sector services dependent on precarious funding;
- Tensions between medical models and community-led approaches to gender-affirming care;
- Ensuring rural/remote access where specialist services are concentrated in urban areas;
- Addressing intersecting vulnerabilities (e.g., LGBTQ+ young people, LGBTQ+ migrants).

We also noted cross-references, LGBTQ+ youth services are also discussed in Section 3.2.1 (Children, adolescents, youth), reflecting the significant overlap between these population categories. McDermott et al. (2024) and Pryjmachuk et al. (2024) are discussed in both sections given their dual focus on youth and LGBTQ+ populations.

3.2.4 Ethnic and religious minorities

Overview

Four studies (7%) primarily addressed ethnic or religious minorities (see Section 3.1.3 for full reference list): Alfayumi-Zeadna et al. (2025) on Bedouin women in Israel; Edge et al. (2018) on African-Caribbean families in the UK; Keogh et al. (2020) on Irish Travellers; and Stockwell et al. (2025), a systematic review on Black men's mental health. Studies were from the UK, Ireland, and Israel.

Several additional studies included ethnic minority populations as secondary groups or reported on ethnic diversity within their samples. Smith et al. (2025) explicitly noted ethnic and religious minorities as a secondary population in their youth mental health study. Carey et al. (2025) identified marginalised groups including ethnic minorities among those reached by youth advocate programmes. Carballeira Carrera et al. (2020), while primarily classified as addressing migrants, focused on transcultural psychiatric consultations serving ethnic minorities within migrant communities. Youth studies such as Bechdolf et al. (2024, 2025) and Crombach et al. (2025) recruited ethnically diverse samples, with 32% of Crombach's participants born outside the Netherlands.

This relatively small primary evidence base (7%) represents a notable gap, given the documented mental health inequalities facing ethnic minority populations across Europe.

Solution Mechanisms

Solutions emphasised culturally adapted interventions, community-based delivery through trusted settings and personnel, and dedicated bridging roles between communities and services:

- **Culturally adapted therapy:** The Culturally-adapted Family Intervention (CaFI) for African-Caribbean families affected by psychosis systematically adapted evidence-based family therapy to incorporate cultural explanatory models, address experiences of racism and discrimination, acknowledge spirituality, and reflect African-Caribbean family structures. Adaptations were developed with community stakeholder involvement while maintaining therapeutic fidelity (Edge et al., 2018).
- **Community-based peer support:** Peer support programmes delivered by trained community members addressed barriers of mistrust and cultural distance from formal services. The Mom-to-Mom (M2M) programme for Bedouin women trained community paraprofessionals to provide peer support for postpartum depression, delivered in Arabic through home visits,

group sessions, and a dedicated community centre (Alfayumi-Zeadna et al., 2025). Stockwell et al. (2025) identified peer support and community-based approaches as key mechanisms in interventions for Black men.

- **Dedicated community liaison roles:** The Traveller Mental Health Liaison Nurse (TMHLN) role created a dedicated bridge between Irish Traveller communities and mental health services, combining direct support with cultural capacity-building for mainstream staff (Keogh et al., 2020). This role operated within Traveller health projects and community structures, ensuring cultural legitimacy.
- **Non-traditional intervention formats:** Stockwell et al. (2025) found that effective interventions for Black men often used non-traditional formats including exercise programmes, arts-based approaches (photography, theatre), social media, and health literacy sessions rather than conventional mental health treatment formats. These approaches reduced stigma by framing support outside medical/psychiatric frameworks.
- **Community engagement and co-design:** All four primary studies emphasised community involvement in intervention design and delivery. Edge et al. (2018) involved community stakeholders in developing cultural adaptations; Alfayumi-Zeadna et al. (2025) partnered with religious leaders and community organisations; Keogh et al. (2020) embedded services within Traveller health structures; and Stockwell et al. (2025) identified community engagement as a cross-cutting enabler.

Key Exemplars

- **CaFI – Culturally-adapted Family Intervention (UK):** Adaptation of evidence-based family intervention (Barrowclough & Tarrier CBT model) for African-Caribbean families affected by schizophrenia and psychosis. The 10-session intervention, delivered by pairs of trained therapists, maintained core components (assessment, psychoeducation, stress management, coping skills, problem-solving) while incorporating cultural adaptations addressing: racism and discrimination experiences; spirituality and religious beliefs; African-Caribbean family structures and kinship patterns; cultural identity; and historical context of Black communities' experiences with psychiatric services. A key innovation was the use of Family Support Members (FSMs) as 'proxy families' when biological family involvement was not possible. The pilot RCT demonstrated feasibility, acceptability, and promising clinical outcomes. The model addresses the well-documented over-representation of African-Caribbean people in restrictive psychiatric care and their under-representation in psychological therapy (Edge et al., 2018).
- **Mom-to-Mom Programme for Bedouin Women (Israel):** A structured peer-support programme culturally adapted for Arab Bedouin women experiencing postpartum depression. The programme established the first dedicated M2M Centre in a Bedouin village, co-located with Maternal Child Health clinics and Early Childhood Centres to normalise access. Key adaptations included: all materials in Arabic; female Bedouin professionals and paraprofessionals only; choice of individual or group support via home visits, clinic attendance, phone, or video; confidentiality protocols addressing stigma concerns; and community events involving religious leaders to build legitimacy. The intervention significantly reduced PPD symptoms (31% to 18% above clinical threshold), with 89% retention over one year. Notably, 23% of participants were successfully referred to mental health services, demonstrating the programme's role as a pathway to formal care (Alfayumi-Zeadna et al., 2025).
- **Traveller Mental Health Liaison Nurse (Ireland):** A specialist nursing role introduced in 2014 to bridge between Irish Traveller communities and mental health services in the South-East region. The TMHLN works within Traveller Health Units and Community Health Projects, providing: direct one-to-one support; Traveller Wellbeing Group sessions; referral and

signposting to mental health services; information exchange between communities and services; cultural capacity-building for mainstream mental health staff; and stigma reduction activities. The role is embedded within existing Traveller health infrastructure, ensuring cultural legitimacy and trust. Multi-stakeholder partnerships include Traveller Health Office, Public Health Nurses, Local Mental Health Services, voluntary mental health organisations, and Traveller Community Health Projects (Keogh et al., 2020).

- **Interventions for Black Men (UK/USA – Systematic Review):** Stockwell et al. (2025) synthesised evidence on mental health and wellbeing interventions for Black men, identifying five studies using diverse approaches: resistance training/exercise; online behavioural health via social media; health literacy educational sessions; photography-based mental health conversations; and arts-based community programmes. All interventions were recreational, lifestyle-based, or educational rather than traditional mental health treatment formats. Key mechanisms included peer support, community-based delivery, non-clinical framing, and approaches that aligned with constructs of masculinity emphasising strength and self-improvement. The review highlighted the limited evidence base and the need for interventions that address structural racism and intersecting barriers facing Black men.

Access Barriers Addressed

Solutions targeted a range of barriers, including:

- Cultural mistrust of mental health services — via community-based delivery, peer support from community members, and embedding services within trusted community structures;
- Lack of cultural relevance of standard interventions — via systematic cultural adaptation of evidence-based approaches;
- Stigma within communities — via non-clinical framing, confidential delivery, involvement of community leaders, and normalisation through co-location with general health services;
- Historical experiences of discrimination in healthcare — via explicit acknowledgment of racism in therapeutic content and workforce diversification;
- Lack of representation in workforce — via training and employing community members as peer supporters, paraprofessionals, and liaison workers;
- Geographic and structural barriers — via community-based delivery, home visits, and flexible access options (particularly for Bedouin women in remote areas).

Implementation Insights

Key enablers identified were:

- Deep community involvement in design, delivery, and governance;
- Employment and training of community members as peer supporters and paraprofessionals;
- Embedding services within existing trusted community structures and settings;
- Systematic cultural adaptation while maintaining therapeutic fidelity;
- Partnership with community leaders (including religious leaders) to build legitimacy;
- Flexible delivery formats respecting community preferences;
- Non-clinical framing to reduce stigma;
- Explicit acknowledgment of racism and discrimination in therapeutic approaches.

Key challenges identified were:

- Limited evidence base for ethnic minority mental health interventions in Europe (majority of evidence from USA);

- Heterogeneity of ethnic minority populations requiring tailored approaches;
- Sustainability of community-based programmes dependent on dedicated funding;
- Balancing cultural adaptation with evidence-based practice requirements;
- Addressing intersecting barriers (e.g., ethnicity + gender + socioeconomic disadvantage);
- Engaging men from ethnic minority backgrounds who may avoid mental health services;
- Building trust in contexts of historical mistreatment by healthcare systems.

We would also like to note the following cross-references. Studies addressing ethnic minorities within migrant populations are discussed in Section 3.2.2 (Migrants, refugees, asylum seekers), including Carballeira Carrera et al. (2020) on transcultural psychiatric consultations. Youth studies with ethnically diverse samples are discussed in Section 3.2.1.

3.2.5 People with disabilities

Overview

No studies prioritised in this review (0%) primarily addressed people with physical or neurodevelopmental disabilities (see Section 3.1.3). However, several youth-focused studies (Section 3.2.1) included children and young people with neurodevelopmental conditions as secondary populations or addressed disability-related needs within their samples:

- Burbach & Stiles (2021) — G3 Youth primary, with neurodevelopmental conditions (autism, ADHD) as secondary focus; evaluated digital mental health and neurodevelopmental assessment services;
- Price et al. (2019) — G3 Youth primary, with ADHD as secondary; examined information needs during CAMHS-to-adult transition for young people with ADHD;
- Parr et al. (2024) — G3 Youth primary, with autism as secondary; national survey of childhood autism assessment services;
- Gee et al. (2024) — G3 Youth primary; noted 11.8% of users had disabilities; evaluated digital anxiety intervention (Lumi Nova app);
- Gilmour et al. (2022) — G3 Youth primary; included young people with ADHD and ASD in online therapy service evaluation;
- Leijdesdorff et al. (2021) — G3 Youth primary; mentioned LGBTQ+ youth and those with intellectual disabilities among @ease service users.

The majority of relevant evidence thus concerns neurodevelopmental conditions (autism, ADHD) in children and young people, with solutions addressing assessment, post-diagnostic support, and transition services. Studies were predominantly from the UK.

Solution Mechanisms (from secondary population evidence)

Solutions for people with neurodevelopmental conditions emphasised digital delivery, adapted interventions, and transition support:

- **Digital assessment and therapy:** Remote assessment platforms for autism and ADHD reduced waiting times and addressed geographic barriers to specialist services. Burbach & Stiles (2021) evaluated Healios, a digital platform delivering video-based assessment and therapy for children with mental health and neurodevelopmental conditions, demonstrating feasibility of remote diagnosis and post-diagnostic support. Gilmour et al. (2022) found that online CBT services could effectively reach young people with ADHD and ASD.

- **Adapted digital interventions:** Gee et al. (2024) evaluated Lumi Nova, a prescription-only digital therapeutic using immersive gaming technology to deliver exposure-based anxiety treatment for children aged 7–12. The app was designed to be engaging and accessible, with 11.8% of users having disabilities. Real-world evaluation showed significant anxiety reduction, demonstrating potential for digitally-delivered adapted interventions.
- **Transition support:** Price et al. (2019) identified critical information needs for young people with ADHD transitioning from CAMHS to adult services. Key findings included: young people often unaware that ADHD persists into adulthood; inadequate information about adult services; lack of GP knowledge about adult ADHD; and need for developmentally appropriate, ADHD-accessible information formats. Recommendations included earlier transition preparation, written information resources, and improved GP training.
- **Assessment pathway improvements:** Parr et al. (2024) surveyed UK childhood autism assessment services, identifying opportunities to reduce waiting times, improve diagnostic consistency, and enhance post-diagnostic support. Key challenges included long waiting lists, variability in diagnostic practice, and inadequate post-diagnostic provision.

Key Exemplars (from secondary population evidence)

- **Healios Digital Neurodevelopmental Services (UK):** A video-based platform providing remote assessment and therapy for children with mental health and neurodevelopmental conditions. Services include autism and ADHD assessment, post-diagnostic support, and evidence-based therapies delivered via video consultation. The platform enables access regardless of geographic location, addressing barriers faced by families in areas with limited specialist provision. Case-based evaluation demonstrated feasibility, acceptability, and clinical utility, with families valuing reduced travel burden and increased flexibility (Burbach & Stiles, 2021).
- **Lumi Nova App (UK):** A prescription digital therapeutic using immersive gaming technology to deliver exposure-based anxiety treatment for children aged 7–12. The app, developed through NHS innovation partnerships, provides gamified CBT content that children can engage with independently. Real-world evaluation with 644 children showed significant anxiety reduction (d=0.8), with effectiveness consistent across deprivation levels. The platform demonstrates potential for digitally-delivered interventions that may be more accessible and engaging for children with neurodevelopmental conditions (Gee et al., 2024).
- **ADHD Transition Information Needs (UK):** Price et al. (2019) conducted qualitative research with young people with ADHD at different transition stages, identifying critical information gaps. Solutions identified include: providing information earlier in CAMHS (not just at transition point); offering multiple formats including websites, apps, and videos suitable for those with attention difficulties; addressing misconceptions about ADHD persistence; involving young people in information design; and improving GP knowledge about adult ADHD services. The study provides an evidence-based framework for improving transition support.

Access Barriers Addressed

Solutions from secondary evidence targeted:

- Long waiting times for assessment — via digital platforms increasing assessment capacity;
- Geographic barriers to specialist services — via remote video-based assessment and therapy;
- Lack of adapted interventions — via digitally-delivered, gamified approaches suitable for neurodevelopmental profiles;

- Poor transition between child and adult services — via earlier preparation, better information provision, and improved adult service awareness;
- Inadequate post-diagnostic support — via integrated pathways from assessment to ongoing care;
- Information access barriers — via developmentally appropriate, ADHD-accessible formats.

Implementation Insights

Key enablers identified were:

- Digital platforms enabling remote delivery and reducing geographic barriers;
- Gamified approaches increasing engagement for children with neurodevelopmental conditions;
- Multi-format information provision (visual, interactive, not just text-based);
- Integration of assessment with post-diagnostic support pathways;
- Earlier transition preparation beginning well before service boundaries.

Key challenges identified were:

- Long waiting lists for assessment services - Variability in diagnostic practice and service provision - Inadequate adult services for conditions historically seen as childhood-only (especially ADHD) - Digital exclusion affecting some families - Limited evidence base for adapted interventions for adults with disabilities - Absence of evidence addressing physical disabilities and mental health access.

We would also like to not cross-references. Studies addressing neurodevelopmental conditions in young people are discussed in Section 3.2.1 (Children, adolescents, youth), where they are classified as primary youth studies.

Note on classification: The original report listed 10 studies (18%) as addressing people with disabilities. This figure included youth studies where neurodevelopmental conditions were secondary populations. The corrected classification recognises these as G3 (Youth) primary, resulting in 0 primary G6 (Disabilities) studies. This reclassification does not diminish the relevance of these studies to people with disabilities, but more accurately reflects their primary population focus.

3.2.6 Socioeconomically disadvantaged, including rural populations

Overview

Two studies (4%) primarily addressed socioeconomically disadvantaged or rural populations (see Section 3.1.3): Hassan et al. (2020) on social prescribing for people with mental health needs in deprived urban areas of North West England; and Saillant et al. (2020) on suicide prevention training for agricultural workers in rural Switzerland.

However, socioeconomic disadvantage featured as a secondary characteristic in numerous studies, reflecting the intersection of poverty and deprivation with other vulnerabilities. Studies explicitly noting socioeconomic disadvantage as a secondary population included:

- Freţian et al. (2023) — G3 Youth primary; school-based mental health literacy in schools with higher proportions of socioeconomically disadvantaged students;
- Ganga et al. (2024) — G3 Youth primary; digital CAMHS referral platform serving high-deprivation areas (Liverpool/Sefton);

- Gee et al. (2024) — G3 Youth primary; noted children from most deprived areas less likely to complete digital anxiety intervention;
- Santa et al. (2024) — G3 Youth primary; serving area where over half of children live in poverty;
- Koet et al. (2024) — G3 Youth primary; collaborative care in disadvantaged areas with high immigrant populations;
- Alfayumi-Zeadna et al. (2025) — G2 Ethnic minorities primary; Bedouin population with high unemployment and lack of infrastructure;
- Surkan et al. (2024) — G1 Migrants primary; refugees in accommodation centres facing economic hardship.

Additionally, several studies addressed rural or geographic access barriers as part of their solution design, including: Nieder et al. (2024) using telehealth for transgender individuals in remote areas; Porter et al. (2022) evaluating online therapy across geographically dispersed NHS trusts; Gilmour et al. (2022) providing video-based assessment reducing travel burden; and Holmen et al. (2023) describing low-threshold services accessible regardless of location.

The small number of primary studies (4%) reflects that socioeconomic disadvantage more often intersects with other vulnerabilities (youth, ethnicity, migration status) rather than serving as the primary classification criterion.

Solution Mechanisms

Solutions for socioeconomically disadvantaged and rural populations emphasised community-based delivery, social determinants approaches, digital solutions for geographic access, and gatekeeper training:

- **Community-based social prescribing:** The Life Rooms model (Hassan et al., 2020) provided social prescribing within disadvantaged communities, offering non-clinical community spaces with multiple support pathways including Recovery College courses, pathways advice (housing, debt, employment), volunteering opportunities, and safe spaces with community resources. The model addressed the social determinants of mental health rather than focusing solely on clinical intervention.
- **Gatekeeper training in rural settings:** The Sentinel Programme (Saillant et al., 2020) trained agricultural community members (farmers, veterinarians, milk controllers, technical advisors) to recognise and respond to mental health difficulties and suicide risk among agricultural workers. This addressed the challenge of limited mental health services in rural areas by building capacity within existing community networks.
- **Digital solutions for geographic access:** Multiple studies (discussed in Section 3.2.1) used digital platforms to overcome geographic barriers, including: video-based therapy and assessment (Gilmour et al., 2022; Burbach & Stiles, 2021; Porter et al., 2022); telehealth for specialist care in remote areas (Nieder et al., 2024); and online self-help tools accessible regardless of location (Reich et al., 2024).
- **Integration with existing community structures:** Both primary studies embedded mental health support within existing community settings and networks rather than creating separate clinical services. Life Rooms operated within NHS trusts but in non-clinical community spaces; the Sentinel Programme trained people already embedded in agricultural communities.

Key Exemplars

- **Life Rooms Social Prescribing (UK):** A community-based service model in Liverpool and Sefton (North West England — among the most deprived areas in the UK) providing social prescribing for people with mental health needs. The model operates in non-clinical community settings offering: Recovery College with free courses on wellbeing, mental health management, and social/creative topics; Pathways advice service for housing, debt, and employment support; employment and volunteering opportunities; and safe spaces with community resources (library, computers, café). Key features include open access without formal referral requirements, co-production with service users and carers, and a holistic approach addressing social determinants of mental health. Evaluation showed Life Rooms addressed barriers including stigma (non-clinical setting), social isolation (community connections), and practical needs (housing, debt advice) that affect mental health recovery in disadvantaged communities (Hassan et al., 2020).
- **Sentinel Programme for Agricultural Workers (Switzerland):** A gatekeeper training programme for suicide prevention among agricultural populations in the cantons of Vaud and Neuchâtel. The programme trained 220 participants across nine half-day sessions, targeting people already embedded in agricultural communities: farmers, veterinarians, milk controllers, peer controllers, accountants, and technical advisors. Training content covered: recognising signs of distress; communication skills; resources and referral pathways; and sector-specific risk factors (income instability, climatic dependence, social isolation, access to firearms). Sessions were held in agricultural schools and farm buildings to maximise acceptability. The model addresses the challenge that rural agricultural populations face multiple barriers to mental health services (geographic distance, stigma, limited services) by building recognition and response capacity within existing community networks (Saillant et al., 2020).

Access Barriers Addressed

Solutions targeted barriers including:

- Geographic barriers and limited local services — via digital/telehealth solutions, training community gatekeepers, and embedding support in existing community settings;
- Stigma in small communities — via non-clinical service settings, community-based delivery, and normalising mental health through trusted community members;
- Social determinants of mental health — via holistic approaches addressing housing, debt, employment alongside mental health;
- Practical barriers (transport, time off work) — via flexible access, community-based locations, and digital options;
- Social isolation in rural areas — via community connections and group-based activities;
- Lack of mental health literacy — via gatekeeper training increasing recognition of difficulties within communities.

Implementation Insights

Key enablers identified were:

- Embedding services within existing community settings and networks;
- Non-clinical framing and environments reducing stigma;
- Co-production with service users and community members;
- Addressing social determinants alongside mental health;
- Training trusted community members as gatekeepers;

- Multi-sector partnerships (health, agriculture, social services);
- Flexible access without formal referral requirements;
- Digital options for geographically dispersed populations.

Key challenges identified were:

- Sustainability of community-based services dependent on continued funding;
- Reaching the most isolated individuals who may not engage with community programmes;
- Digital exclusion affecting those without internet access or digital literacy;
- Maintaining confidentiality in small rural communities where everyone knows each other;
- Limited specialist services for onward referral in rural areas;
- Economic pressures in agricultural communities affecting programme engagement;
- Measuring outcomes for social prescribing and community-based approaches.

We also note cross-references. Many studies in Sections 3.2.1–3.2.5 addressed populations experiencing socioeconomic disadvantage alongside other vulnerabilities. Digital solutions addressing geographic barriers are discussed throughout Section 3.2.

3.2.7 Older Adults

Overview

Three studies (5%) primarily addressed older adults (see Section 3.1.3 for full reference list): Adriaenssens et al. (2019) on policy analysis of mental health services for the elderly in Belgium with international comparison; Harty et al. (2023) on national digital CBT implementation in Ireland, which identified older adults as significantly underrepresented; and Venkataraman et al. (2024) on a remote biomarker-enhanced memory clinic for people with mild cognitive impairment in the UK.

Additionally, Schoenmakers et al. (2017) addressed the intersection of migration and ageing, examining psychosocial service access for elderly migrants (Turkish, Moroccan, Surinamese) in the Netherlands. This dual-coded study (G1 Migrants + G5 Older adults) is discussed in Section 3.2.2 but is also relevant here given its focus on barriers specific to older populations.

Studies were from Belgium, Ireland, the Netherlands, and the UK. The limited evidence base (5%) represents a significant gap, given Europe's ageing demographics — Belgium's population aged 65+ is projected to increase from 18.7% (2018) to 24.2% (2040), with similar trends across the region.

Solution Mechanisms

Solutions for older adults emphasised integrated care models, digital adaptations, remote service delivery, and attention to intersecting barriers:

- **Integrated care models for older adults:** Adriaenssens et al. (2019) identified effective organisational approaches from international comparison, including: collaborative care integrating primary care, specialist mental health, and geriatric services; mobile crisis teams and outreach services; stepped care approaches; community-based alternatives to institutional care; and the CARITAS principles (Comprehensive, Accessible, Responsive, Individualised, Transdisciplinary, Accountable, Systemic) as a framework for service design.
- **Digital mental health with age-specific considerations:** Harty et al. (2023) evaluated Ireland's national digital CBT service (SilverCloud), finding that while effective overall, older adults (65+) were severely underrepresented (2.3% of users vs 14.8% of population). This highlighted the need for targeted outreach and alternative access routes for digitally excluded

older adults. The study recommended awareness campaigns specifically targeting older populations and their healthcare providers.

- **Remote specialist services:** Venkataraman et al. (2024) developed a remote memory clinic (Brain Health Clinic) combining video consultations with biomarker-enhanced assessment for people with mild cognitive impairment. The service addressed long waiting times (13 weeks from referral to diagnosis) and travel burden for elderly patients. Notably, 27% could only complete telephone rather than video assessment, indicating the need for multiple modalities to accommodate varying digital capabilities.
- **Addressing intersecting barriers:** Schoenmakers et al. (2017) identified how age-specific barriers compound migration-related barriers for elderly migrants, including: low mental health literacy in both elderly individuals and their social networks; dependence on children for translation and navigation; stigma and taboo within communities; and assumptions that depression is a normal part of ageing. Recommendations included educating social networks and community-based mental health literacy initiatives.

Key Exemplars

- **CARITAS Framework and International Models (Belgium/International):** Adriaenssens et al. (2019) conducted a multi-modal policy analysis commissioned by Belgian federal authorities, combining literature review, stakeholder survey, and international comparison (England, France, Netherlands, Canada). The study identified the CARITAS principles as a guiding framework for mental healthcare for the elderly (MHCE): Comprehensive (addressing full range of needs), Accessible (geographically and financially), Responsive (timely), Individualised (person-centred), Transdisciplinary (integrated teams), Accountable (quality monitoring), and Systemic (addressing social determinants). The Chronic Care Model was identified as an effective organisational approach, emphasising community resources and policies; health system organisation; self-management support; delivery system design; decision support; and clinical information systems. Key recommendations included developing specific care networks for older adults (Belgium's 2010 mental health reform covered only ages 16–65), training workforce in geriatric mental health, and establishing mobile outreach and community-based services (Adriaenssens et al., 2019).
- **SilverCloud National Digital CBT Service (Ireland):** A national implementation of supported digital CBT through Ireland's Health Service Executive, with 5,298 referrals in the first year from 993 GPs across all 26 counties. The service demonstrated large effect sizes for depression (d=0.89) and anxiety (d=0.76) reduction with 48% reliable improvement. However, the evaluation identified critical access inequities: older adults (65+) comprised only 2.3% of users despite being 14.8% of the population, and males were underrepresented (25.7% vs ~50% population). The study provides a model for national-scale digital implementation while highlighting the need for complementary strategies to reach older adults who may face digital exclusion. Recommendations included targeted awareness campaigns for older adults and ensuring alternative access routes (Harty et al., 2023).
- **Brain Health Clinic — Remote Memory Assessment (UK):** An innovative service within South London and Maudsley NHS Foundation Trust providing biomarker-enhanced assessment for people with mild cognitive impairment (MCI) or early dementia. The clinic combines: remote cognitive assessments via telephone or video; biomarker testing (CSF analysis, genetic testing, automated MRI volumetrics, blood biomarkers); and online intervention groups (Cognitive Wellbeing Group for psychoeducation; Lifestyle Intervention Group for dementia prevention). In 146 referrals, the service achieved notable ethnic diversity (42–43% minoritised ethnicity vs 13% nationally), demonstrating that intentional service

design can address access inequities. Key features included satellite biomarker facilities to reduce travel, multiple assessment modalities (telephone/video), and integration across three memory services. The model addresses projected waiting times of 56–129 months for emerging disease-modifying therapies (Venkataraman et al., 2024).

Access Barriers Addressed

Solutions targeted barriers such as:

- Structural exclusion from mental health reforms — via policy advocacy and dedicated care networks for older adults (Belgian reform excluded ages 65+);
- Service fragmentation — via integrated collaborative care models spanning primary care, specialist mental health, and geriatric services;
- Long waiting times for assessment — via remote clinics and biomarker-enhanced pathways
- Geographic and travel barriers — via remote consultations, mobile outreach, and satellite facilities;
- Digital exclusion — via multiple modalities (telephone, video, in-person options) and targeted awareness campaigns;
- Workforce knowledge gaps — via specific training for GPs, psychologists, nurses in geriatric mental health;
- Stigma and normalisation of distress — via community education addressing misconceptions that mental health difficulties are inevitable in ageing;
- Intersecting migration and age barriers — via attention to language, cultural factors, and social network involvement.

Implementation Insights

Key enablers identified were:

- National-level policy commitment to older adult mental health (dedicated care networks, not just extensions of adult services);
- Integrated care models spanning multiple sectors (primary care, mental health, geriatric medicine, social care);
- Multiple access modalities accommodating varying digital capabilities;
- Training healthcare workforce specifically in geriatric mental health;
- Mobile and outreach services reducing travel burden;
- Community-based alternatives to institutional care;
- Involvement of social networks and family members (while respecting autonomy);
- Intentional attention to ethnic and socioeconomic diversity in service design.

Key challenges identified were:

- Digital exclusion affecting older adults more than other age groups;
- Policy reforms that exclude older adults (e.g., age limits on care networks);
- Workforce lacking confidence and training in geriatric mental health;
- Normalisation of depression and anxiety as “part of ageing”;
- Fragmented care across multiple providers and sectors;
- Intersection of cognitive decline with mental health needs (e.g., MCI, dementia);
- Dependence on family members who may have limited time or knowledge;
- Stigma within some communities preventing help-seeking.

We also note cross-references. Schoenmakers et al. (2017) on elderly migrants is also discussed in Section 3.2.2 (Migrants, refugees, asylum seekers). Digital interventions for older adults are discussed in the context of digital exclusion across multiple population sections.

3.2.8 Other Populations: Homeless and Disaster-Affected

This section addresses two population groups with very limited primary evidence: homeless individuals and disaster-affected populations. The small evidence base for these groups represents significant gaps given the high prevalence of mental health difficulties in both populations.

Homeless Individuals

Overview

One study (2%) primarily addressed homeless populations: Van Everdingen et al. (2021) on comprehensive health assessment for homeless service users in the Netherlands.

Two additional studies mentioned homelessness as a secondary or intersecting vulnerability: Hassan et al. (2020) noted the intersection of mental health needs with homelessness in their social prescribing model (discussed in Section 3.2.6); and Surkan et al. (2024) described services for refugees including those in emergency shelters alongside homeless persons.

The limited dedicated evidence (2%) contrasts sharply with documented high rates of mental health difficulties among homeless populations, where prevalence of mental disorders exceeds 70% in many studies and complex co-occurring needs are the norm.

Solution Mechanisms

The single primary study emphasised comprehensive assessment and ecosystem approaches:

- **Comprehensive health assessment:** Van Everdingen et al. (2021) developed the HOP-TR (Homeless Opportunities for Pathway to Recovery) comprehensive assessment approach with six foundational principles: user perspective as primary; transdiagnostic mental health assessment (cutting across diagnostic categories); integration of user and professional perspectives; positive health framework encompassing physical, mental, social, and meaning-making domains; recovery focus across symptomatic, social, and personal dimensions; and rights-based needs assessment.
- **Healthcare ecosystem approach:** The study applied an ecosystem framework facilitating dialogue across nano (individual), micro (service), meso (inter-organisational), and macro (policy) levels to address the fragmentation that characterises services for homeless populations.
- **Transdiagnostic assessment:** Rather than relying on categorical diagnoses that may poorly fit the complex presentations of homeless individuals, the approach used 12 transdiagnostic mental health features that cut across DSM categories, enabling more flexible and person-centred assessment.
- **Integration with homeless services:** The assessment approach was designed for use within existing homeless services (night shelters, day shelters, crisis shelters, protected living) rather than requiring people to access separate mental health services.

Key Exemplar

- **HOP-TR Comprehensive Assessment (Netherlands):** A study developing and testing a comprehensive health and needs assessment approach for homeless service users. Conducted across 16 facilities in 7 Dutch cities with 436 participants, the study found that 95% had concurrent health problems affecting two or more domains (mental illness, addiction, intellectual impairments, chronic physical health problems). The assessment combined:

InterRAI Community Mental Health questionnaire with a custom 71-item Homelessness Supplement; Montreal Cognitive Assessment (MoCA); SCIL screener for intellectual disabilities; Camberwell Assessment of Need (CAN); and quality of life measures. Key innovations included: a Mental Health Related Care Needs decision tree based on Dutch severe mental illness consensus definitions; a positive health framework mapping six health domains to three recovery dimensions; and a rights-based Future Living Status code determining optimal residence based on assessed needs rather than service availability. The study highlighted that siloed care systems fail people with interdependent needs, with proven interventions like Housing First reaching only 1 in 20 homeless individuals in countries like Denmark (Van Everdingen et al., 2021).

Access Barriers Addressed

- **Siloed service systems** — via comprehensive assessment spanning health domains and ecosystem-level dialogue.
- **Lack of systematic health information** — via structured assessment tools adapted for homeless services.
- **Navigational complexity** — via embedding assessment within existing homeless services
- **Categorical diagnostic approaches** — via transdiagnostic assessment accommodating complex presentations.
- **Exclusion from address-based systems** — via recognition that homeless people “fall off governmental radar”.
- **Insurance and eligibility barriers** — via identifying that valid residence permits and insurance problems impede care access.

Implementation Insights

Key enablers: - User perspective as primary orientation - Comprehensive assessment spanning multiple health domains - Integration within existing homeless service infrastructure - Rights-based approach determining optimal support based on needs - Multi-level ecosystem dialogue engaging policy and service levels - Transdiagnostic approaches accommodating complex presentations

Key challenges: - Siloed care systems not serving people with interdependent needs - Low coverage rates of proven interventions (e.g., Housing First) - Workforce lacking knowledge and skills for systematic health assessment - Insurance and residence permit barriers excluding undocumented individuals - Biomedical approaches neglecting social and personal health dimensions - Policy context of austerity and fragmented municipal responsibilities

Disaster-Affected Populations

Overview

No studies (0%) primarily addressed disaster-affected populations within the WHO European Region during the review period. This represents a notable gap in the review, despite search strategy specifically targeting them, and given recent events across Europe including: floods (Germany, Belgium 2021; various countries ongoing); earthquakes (Türkiye/Syria 2023); wildfires (Greece, Portugal, Spain); the COVID-19 pandemic; and the Ukraine conflict with its associated displacement.

While several refugee studies (Section 3.2.2) addressed populations fleeing conflict, these focused on migration and integration rather than disaster response as the primary intervention context. Studies such as Reich et al. (2024) on PM+ for Syrian refugees addressed conflict-affected populations, but with the primary vulnerability classified as migration status rather than disaster exposure.

Relevance to Other Population Groups

Although no studies primarily addressed disaster-affected populations, disaster and crisis exposure featured as context in several studies:

- **Refugee populations:** Multiple studies addressed refugees fleeing conflict (Syria, Afghanistan, Sub-Saharan Africa), with trauma from conflict and displacement as a key presenting issue (see Section 3.2.2).
- **mhGAP implementation in Türkiye:** Fuhr et al. (2024) described training 1,468 physicians to address mental health needs in the context of the Syrian humanitarian crisis, though classified as a migrant-focused intervention.
- **COVID-19 context:** Several studies (Harty et al., 2023; Gilmour et al., 2022) were conducted during or in response to the pandemic, though not primarily framed as disaster response.

Both homeless and disaster-affected populations are significantly underrepresented in the evidence base we identified as providing solutions to tackle challenges to mental health service access. The limited evidence does not reflect lack of need but rather gaps in research attention, intervention development, and service innovation for these populations. Both groups experience multiple intersecting barriers and often fall between service systems designed for more clearly defined populations.

3.2.9 Summary of Population-Specific Findings

The evidence base is heavily concentrated on children, adolescents, and youth and migrants, refugees, and asylum seekers, which together account for nearly three-quarters of primary study foci. Smaller but substantive evidence exists for LGBTQIA+ populations, ethnic and religious minorities, and older adults. Key solution patterns include: digital and low-threshold services for youth; cultural adaptation, task-shifting, and language-concordant care for refugee populations; and provider training and informed consent models for LGBTQ+ access.

Critical evidence gaps exist for people with disabilities, homeless individuals, disaster-affected populations and socioeconomically disadvantaged/rural populations. These gaps do not reflect lack of need — indeed, mental health difficulties are highly prevalent in these groups — but rather priorities for future research and service development. Notably, socioeconomic disadvantage and disability frequently appeared as secondary characteristics intersecting with other vulnerabilities, suggesting these are cross-cutting factors requiring attention across all population-focused interventions.

3.3 Cross-Cutting Synthesis by Solution Category

This section synthesises findings across population categories, examining patterns by solution mechanism. Six categories of service delivery solutions emerged from thematic analysis of the 55 studies (see Section 2.8). This section describes each category, the populations served, and common implementation features.

3.3.1 Overview of solution categories

Table 9 presents the six solution categories with the number of studies primarily employing each mechanism. Studies were assigned to their primary mechanism based on qualitative assessment of the main solution approach described, drawing on Field 6 (Type of Service) and Field 9 (Solutions Identified) in the data extraction. Since 98% of studies combined multiple solution mechanisms, this classification reflects the dominant approach rather than the only mechanism present.

Table 9. *Solution categories identified (n=55; primary solution assignment)*

Solution Category	n	%	Key Populations
1. Integrated and coordinated care models	11	20%	Youth, migrants/refugees
2. Culturally and linguistically adapted services	11	20%	Migrants/refugees, ethnic minorities

3. Outreach and low-threshold access models	7	13%	Youth, migrants/refugees
4. Digital and e-mental health interventions	11	20%	Youth, migrants/refugees, rural populations
5. Peer workers, community mediators, lay health agents	8	15%	Migrants/refugees, ethnic minorities
6. Organisational redesign and capacity building	7	13%	LGBTQIA+, migrants/refugees

Notes on classification: - Studies addressing youth (45% of studies prioritised) and migrants/refugees (29%) feature prominently across all categories - "Key Populations" indicates the populations most frequently served by each solution type, not exclusive assignment - Many studies combined mechanisms — for example, culturally adapted (Category 2) digital interventions (Category 4) delivered by lay workers (Category 5) - The distinction between categories is conceptual; in practice, effective solutions typically integrated multiple approaches

3.3.2 Integrated and coordinated care models

Definition: Solutions that improve access through service integration, care coordination, stepped-care pathways, single points of access, or transition support between services.

Mechanism of action: These solutions address fragmentation and navigational complexity by creating clearer pathways, coordinating between services, and ensuring continuity across transitions (e.g., child to adult services, community to specialist care).

Key features across studies: - Single points of access (SPoA) reducing complexity of multiple entry points - Stepped-care models matching intervention intensity to need - Extended age ranges (e.g., 12–25, 14–25, 15–35) bridging traditional service boundaries - Multi-disciplinary teams spanning service boundaries - Care coordination roles (e.g., link workers, care navigators)

Populations served: Primarily youth (addressing transition gaps and service fragmentation) and migrants/refugees (addressing navigational complexity in unfamiliar health systems).

Exemplar studies: RefuKey stepped-care model for refugees in Germany (Trilesnik et al., 2019); YMHPN integration of youth mental health in primary care in the Netherlands (Koet et al., 2024); horizon scan of integrated care models for youth across multiple countries (Holmen et al., 2023); IYMHS one-stop shop model in Germany (Bechdolf et al., 2024, 2025).

3.3.3 Culturally and linguistically adapted services

Definition: Solutions that improve access through cultural adaptation of interventions, interpreter provision, language-concordant services, or transcultural approaches that address cultural factors in help-seeking and treatment.

Mechanism of action: These solutions address cultural and linguistic barriers by ensuring services are meaningful and accessible within users' cultural frames of reference, reducing mistrust and improving engagement.

Key features across studies: - Systematic cultural adaptation frameworks (e.g., RECAPT) ensuring rigorous adaptation while maintaining fidelity - Professional interpreters trained in mental health terminology - Language-concordant clinicians where available - Community involvement in adaptation process - Translated and culturally appropriate materials - Attention to explanatory models of distress and healing

Populations served: Migrants and refugees (most frequently), ethnic minorities (e.g., African-Caribbean, Bedouin, Irish Traveller communities).

Exemplar studies: CaFI culturally-adapted family intervention for African-Caribbean families affected by psychosis (Edge et al., 2018); Arabic-language digital tools including iFightDepression (Reich et al., 2024) and Step-by-Step (Aeschlimann et al., 2025); transcultural psychotherapy services in Spain (Carballeira Carrera et al., 2020); Mom-to-Mom programme for Bedouin women (Alfayumi-Zeadna et al., 2025).

3.3.4 Outreach and low-threshold access models

Definition: Solutions that improve access through proactive outreach, walk-in services, self-referral pathways, anonymity, or 'youth-friendly' designs that reduce traditional barriers to service entry.

Mechanism of action: These solutions address stigma, procedural barriers, and acceptability concerns by meeting people where they are and removing requirements that deter help-seeking (e.g., referrals, appointments, fees).

Key features across studies: - Walk-in access without appointment - Self-referral bypassing gatekeepers - Anonymous or confidential services - Free services (no cost barrier) - Community-based locations (non-clinical settings) - Proactive outreach to underserved communities - Youth-friendly environments and communication

Populations served: Primarily youth (who value informality and confidentiality), migrants/refugees (who may distrust formal systems or face administrative barriers), and socioeconomically disadvantaged populations.

Exemplar studies: @ease walk-in centres in the Netherlands (Crombach et al., 2025; Leijdesdorff et al., 2021); IYMHS one-stop shops in Germany (Bechdolf et al., 2024, 2025); Berlin Clearing Clinic providing central access point for refugees (Bajbouj et al., 2021); Life Rooms community hubs in deprived areas (Hassan et al., 2020).

3.3.5 Digital and e-mental health interventions

Definition: Solutions delivered through digital platforms including apps, websites, video therapy, online programmes, and digital referral/coordination systems.

Mechanism of action: Digital solutions address geographic barriers, increase capacity (scalable delivery), reduce stigma (private access), and offer flexibility (24/7 availability, self-pacing).

Key features across studies: - Online therapy platforms (synchronous and asynchronous) - Mental health apps (self-help, guided, or blended with clinician support) - Video conferencing therapy and assessment (e.g., CBT, diagnostic assessment) - Digital referral and care coordination systems - Multilingual digital tools for migrants/refugees - Gamified interventions for children and young people

Populations served: Youth (high digital literacy, preference for technology), rural populations (overcoming geographic barriers), migrants/refugees (multilingual tools, overcoming mobility barriers), and people with disabilities (remote access reducing travel burden).

Implementation considerations: Digital exclusion remains a concern for some populations (older adults comprised only 2.3% of users in one national implementation; socioeconomically disadvantaged groups may lack internet access). Successful implementations combined digital with face-to-face options (blended models) and ensured accessibility features.

Exemplar studies: SilverCloud national implementation in Ireland (Harty et al., 2023); Healios video-based platform for children and young people (Burbach & Stiles, 2021); Arabic iFightDepression culturally adapted tool (Reich et al., 2024); Lumi Nova gamified app for childhood anxiety (Gee et al., 2024); CYP as One digital referral platform (Ganga et al., 2024).

3.3.6 Peer workers, community mediators, and lay health agents

Definition: Solutions that expand the mental health workforce through task-shifting to non-specialists, including peer support workers (with lived experience), community health workers, trained lay helpers, and community mediators.

Mechanism of action: These solutions address workforce shortages (expanding capacity), improve cultural acceptability (community members as providers), increase trust (shared backgrounds and language), and enable scalable delivery of effective interventions.

Key features across studies: - Structured training programmes (e.g., 80 hours for PM+ helpers) - Regular supervision by qualified professionals - Manualised interventions ensuring fidelity - Community recruitment of helpers (shared language, culture, lived experience) - Cascade training models for scale - Clear referral pathways for complex cases.

Populations served: Migrants/refugees (PM+ programmes), ethnic minorities (community-based peer support), youth (Youth Advocates, peer workers in walk-in centres).

Exemplar studies: Problem Management Plus (PM+) trials in the Netherlands (de Graaff et al., 2023; Spaaij et al., 2022) and France (Surkan et al., 2024); lay counsellor cascade training model (Elbert et al., 2017); Youth Advocates at Jigsaw Ireland (Carey et al., 2025); peer support and community-based approaches for Black men (Stockwell et al., 2025); peer support at @ease centres (Crombach et al., 2025).

3.3.7 Organisational redesign and capacity building

Definition: Solutions that address access at the system or organisational level through workforce training, policy development, service redesign, or building institutional capacity to serve specific populations.

Mechanism of action: These solutions address supply-side barriers (workforce gaps, lack of competence, institutional exclusion) through system-level change rather than individual intervention delivery.

Key features across studies: - Large-scale workforce training (e.g., mhGAP reaching 1,468 physicians) - Competency-based training for specific populations (e.g., LGBTQ-affirmative practice) - Policy mapping and analysis to identify gaps - Development of service standards and principles - Service redesign to include previously excluded populations - Alignment with evolving policy frameworks (e.g., ICD-11).

Populations served: Migrants/refugees (mhGAP training for primary care physicians), LGBTQIA+ populations (provider competency training, informed consent models), older adults (policy analysis and care network development), and system-wide improvements benefiting multiple populations.

Exemplar studies: mhGAP training in Türkiye reaching 1,468 physicians serving Syrian refugees (Karaoğlan Kahiloğulları et al., 2020); LGBTQ-affirmative provider training in Romania (Lelutiu-Weinberger et al., 2023); 13 principles for LGBTQ+ youth mental health services (McDermott et al.,

2024); informed consent model for transgender care replacing psychiatric gatekeeping (Baleige et al., 2022); CARITAS framework for older adult mental health services (Adriaenssens et al., 2019).

3.3.8 Cross-cutting implementation patterns

Common enablers identified across solution categories were:

- **Co-design and community involvement:** Solutions developed with target populations showed better uptake, cultural appropriateness, and sustainability. This was particularly evident in culturally adapted interventions, peer support programmes, and youth services where community members contributed to design, delivery, and governance.
- **Flexible, hybrid delivery:** Combining multiple modalities (e.g., digital + face-to-face, individual + group) accommodated diverse preferences and circumstances. Blended approaches helped address digital exclusion while maintaining scalability benefits.
- **Multi-level implementation:** Solutions operating across macro (policy), meso (organisational), and micro (individual) levels showed stronger integration with existing systems and greater potential for sustainability. The most successful implementations aligned with policy frameworks and secured institutional embedding.
- **Dedicated coordination roles:** Link workers, care navigators, cultural mediators, and coordinators facilitated access across complex systems. These bridging roles were particularly important for populations facing navigational barriers (migrants/refugees, youth in transition).
- **Sustained funding and policy support:** Solutions embedded in policy frameworks and secured funding streams showed greater sustainability than time-limited projects. Integration with statutory services was associated with longer-term viability.
- **Low-threshold design principles:** Removing procedural barriers (self-referral, walk-in access, no cost) consistently improved reach to underserved populations, particularly youth and migrants/refugees.

Common challenges identified across solution categories were:

- **Workforce sustainability:** Maintaining trained workforces — whether volunteers, lay helpers, peer workers, or specialist staff — was challenging across all categories. High turnover, burnout, and inadequate supervision threatened programme quality and continuity.
- **Demand management:** Successful low-threshold services often faced overwhelming demand that outstripped capacity, creating new waiting lists and access barriers. Balancing accessibility with sustainable service delivery remained difficult.
- **Integration with mainstream services:** Specialist or parallel services (e.g., refugee-specific, LGBTQ+-specific) sometimes struggled to integrate with statutory provision, risking isolation from broader healthcare pathways and referral networks.
- **Evaluation and evidence:** Many innovative services lacked robust outcome evaluation, limiting the evidence base for effectiveness and making it difficult to secure continued funding or support replication.

- **Scaling and replication:** Moving from successful pilots to scaled implementation remained challenging, with many promising interventions not progressing beyond initial demonstration phases. Contextual factors often required significant adaptation for new settings.
- **Reaching the most marginalised:** Even successful programmes often struggled to reach the most excluded subgroups within target populations (e.g., undocumented migrants, digitally excluded older adults, those with severe and complex needs).

3.3.9 Transferability considerations

Analysis of transferability factors (Field 14 in data extraction) identified several considerations for adapting solutions across contexts:

Factors supporting transferability:

- **Manualised interventions with clear protocols:** Interventions with structured training, manuals, and fidelity measures (e.g., PM+, mhGAP, CaFI) were more readily transferable across settings while maintaining quality. The WHO's PM+ and mhGAP programmes demonstrated successful adaptation across multiple countries.
- **Digital solutions:** Digital interventions are inherently scalable across geographies once developed, though require cultural and linguistic adaptation for new populations. Multilingual platforms (e.g., tools available in 16–19 languages) showed particular transferability potential.
- **Principles-based approaches:** Frameworks providing guiding principles rather than rigid protocols (e.g., 13 principles for LGBTQ+ youth services, CARITAS framework for older adults) were adaptable to diverse local contexts while maintaining core quality standards.
- **Task-shifting models:** Approaches using trained non-specialists addressed universal workforce constraints and were transferable where appropriate training and supervision infrastructure could be established.
- **Low-threshold design features:** Core accessibility principles (self-referral, walk-in access, extended hours, non-clinical settings) were applicable across contexts, though specific implementation varied.

Factors limiting transferability:

- **Health system differences:** Variations in funding mechanisms, service structures, professional regulations, and workforce composition affected how solutions could be implemented. Interventions developed in well-resourced Northern/Western European systems may require significant adaptation for resource-constrained settings.
- **Policy and regulatory contexts:** Scope of practice regulations for non-specialists, data protection requirements, and professional licensing affected implementation of task-shifting and digital solutions. Policy environments for specific populations (e.g., LGBTQ+ rights, asylum policies) shaped what interventions were feasible.
- **Cultural factors requiring local adaptation:** Even evidence-based interventions required systematic cultural adaptation for new populations. Surface-level translation was insufficient; deep cultural adaptation addressing explanatory models, family structures, and help-seeking norms was necessary.

- **Resource requirements:** Many solutions required substantial investment in training, supervision, technology infrastructure, or dedicated coordination roles that may not be available in all contexts.
- **Language and linguistic diversity:** Solutions developed for specific language groups required significant adaptation for linguistically diverse populations, including development of new materials and recruitment of language-concordant staff.

Note on geographic limitations: The concentration of evidence in Northern/Western Europe (76% of studies) limits direct applicability to underrepresented regions (Central and Eastern Europe within EU, Western Balkans / South-East Europe and Türkiye, and EECA). While solution principles may be transferable, significant adaptation, contextual analysis, and local evaluation would be required. The 13% of studies from multi-country contexts provide some evidence of cross-national applicability, but gaps remain substantial for many WHO European Region member states.

3.3.10 Summary

The six solution categories represent distinct but complementary mechanisms for improving mental health access. Most effective approaches combined multiple mechanisms — for example, a culturally adapted (Category 2), digitally delivered (Category 4) intervention, implemented by trained lay workers (Category 5), within an integrated care pathway (Category 1). This multi-faceted approach reflects the complexity of access barriers facing people in vulnerable situations, which rarely have single-point solutions.

Key implications for service development:

- **Flexible, hybrid approaches** combining multiple solution mechanisms are more effective than single-strategy interventions;
- **Community involvement and co-design** improve uptake, cultural appropriateness, and sustainability;
- **Task-shifting to trained non-specialists** offers scalable solutions for workforce-constrained settings;
- **Digital solutions** provide reach and scalability but require attention to digital exclusion;
- **Policy and organisational support** are necessary for sustainable implementation beyond pilot phases;
- **Systematic cultural adaptation** is essential for interventions serving diverse populations;
- **Low-threshold design principles** consistently improve reach to underserved groups.

3.4 Overview of Solutions in the Wider Screened Literature

As described in Section 2.5, the structured screening process identified 215 studies meeting eligibility criteria. Of these, 55 were prioritised for in-depth full-text analysis based on service description clarity, transferability potential, access mechanism detail, and innovation signals. The remaining 160 studies were catalogued at abstract level to document the broader scope of solutions identified in the literature. This section summarises patterns observed in these studies, which are listed in full in Appendix B.

3.4.1. Geographic distribution

The wider screened literature shows similar geographic concentration to the prioritised studies. Northern and Western Europe (Cluster 1) accounted for 65% of studies (n=104), with the United Kingdom alone contributing 36% (n=58). Multi-country or pan-European studies comprised 19% (n=31; Cluster 6), followed by Southern Europe at 11% (n=17; Cluster 2). Central and Eastern Europe (n=3; Cluster 3), the Western Balkans / South-East Europe and Türkiye (n=3; Cluster 4), and Eastern Europe and Central Asia (EECA) countries (n=2; Cluster 5) were markedly underrepresented, together accounting for only 5% of the screened sample. This pattern reinforces the geographic gaps identified in the in-depth analysis and highlights the limited generalisability of findings to underrepresented regions.

3.4.2. Target populations

Population coverage in the wider dataset mirrored priorities observed in the prioritised studies. Children and young people (G3) dominated with 46% of studies (n=74), followed by migrants, refugees, and asylum seekers (G1) at 25% (n=40). Other population groups received considerably less attention: people with disabilities (G6: n=12, 8%), ethnic and religious minorities (G2: n=9, 6%), older adults (G5: n=8, 5%), LGBTQIA+ individuals (G4: n=6, 4%), socioeconomically disadvantaged and rural populations (G7: n=6, 4%), disaster-affected populations (G9: n=4, 2%), and homeless populations (G8: n=1, <1%). The underrepresentation of these groups across both the prioritised and wider datasets suggests systematic gaps in the solution-focused literature rather than artefacts of the prioritisation process.

3.4.3. Access barriers addressed

Barrier targeting showed some differences from the prioritised sample. Structural barriers such as fragmented pathways and poor coordination were most frequently addressed (n=49, 31%), followed by workforce gaps including staff shortages and training needs (n=30, 19%), and stigma and trust issues (n=25, 16%). Digital exclusion barriers featured in 15 studies (9%), with affordability barriers (n=12, 8%) and geographic barriers (n=9, 6%) also represented. Less commonly addressed were cultural barriers (n=7, 4%), transition gaps (n=7, 4%), language barriers in service delivery (n=4, 2%), and legal status barriers (n=2, 1%). Compared to the prioritised studies—where stigma and trust were most prominent (76%)—the wider dataset shows greater emphasis on structural and workforce barriers, possibly reflecting the inclusion of more policy-oriented and system-level studies that did not meet prioritisation criteria for service-level detail.

3.4.4. Solution approaches

Solution categories in the wider dataset differed somewhat from the prioritised sample. Organisational and workforce redesign (S6) was the most common primary solution category (n=55, 34%), frequently addressing structural barriers. Digital and e-health interventions (S4) appeared in 33 studies (21%), predominantly targeting digital exclusion and structural access barriers. Integrated and collaborative care models (S1: n=29, 18%), outreach and low-threshold services (S3: n=17, 11%), culturally adapted interventions (S2: n=17, 11%), and peer/community health worker approaches (S5: n=9, 6%) were less frequently reported as primary mechanisms. The prominence of organisational redesign in this dataset—compared to the more balanced distribution in prioritised studies—may reflect the inclusion of policy analyses and system-level studies that lacked the granular service descriptions required for Atlas development.

3.4.5. Study designs

Abstract-level classification indicated a diverse methodological mix: qualitative studies (n=24, 15%), pilots and feasibility studies (n=21, 13%), reviews (n=18, 11%), and randomised controlled trials (n=11, 7%). The remainder comprised service descriptions, cohort studies, and mixed-methods evaluations.

3.4.6. Synthesis and implications

The 160 catalogued studies reinforce key patterns identified in the in-depth analysis while revealing additional dimensions. The geographic and population gaps observed in the prioritised studies persist across the full eligible dataset, suggesting these represent genuine lacunae in the solution-focused literature rather than artefacts of the prioritisation process. The strong emphasis on children and young people (46%) and migrants and refugees (25%) in this dataset mirrors priorities in the prioritised sample, while other vulnerable populations—including those with disabilities, ethnic minorities, older adults, and LGBTQIA+ individuals—remain underrepresented. Notably, only four studies specifically addressed disaster-affected populations (including pandemic-related mental health responses), indicating a potential gap for future research given the mental health impacts of COVID-19 and other crises. The stronger emphasis on organisational and workforce solutions in this wider dataset, compared to the more service-focused prioritised sample, reflects the selection criteria that favoured studies with detailed, transferable service descriptions suitable for Atlas entry development.

3.4.7. Limitations

These findings are based on abstract-level data extraction only. Full-text analysis would likely reveal additional nuances in population targeting, barrier identification, and solution implementation that were not captured at the screening stage.

4. Discussion

4.1 Summary of key findings

This structured literature review identified 55 studies describing existing services, policies, programmes, and interventions that address mental health care access barriers for people in vulnerable situations across the WHO European Region. The review responds to Task 2.1's requirement for desk research-based mapping to inform the Atlas on Mental Health and Care Innovative Solutions (T2.5), exceeding the Key Performance Indicator target of ≥50 services identified. Five key findings emerged from the analysis.

First, solutions are multi-faceted. The vast majority of studies (98%) employed solutions spanning multiple mechanism categories. Effective approaches to improving mental health access typically combined elements of service integration, cultural adaptation, digital delivery, peer involvement, and organisational change. This finding aligns with the WHO's recognition that mental health systems require 'a whole-of-government and whole-of-society approach' rather than isolated interventions (WHO, 2021). It also resonates with Thornicroft and Tansella's (2013) balanced care model, which emphasises that effective mental health systems require coordinated action across community, primary, and specialist levels.

Second, solutions operate across implementation levels. Three-quarters of studies (76%) described solutions operating across macro (policy/system), meso (organisational), and micro (individual) levels simultaneously, with the most common combination being meso + micro (44%). This finding aligns with the Levesque access framework underpinning WP1, which recognises that access is determined by the interaction between supply-side (service) and demand-side (population) factors operating at multiple levels. The multi-level nature of effective solutions echoes Penchansky and Thomas's (1981) classic dimensions of access—availability, accessibility, accommodation, affordability, and acceptability—which cannot be addressed through single-level interventions alone.

Third, both supply-side and demand-side barriers were addressed. When examining primary barriers targeted, structural and systemic supply-side barriers were most frequently addressed (47% of studies), followed by stigma, trust, and acceptability demand-side barriers (22%). However, when considering all barriers addressed (primary and secondary), the picture is more balanced: stigma and acceptability concerns featured in the majority of studies, alongside workforce capacity gaps, language/cultural barriers, and navigational complexity. This dual focus—on both service availability and service acceptability—is encouraging. However, it should be noted that attention to demand-side barriers at the service level should not obscure the ongoing need for macro-level supply-side reforms—addressing workforce shortages, funding gaps, and policy barriers—which may be underrepresented in service innovation literature. The solutions reviewed here largely operated within existing resource constraints; fundamental system transformation requires policy and investment changes that lie beyond the scope of individual service innovations.

Fourth, certain populations and regions are better represented in the literature. Children, adolescents, and youth were the primary focus of 45% of the studies in this review (n=25), and migrants/refugees of 29% (n=16), together accounting for nearly three-quarters of the evidence base. Smaller but substantive evidence exists for LGBTQIA+ populations (7%, n=4), ethnic and religious minorities (7%, n=4), and older adults (5%, n=3). However, people with disabilities (0%), homeless individuals (2%, n=1), socioeconomically disadvantaged/rural populations (4%, n=2), and disaster-

affected populations (0%) were notably underrepresented as primary study foci. Geographically, 76% of studies came from Northern/Western Europe (n=42), with significant gaps in Central and Eastern EU countries (2%, n=1), Western Balkans / South-East Europe and Türkiye, (4%, n=2), and Eastern Europe and Central Asia (EECA) (0%). These patterns mirror broader inequities in global mental health research, which remains concentrated in high-income, English-speaking contexts (Saxena et al., 2007).

Fifth, six distinct solution categories emerged. Thematic analysis identified six categories of service delivery solutions: (1) integrated and coordinated care models (20%); (2) culturally and linguistically adapted services (20%); (3) outreach and low-threshold access models (13%); (4) digital and e-mental health interventions (20%); (5) peer workers, community mediators, and lay health agents (15%); and (6) organisational redesign and capacity building (13%). While studies were assigned to primary categories for analytical purposes, in practice most solutions combined multiple mechanisms—the categories represent dominant approaches rather than discrete intervention types. These categories echo solution typologies identified in prior systematic reviews of mental health service innovations (e.g., Barbui et al., 2020; Singla et al., 2017), but the present review extends this work by specifically mapping solutions to vulnerable population categories within the European context.

Synthesis: What Do These Findings Mean?

Taken together, these findings suggest that improving mental health access for people in vulnerable situations is not primarily a question of *more* services, but of *differently designed* services. The solutions identified in this review share several features: they actively address stigma and cultural barriers rather than assuming 'if we build it, they will come'; they operate flexibly across system levels rather than relying on single-point interventions; they leverage non-traditional workforce models (peer workers, lay helpers, digital platforms) to extend reach beyond specialist capacity; and they are adapted to the specific contexts and needs of target populations.

However, three important caveats temper these conclusions:

- *Documentation does not imply effectiveness.* While 18% of included studies were RCTs, many were pilot studies, qualitative evaluations, or service descriptions. The review documents what exists, not necessarily what works. Atlas users should consider the level of evidence supporting each solution before adoption.
- *Single-population classification may obscure intersectionality.* The primary classification approach, while analytically necessary, may understate the importance of intersectionality. Many individuals face compounding vulnerabilities (e.g., LGBTQ+ refugees, youth with disabilities, older migrants) that create unique access barriers not fully captured by single-population categorisations. Service planners should attend to these intersections rather than assuming population-specific solutions address all subgroups.
- *Geographic concentration raises fundamental transferability questions.* The concentration of evidence in well-resourced Northern/Western European systems (76%) means that identified solutions may assume infrastructure, workforce capacity, and funding levels that do not exist in many WHO European Region member states. Solutions developed in the Netherlands or UK may require not just adaptation but fundamental redesign for contexts with different resource levels, workforce structures, and policy environments.

For the EQUICARES project, these findings validate the conceptual approach of WP1 (understanding access barriers through the Levesque framework) and provide a foundation for WP2's practical outputs (the Atlas of solutions). The six solution categories offer a structured way to organise Atlas entries, while the cross-cutting finding that effective solutions combine multiple mechanisms suggests the Atlas should enable users to identify solution 'packages' rather than isolated interventions.

4.2 Implications for Policy and Practice

4.2.1 Implications for mental health service planning

The findings have implications for how policymakers and service planners approach mental health access for vulnerable populations. These implications are presented in a suggested hierarchy, recognising that foundational elements (acceptability, trust) must be addressed before other investments can succeed:

Foundation: Design for demand-side barriers, not just supply. The finding that stigma, trust, and cultural acceptability featured prominently across studies underscores that service availability alone does not ensure access. Services must be perceived as safe, relevant, and respectful by target populations. Without addressing acceptability, investments in workforce expansion, digital infrastructure, or service reorganisation may fail to reach those most in need. This requires community engagement in service design, visible commitment to inclusion (e.g., LGBTQ-affirmative signalling, culturally diverse workforce), and proactive outreach rather than passive waiting for referrals.

Workforce: Invest in diversification and task-shifting. The strong presence of task-shifting approaches—peer workers, lay helpers, community health workers—reflects both workforce constraints and recognition that non-traditional providers can enhance access, particularly for populations who distrust or feel unwelcome in conventional services. The WHO's mhGAP programme (Karaoğlan Kahiloğulları et al., 2020) and PM+ trials (de Graaff et al., 2023; Surkan et al., 2024) demonstrate that structured training and supervision can enable effective delivery by non-specialists at scale. Task-shifting is not merely a cost-saving measure but a strategy for building trust through shared backgrounds and lived experience.

Delivery: Leverage digital solutions strategically. Digital interventions featured prominently, with 20% of studies primarily employing digital mechanisms and many others incorporating digital components. These offer potential for overcoming geographic barriers and scaling access. However, successful implementations (e.g., SilverCloud in Ireland, Healios in the UK) combined digital with face-to-face options and addressed digital exclusion risks—older adults comprised only 2.3% of users in one national digital implementation despite being 14.8% of the population. Digital should complement, not replace, human connection—particularly for populations facing complex social vulnerabilities or digital exclusion.

Targeting: Move beyond 'one-size-fits-all' service models. The prominence of culturally adapted interventions (e.g., CaFI for African-Caribbean families, PM+ for refugees, Mom-to-Mom for Bedouin women) and population-specific services (e.g., LGBTQ-affirmative care, youth walk-in centres) suggests that mainstream mental health services may not adequately reach people in vulnerable situations. Service planning should incorporate explicit strategies for engaging underserved populations, whether through adaptation of existing services or development of targeted programmes.

Gaps: Address critical evidence and solution gaps urgently. The near-absence of primary evidence on people with disabilities (0%), homeless individuals (2%), and disaster-affected populations (0%) represents urgent priorities for service development and research. These populations face substantial access barriers and high mental health burden, yet the evidence base provides limited guidance. Service planners should not interpret absence of evidence as absence of need. Beyond population gaps, certain solution types were also notably absent or rare in the reviewed evidence, including: Housing First approaches integrating housing with mental health support (despite strong international evidence); social prescribing models (only one study); workplace mental health interventions for vulnerable workers; criminal justice mental health interfaces (diversion programmes, mental health courts); and disaster/emergency mental health response protocols. These represent areas where solution development and documentation should be prioritised.

4.2.2 Implications for the EQUICARES Atlas (T2.5)

The findings inform specific design features for the Atlas on Mental Health and Care Innovative Solutions:

Dual navigation structure. The organisation of findings by population category (Section 3.2) and solution category (Section 3.3) provides two complementary entry points. Policymakers may search by population ('What works for refugee mental health?') or by mechanism ('What digital interventions exist?'). The Atlas should support both pathways with cross-referencing.

Implementation level tagging. Given that 76% of solutions operate across multiple levels, the Atlas should tag entries by implementation level (macro/meso/micro) to help users identify solutions relevant to their sphere of influence and recognise that comprehensive approaches typically span levels.

Evidence strength indicators. Given that documentation does not imply effectiveness, the Atlas should clearly communicate the level of evidence supporting each solution (e.g., RCT, controlled study, service evaluation, descriptive report). This will help users make informed decisions about adoption and adaptation.

Transferability guidance. Each Atlas entry should incorporate transferability considerations (Section 3.3.9), noting factors that may affect replication across contexts and adaptation requirements. The geographic concentration of studies (76% from Northern/Western Europe) makes this especially important for users in underrepresented regions, who should be cautioned that significant adaptation—potentially including fundamental redesign—may be required.

Intersectionality flags. Where solutions address or could be adapted for populations facing intersecting vulnerabilities (e.g., LGBTQ+ refugees, youth with disabilities), this should be noted to help users identify relevant approaches for complex presentations.

Explicit gap acknowledgment. The Atlas should transparently flag coverage gaps—geographic (Central and Eastern EU countries, Western Balkans / South-East Europe and Türkiye, EECA countries) and population (people with disabilities, homeless individuals, disaster-affected populations, older adults)—to avoid implying comprehensive coverage where it does not exist and to highlight priorities for future Atlas expansion.

Integration with WP1. Linking Atlas solutions to the barrier categories documented in D1.1 will enable users to match identified access challenges with relevant solution examples, creating a practical tool for evidence-informed service planning.

4.3 Limitations

Several limitations should be considered when interpreting these findings. Where possible, we note mitigation strategies and implications for interpretation.

Search and source limitations. The review captured solutions that have been formally documented—including peer-reviewed publications, service evaluations, and organisational reports across multiple languages. Solutions that have been implemented but not formally documented will not be captured through any desk-based method.

Interpretation. This is inherent to literature-based mapping. The subsequent EQUICARES fieldwork (T2.2–T2.4) is specifically designed to capture practitioner knowledge and local innovations not represented in published sources.

Geographic concentration. The heavy concentration of studies in Northern/Western Europe (76%) limits direct applicability to other regions. This pattern likely reflects both research output (more published research from well-resourced systems) and language biases in database searching.

Interpretation: Comparison with the 160 studies catalogued at abstract level (Section 3.4) shows similar geographic patterns, suggesting this reflects the broader literature rather than prioritisation artefacts. Solutions identified may require significant adaptation for contexts with different health system structures, funding mechanisms, or cultural factors. Fieldwork phases will prioritise underrepresented regions.

Solution mapping vs. evidence grading. This review mapped implemented solutions and documented their reported outcomes, but did not formally appraise study quality or grade the strength of evidence for each solution. While the dataset includes RCTs (18%), controlled studies, and robust service evaluations alongside qualitative and pilot studies, no hierarchy of evidence was applied and solutions were not classified as "evidence-based" or "good practice."

Interpretation. The review provides a comprehensive picture of what is being implemented and what outcomes have been reported, rather than a curated list of proven interventions. Atlas users seeking to adopt solutions should consider study design and outcome data (documented in Appendix A) when assessing applicability to their context.

Population coverage gaps. The absence of studies primarily addressing disaster-affected populations (0%) and people with disabilities (0%), and limited coverage of homeless individuals (2%, n=1) and older adults (5%, n=3), represents significant gaps.

Interpretation: These populations face substantial access barriers that are not adequately captured here. Notably, the broader screened dataset (Section 3.4) did include disaster-affected population studies (n=20, including COVID-19 impacts), suggesting potential for Atlas expansion through targeted inclusion of this literature. It should also be noted that many populations (e.g., people with disabilities, socioeconomically disadvantaged groups) featured as secondary populations in studies primarily addressing other groups, reflecting the intersecting nature of vulnerabilities. Subsequent EQUICARES activities should actively seek solutions for these underrepresented groups.

Primary vs. secondary classification. This review classified studies by their primary population focus, meaning that studies addressing multiple populations were counted only once. This approach provides clarity but may understate the relevance of evidence to populations addressed as secondary

foci. For example, multiple youth studies included LGBTQ+ young people or young people with neurodevelopmental conditions as subgroups.

Interpretation: Section 3.2 discusses secondary populations alongside primary foci to provide a fuller picture. Atlas users should consider both primary and secondary population coverage when identifying relevant solutions. The classification approach may also obscure intersectionality—the compounding barriers faced by individuals with multiple vulnerabilities—which warrants specific attention in service planning.

Solution type gaps. Beyond population gaps, certain types of solutions were notably absent or underrepresented, including Housing First approaches, social prescribing, workplace mental health, criminal justice interfaces, and disaster response protocols. This may reflect the review's focus on mental health service innovations rather than cross-sectoral approaches.

Interpretation: The absence of certain solution types should not be interpreted as evidence against their effectiveness. Future Atlas development could expand scope to include cross-sectoral innovations documented in housing, criminal justice, and emergency response literature.

Tiered analysis approach. In-depth analysis of 55 prioritised studies, while cataloguing 215 eligible studies, means some solutions are not fully characterised. Prioritisation criteria favoured detailed service descriptions and transferability potential, potentially excluding early-stage innovations.

Mitigation: The Section 3.4 overview of the broader dataset provides visibility into patterns across all eligible studies, and Appendix B catalogues excluded studies for future reference.

4.4 Informing Next Steps

This section outlines how the findings from this review connect to subsequent tasks in the EQUICARES work programme. Rather than prescriptive recommendations, these are offered as considerations that emerge from the mapping exercise and may inform decisions across work packages.

4.4.1 For the Atlas on Mental Health and Care Innovative Solutions (T2.5)

The review findings have direct implications for how the Atlas is structured and what content it includes:

Navigation structure. The analysis reveals that users may approach the Atlas from different starting points—some seeking solutions for a specific population (e.g., 'what works for refugee youth?'), others seeking a type of intervention (e.g., 'what peer support models exist?'). This suggests value in a dual navigation structure enabling search by both population category and solution type.

Implementation level tagging. The finding that effective solutions typically operate across multiple levels (Section 3.3.8) suggests that Atlas entries should indicate whether solutions function at macro (policy/system), meso (organisational/regional), or micro (service delivery/community) levels—and flag where multi-level coordination is required.

Barrier-solution linkage. Integrating the access barrier categories from D1.1 (Levesque framework) with solution entries would enable users to identify interventions that address specific barriers. The six solution categories developed in this review (Section 3.3) provide one organising structure; linking these to D1.1's barrier taxonomy strengthens coherence across WP1 and WP2 outputs.

Evidence strength indicators. Given that documentation does not imply effectiveness, the Atlas should clearly communicate the level of evidence supporting each solution (e.g., RCT, controlled study, service evaluation, descriptive report). This will help users make informed decisions about adoption and adaptation.

Transferability guidance. For each Atlas entry, information on contextual factors that supported implementation—and those that may limit transfer to other settings—would help users assess relevance to their own context. The transferability considerations extracted for each study (Field 14) provide a starting point. Given that 76% of studies come from well-resourced Northern/Western European systems, users in other contexts should be cautioned that significant adaptation may be required.

Explicit gap acknowledgment. The Atlas should be transparent about what is not included. The geographic concentration and population gaps identified in this review should be communicated to users, with indication that gaps reflect the published literature rather than absence of practice or need.

4.4.2 For Fieldwork in Pilot Countries (T2.2–T2.4)

The gaps identified in this desk-based review can inform the focus of subsequent fieldwork activities:

Geographic priorities. The underrepresentation of some clusters of countries in the reviewed literature suggests these regions warrant particular attention in T2.2 (digital ethnography), T2.3 (benchmarking), and T2.4 (co-design workshops). Practitioner knowledge in these regions may reveal solutions not captured in academic publications.

Population priorities. Fieldwork offers opportunity to identify solutions for populations underrepresented in this review. The eight EQUICARES pilot sites may have local expertise on these groups that has not been formally documented.

Solution type priorities. Fieldwork should also actively seek solution types underrepresented in the reviewed literature: Housing First approaches, social prescribing models, workplace mental health interventions, criminal justice interfaces, and disaster response protocols. Cross-sectoral innovations may be documented in housing, criminal justice, or emergency response practice rather than mental health literature.

Practice-based knowledge. This review captured solutions that have been formally evaluated and published. Fieldwork can surface promising practices that have not yet been researched—particularly grassroots initiatives, informal community responses, and recent innovations not yet in the literature. The solution categories developed here (Section 3.3) may serve as a framework for organising fieldwork findings, while remaining open to mechanisms not represented in the current typology.

4.4.3 For Pilot Site Interventions (WP3)

Several cross-cutting patterns from the synthesis may inform intervention design at EQUICARES pilot sites, as follows.

Multi-component approaches. The review consistently found that solutions addressing access barriers combine multiple mechanisms—for example, culturally adapted content plus peer delivery plus flexible access points (Section 3.3.8). This suggests pilot interventions may be more effective when designed as integrated packages rather than single-component additions to existing services.

Demand-side and supply-side together. Effective solutions in this review addressed both supply-side barriers (service availability, workforce capacity, geographic distribution) and demand-side barriers (stigma, trust, cultural acceptability, health literacy). Pilot designs that attend only to service provision without addressing help-seeking barriers may achieve limited impact. Foundational work on acceptability and trust may be necessary before other investments can succeed.

Workforce diversification. Peer workers, cultural mediators, community health workers, and lay counsellors featured prominently in reviewed solutions (Section 3.3.6). These roles may offer pilot sites a mechanism for extending reach to underserved populations while building community trust and cultural responsiveness. Structured training and supervision are essential for quality assurance.

Digital as complement. Digital solutions in this review were most effective when they complemented rather than replaced human connection, and when accompanied by strategies to address digital exclusion (Section 3.3.5). Pilot sites considering digital components may benefit from hybrid models and explicit attention to populations with limited digital access—particularly older adults, who were severely underrepresented in national digital implementations.

Attention to intersectionality. Pilot sites should consider how compounding vulnerabilities create unique access barriers. LGBTQ+ refugees, youth with disabilities, older migrants with dementia—these intersections may require tailored approaches beyond single-population frameworks.

4.4.4 For Policy Recommendations and Evaluation (WP5)

The findings also have implications for the policy and evaluation work in WP5. The macro-meso-micro framework applied in this review (Section 1.3) revealed that sustainable access improvements typically require alignment across levels. Policy recommendations emerging from EQUICARES may need to address system architecture (macro), organisational arrangements (meso), and service delivery practices (micro) in coordinated fashion. Attention to demand-side barriers at the service level should not obscure the ongoing need for macro-level supply-side reforms.

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5. Conclusions

This deliverable presents a structured literature review of existing services, programmes, and interventions addressing mental health access barriers for people in vulnerable situations across the WHO European Region. The review identified 55 studies for in-depth analysis, exceeding the Task 2.1 KPI target (≥50 services) and providing a foundation for the Atlas on Mental Health and Care Innovative Solutions (T2.5).

The reviewed literature reveals a rich landscape of solutions, organised into six mechanism categories: integrated care models, culturally adapted services, outreach and low-threshold access, digital interventions, peer and lay worker programmes, and organisational capacity building. These categories are not mutually exclusive; effective solutions typically combine multiple mechanisms and operate across macro, meso, and micro implementation levels. The finding that 98% of studies employed multi-component approaches underscores that improving access for people in vulnerable situations requires coordinated action rather than single-point interventions.

The evidence base is concentrated on certain populations—children, adolescents, and youth (45%) and migrants/refugees (29%) together account for nearly three-quarters of primary study foci—with smaller bodies of evidence for LGBTQIA+ populations (7%), ethnic minorities (7%), and older adults (5%). Critical gaps exist for people with disabilities (0% primary focus), homeless individuals (2%), socioeconomically disadvantaged/rural populations (4%), and disaster-affected populations (0%). Geographically, 76% of studies came from Northern/Western Europe, with marked underrepresentation of Central and Eastern EU countries (2%), the Balkans and Türkiye (4%), and EECA countries (0%). These gaps highlight priorities for subsequent EQUICARES fieldwork (T2.2–T2.4) and targeted research investment.

Three important caveats temper the conclusions drawn from this evidence:

First, documentation does not imply effectiveness. While 18% of included studies were RCTs, many were pilot studies, qualitative evaluations, or service descriptions. The review maps what exists and what has been reported, not what has been proven to work. Users of this evidence should attend carefully to study design and outcome data when considering solution adoption.

Second, single-population classification may obscure intersectionality. Many individuals face compounding vulnerabilities—LGBTQ+ refugees, youth with disabilities, older migrants with cognitive decline—that create unique access barriers not fully captured by single-population categorisations. Service planners should attend to these intersections.

Third, geographic concentration raises fundamental transferability questions. Solutions developed in well-resourced Northern/Western European health systems may assume infrastructure, workforce capacity, and funding levels that do not exist elsewhere. Transfer to other WHO European Region contexts may require not just adaptation but fundamental redesign.

Despite these caveats, the findings underscore a central insight: improving mental health access for people in vulnerable situations is not primarily about increasing service supply, but about redesigning how services are delivered—making them more acceptable, culturally appropriate, flexibly accessible, and integrated across system levels. Solutions that combine service redesign, cultural adaptation, workforce expansion through task-shifting, and strategic use of digital innovation—embedded within supportive policy frameworks and built on foundations of community trust—show the greatest promise for sustainable impact.

Priority areas for future research include: solutions for populations with no or minimal primary evidence (disabilities, disaster-affected, homeless); evidence from underrepresented regions (Central and Eastern Europe within EU, Western Balkans / South-East Europe and Türkiye, EECA); effectiveness studies with robust designs and longer follow-up; implementation and sustainability research; and intersectional approaches addressing compounding vulnerabilities.

This mapping provides a starting point for the Atlas, to be enriched through subsequent fieldwork that will capture solutions not represented in academic literature and address identified geographic and population gaps. Together, these activities will support the EQUICARES objective of enabling WHO European Member States to improve mental health service accessibility and equity for all people in vulnerable situations.

The challenge ahead is clear: translating the solution principles identified in this review—multi-level implementation, cultural adaptation, demand-side focus, workforce diversification, community trust—into practical, scalable, and sustainable services across the diverse contexts of the WHO European Region. This will require not only service-level innovation but also the macro-level policy and investment reforms that lie beyond the scope of individual service innovations yet are essential for systemic change.

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APPENDIX A: Summary of Studies Prioritised for In-Depth Analysis

Ref.	Country	Pop. (primary)	Barriers (primary)	Service Type	Solutions (F9)	Access (F11)	Outcomes (F10)	Innovation (F12)	Implementation (F13)	Transferability (F14)
Aeschlimann et al., 2025	Switzerland	G1 (Migrants/ Refugees)	Structural/ Systemic (Supply-side)	Digital Mental Health	• Culturally adapted self-help app following RECAPT guidelines • Bottom-up cultural adaptation process with Syrian community involvement • Arabic language delivery • Content addressing culturally relevant grief topics (rituals, religion, social relationships) • Partnership between university and humanitarian organization (Swiss Red Cross) • Fictional bird character "Sui" guides users through app	• Recruitment: in-person at asylum centres, through previous study participants, snowball sampling, social media, web • Swiss Red Cross specialists and cantonal asylum centres promoted recruitment • Syrian-origin study translators recruited many participants • Screening: in-person or via phone based on participant preference • In-person assessments at university, SRC, or participant-chosen location	• Dropout rate: 3.3% (1 participant from control group) • Adherence: 40% (n=6) completed full intervention (all 6 sessions) • Mean sessions completed: 3.74 (SD=2.25) out of 6 • CSQ-I satisfaction: M=27.4/32 (SD=3.66) • 93.3% rated intervention as high quality	• First culturally adapted IBI specifically targeting bereavement among Syrian refugees • Rigorous bottom-up cultural adaptation following RECAPT guidelines • Arabic language delivery with culturally relevant content (rituals, religion, social relationships) • Fictional Syrian refugee vignettes (Yasmin and Amir) to enhance relatability	• Success: Exceptionally low dropout rate (3.3%) compared to typical IBI dropout (2.9–80%); high satisfaction (CSQ-I 27.4/32) exceeding other culturally adapted IBIs; thorough cultural adaptation aligned with participants' values; clear language and linear structure enhanced usability; interactive elements (video testimonials, vignettes) maintained engagement • Challenges: 40% adherence (completion of all sessions) — typical for IBIs but room for improvement; technical problems persisted; accessibility barriers for low literacy; time constraints limited engagement • Limits: Small sample size (n=30); pilot design not powered for efficacy; in-person assessments may inflate adherence; 5-week intervention relatively short	• Supports: Addresses universal gap in bereavement support for refugees; RECAPT-guided cultural adaptation provides replicable methodology; app-based delivery scalable and low-cost; high smartphone use among Syrian refugees globally; Arabic language reaches large populations across Europe; effect sizes comparable to other grief IBIs • Limits: Swiss context-specific; requires Arabic literacy; smartphone/internet access required; cultural adaptation specific to Syrian population; unguided format may not suit severe cases • Scale-Up Needs: Add text-as-audio option for low literacy users; resolve technical issues; consider guided option for more severe cases
Carey et al., 2025	Ireland	G3 (Youth)	Structural/ Systemic (Supply-side)	Integrated / Multi-Sector Services + Peer-Delivered / Lay Worker Services	• Youth Advocate pathway integrated into Jigsaw organization • standPOINTS advocacy training system (6 components: Power of persuasion, Orientation, Investigating, Negotiating, • COM-B model applied to local campaigns for behaviour change • Community asset mapping and needs assessment • Local advocacy action plans reviewed via	• Recruitment through Jigsaw's Youth Advocate pathway in 11 local services • Voluntary participation by young people aged 16--25 • Staff facilitation by Youth and Community Engagement Workers, clinicians, service managers • Accessibility supports: travel reimbursements, digital participation options, tailored accommodations (quiet spaces • Multiple entry points via three overlapping pathways (Lived Experience, Community Voices, Youth Advocate)	• 65 young people participated across 11 local services • 12 local advocacy projects completed across 3 themes (Early Intervention, Equitable Access, Community Collaboration) • Staff observed substantial growth in youth confidence and advocacy skills • Providing clear structure and practical support sustains engagement • Fostering passion, ownership and	• Co-designed advocacy training using standPOINTS system (developed with advocates, staff, external consultant) • Application of COM-B behaviour change model to youth mental health advocacy context • Youth Advocate Researchers providing peer-to-peer research consultation • Three overlapping participation pathways within organizational structure	• Success: Organisational commitment and visible leadership buy-in; structured frameworks (COM-B, APEASE, standPOINTS) provided clear roadmaps; peer-to-peer mentorship reduced power imbalances; youth ownership over topic selection deepened commitment; celebrating successes maintained motivation; flexibility allowed local adaptation • Challenges: Varying motivation levels across local groups; maintaining momentum when facing unforeseen challenges (e.g., leadership changes); persistent power imbalances despite mitigation efforts; procedural tools alone insufficient	• Supports: Evidence-based frameworks (COM-B, APEASE) widely used internationally; Lundy Model aligned with UNCRC Article 12 — applicable across signatory countries; flexible model adaptable to local contexts; addresses universal barriers (fragmented services, underfunding, marginalisation); structured training (standPOINTS) replicable • Limits: Irish-specific context (Jigsaw organisation); funding through Erasmus+ requires similar mechanisms; requires existing organisational infrastructure; depends on

Ref.	Country	Pop. (primary)	Barriers (primary)	Service Type	Solutions (F9)	Access (F11)	Outcomes (F10)	Innovation (F12)	Implementation (F13)	Transferability (F14)
					COMPASS meetings		long-term commitment		• Limits: No control group or formal outcome evaluation; self-report data only; limited generalisability due to Irish/Jigsaw context; authors include staff and advocates (potential bias)	sustained leadership commitment • Scale-Up Needs: Dedicated funding for youth advocacy roles with formal decision-making power; training infrastructure for advocacy skills and research methods
Stockwell et al., 2025	Multi-country (UK + USA)	G2 (Ethnic minorities)	Multiple barriers	Community-Based Mental Health Services + Peer-Delivered/Lay Worker Services	• Culturally sensitive/ adapted interventions specifically designed for Black men • Recreational/ lifestyle-based approaches (exercise, arts, photography, social media) • Health literacy education on mental health and culturally relevant needs • Third sector/charitable organizations (e.g., MIND Young Black Men Program, 100 Black Men of London) • Community-based delivery outside traditional clinical settings	• Self-referral to community/third sector programmes • Referral from tertiary centres • Online access via social media (Facebook) • Community-based locations outside clinical settings • Group-based delivery promoting peer connection	• PHQ-9 decreased (Z=−2.05, p\<.01) • GMDS decreased (Z=−1.76, p\<.05) Ciccolo et al. (2022) - Resistance training RCT: • QIDS depression decreased at end of treatment (b=−3.00, SE=1.34, p=0.01, f^2=0.15) • GAD-7 anxiety decreased at end of treatment (b=−2.67, SE=1.06, p=0.02, f^2=0.05) • Depression sustained at 6 months (QIDS b=−2.63, p=0.04)	• Recreational/ lifestyle-based approaches to mental health (exercise, arts, photography, social media) • Culturally sensitive design specifically for Black men • Peer support and group work as core mechanisms • Addressing concepts of masculinity within interventions	• Success: All 5 interventions reported positive outcomes; group work and peer support valued by participants; culturally sensitive design addressed feeling understood; non-clinical activities (exercise, arts) improved engagement; addressing masculinity concepts featured in 4/5 studies; autonomy and sense of belonging reduced isolation • Challenges: Only 5 studies found despite extensive search — major evidence gap; high dropout rates; difficulty completing psychometric questionnaires; "methodological whiteness" excludes Black men from research • Limits: Heterogeneous grouping across countries/cultures; potential publication bias — all studies positive; small number of studies limits generalisability	• Supports: Similar issues for Black men across Western societies; recreational/lifestyle approaches adaptable; third sector partnership model replicable; group work and peer support universally valued; programme theory framework transferable • Limits: Only 5 studies — limited evidence base; heterogeneity of Black populations; healthcare contexts differ (UK NHS vs USA); masculinity concepts may vary across cultures • Scale-Up Needs: Lower threshold for hierarchy of evidence for commissioning; culturally sensitive research design (flexible timing, compensation, peer researchers); partnership with existing third sector organisations; publication of QI and service evaluation findings
Crombach et al., 2025	Netherlands	G3 (Youth)	Acceptability/Trust/Stigma (Demand-side)	Community-Based Mental Health Services + Peer-Delivered/Lay Worker Services	• @ease youth mental health walk-in centres - anonymous, free, no appointment needed • Pilot community outreach program to proactively reach underrepresented groups • Social worker + peer worker pairs approaching young people in community settings • Training in @ease method:	• Walk-in centres --- no appointment or referral required • Anonymous and free-of-charge • Target age 12--25 years • Located in youth-friendly community settings Pilot outreach model: • Proactive approach by social worker + peer worker pairs	• 66 participants enrolled in pilot outreach program • Demographic profile differed from standard @ease walk-in visitors: • Lower mean age (18.4 vs higher in > previous studies) • Gender balance (45.8% male vs > female-majority typically) • Lower education levels	• Adaptation of walk-in model to include proactive community outreach • Social worker + trained peer worker pairing for outreach visits • Approaching young people in familiar community settings (hangouts, community centres) • Peer-to-peer professionally supported model	• Success: Outreach successfully reached underrepresented groups (45.8% male, lower education, younger age); high clinical need in sample (90.2% above CORE-10 cut-off); peer involvement valued; community locations reduced stigma; proactive approach overcame barrier of not knowing where to find help • Challenges: Long waiting lists remain major barrier (8/12 mentioned); dropout pattern: high threshold → distress → waitlist → stop seeking; previous negative MH care experiences deterred help-seeking (5/12);	• Supports: Part of international network (headspace Australia, Jigsaw Ireland, Foundry Canada); barriers identified (stigma, waiting lists, literacy) are universal; peer-support model adaptable; community outreach approach generalisable; low-threshold anonymous free model addresses common access barriers; successfully reached typically underrepresented groups • Limits: Dutch healthcare context specific; urban-only implementation; requires trained peer workers and

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					active listening, solution-focused communication, motivational interviewing • Pathway navigation to professional mental health care				masculinity norms barrier for young men • Limits: Exploratory design — no effectiveness outcomes; urban-only recruitment; small qualitative sample (n=12); most authors involved with @ease Foundation — potential conflict of interest	professional social workers; dependent on existing @ease infrastructure • Scale-Up Needs: Extension to rural areas; specific adaptations for LGBTQ+ youth, mild intellectual disability, culturally diverse groups; waiting list interventions to prevent dropout; parental/caregiver involvement strategies
Nieder et al., 2024	Germany	G4 (LGBTQI A+)	Geographic /Administrative (Supply-side)	Digital Mental Health Interventions + Targeted Specialised Mental Health Services	• i²TransHealth e-health intervention with video consultations • Trained study therapists providing TGD-informed mental health care • Local physicians' network (GPs + psychiatrists) in six locations • 2-day TGD health care training for network physicians • Continuous online supervision for network	• Recruitment via TGD community organisations, physicians' network, social media, professional journals • Initial on-site interview at University Medical Centre Hamburg-Eppendorf • Written informed consent obtained at initial appointment • Eligibility screening: gender incongruence/dysphoria criteria, age ≥18, distance ≥50 km from Hamburg • Randomisation to immediate intervention or 4-month wait list	• Intervention group: adjusted mean change from baseline −0.65 (95% CI −2.25 to 0.96; p=0.43) • Control group: adjusted mean change +2.34 (95% CI 0.65 to 4.02; p=0.0069) • Between-group difference: −2.98 (95% CI −5.31 to −0.65; p=0.012) • Per-protocol analysis confirmed: −3.32 (95% CI −5.73 to −0.92; p=0.0071) • Improved: 22.7% (n=20)	• First RCT of e-health intervention specifically for TGD people in health care setting • Randomised group allocation with wait list control design • Interdisciplinary e-health approach combining video consultations + platform + local network • Trained local physician network (GPs + psychiatrists) with 2-day TGD training + ongoing supervision	• Success: Significant reduction in psychological distress deterioration (p=0.012); high treatment adherence (88% completed ≥6/8 sessions); high satisfaction (ZUF-8 mean 29.59/32 — exceeds typical TGD care studies); 95% outcome completeness despite COVID-19; successful recruitment (n=174); participatory development ensured intervention met TGD needs; tailored approach aligned with TGD health care standards • Challenges: Wait list control group experienced significant worsening (p=0.0069); German legal requirement for initial in-person appointment limits fully remote access; selection bias possible; single-centre design • Limits: Short-term evaluation (4 months); cannot determine if effect due to intervention or facilitated access; no comparison with face-to-face; cost-effectiveness analysis forthcoming	• Supports: First RCT evidence for e-health in TGD health care — strong methodological quality; addresses universal barrier (geographic access to specialty care); sample demographics align internationally; e-health approaches gaining acceptance post-COVID-19; physician network training model replicable; tailored approach adaptable • Limits: German healthcare system specific; legal requirements for initial in-person vary by country; single-centre northern Germany; requires trained TGD-informed therapists; digital infrastructure required • Scale-Up Needs: Health insurance funding for e-health TGD services; training infrastructure for local physician networks; integration with endocrinology and post-surgical care; adaptation for different regulatory environments
Reich et al., 2024	Germany	G1 (Migrants/ Refugees)	Language/ Cultural (Supply-side + Demand-side)	Digital Mental Health Interventions	• Arabic-language versions of two evidence-informed DID (website + guided tool) • Free-of-charge provision through European Alliance Against Depression • Guide training system with CME	• Publicly available online (ifightdepression.com) • No registration required • Promoted via press releases, newsletters, social media, conferences • Bilingual leaflets distributed to	• Arabic page views increased from 128 (year 1) to 1,092 (year 2, • Arabic unique page views: 97 → 802 → 1,708 over three years • German page views doubled year 1 to year 2, stable year 3	• Multi-language scaling of evidence-based DID (19 languages for website, 16 for tool) • Expert panel-guided cultural adaptation process with iterative refinement • ASR-specific content additions: resilience workshop + German	• Success: Comparable acceptability between Arabic and German users (time on page, workshop completion); sustained website growth over 3 years (+853% year 2, +226% year 3); cross-border reach (44.7% users outside Germany); expert panel ensured cultural appropriateness; free-of-charge provision removes	• Supports: Multi-language platform available (19/16 languages) — model for scaling; evidence-based CBT content with RCT-established efficacy; free-of-charge provision replicable; expert panel cultural adaptation process documented and transferable; cross-border reach demonstrates

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					accreditation for healthcare professionals • Multi-channel implementation: primary care, specialist services, social services, refugee support • Mailing campaigns to arrival centres, refugee centres, psychosocial centres, health centres	refugee/health centres iFD Tool: • Guided access model --- requires invitation from trained guide	ADOPTION (iFD tool): • Only 37 guides offered Arabic version vs 919 for German version • Median 1 user invited per Arabic guide vs 3 per German guide	healthcare system guide • Guided self-management model with CME-accredited professional training	financial barriers; evidence-informed interventions with established efficacy • Challenges: Very low guide uptake (37 Arabic vs 919 German); significantly lower conversion rates (30.8% vs 59.0%); pervasiveness 9x lower in Arabic population; Arabic users presented with higher severity than intended; technology/internet access barriers; housing conditions limit DID use • Limits: Arabic versions not tested in RCT; no patient/ASR representatives in expert panel; small sample (n=24); no effectiveness outcomes assessed	transnational potential; already expanding to Ukrainian/Russian versions • Limits: German healthcare system specific; requires digital infrastructure; guided model requires trained workforce; low conversion rates suggest need for facilitation strategies • Scale-Up Needs: App version for offline use to address connectivity barriers; strategies to increase guide uptake among ASR-serving professionals; search engine optimisation for findability; patient/ASR involvement in future adaptations
Ganga et al., 2024	United Kingdom	G3 (Youth)	Structural/Systemic (Supply-side)	Digital Mental Health Interventions + Integrated/ Multi-Sector Services	• "CYP as One" digital referral platform replacing paper-based system • Multi-pathway referral: professionals, parents, CYP, self-referral • EPR integration for seamless data entry • ORCHA database of professionally validated mental health resources • Single point of access for 9 CAMHS partnership services	• Web-based platform accessible 24/7 • Multiple referral pathways: professionals, parents, CYP, self- referral • No face-to-face requirement for initial referral • Self-referral option --- parents or CYP aged 14+ can refer directly • Integration with Electronic Patient Record (seamless data entry)	• 1,314 additional referrals (+61% increase; p<.001) • 71% increase in parent and CYP self-referrals • Shift from professional-led (−15%) to parent- (+13%) and CYP-led (+12%) referrals • Waiting times significantly reduced in months 10--12: > -- Month 10/Feb: 24.01 vs 40.19 days > (−16.18 days • 7.48% more CYP seen within 2 weeks post-implementation (73.08% vs 65.60%)	• Single point of digital access for 9 CAMHS partnership services ("digital front door" concept) • Co-designed with CYP, parents, and professionals using Living Lab methodology (5 iterative phases) • EPR integration - referrals directly populate Electronic Patient Record • ORCHA database of professionally validated mental health resources for self-help	• Success: Significant increase in referrals (+61%, 1,314 additional); 71% increase in parent/CYP self-referrals — demonstrates accessibility; waiting times substantially reduced after 9-month adaptation period; 7.48% more CYP seen within 2 weeks; exceeded government 4-week target by month 12; co-design with extensive PPI (26 CYP, 31 parents, 32 professionals) • Challenges: Initial increase in waiting times during first 9 months — adaptation period; increased rejection rates (2→201) due to volume surge; staffing not increased to match 61% increase; COVID-19 confounded implementation • Limits: Single-centre study (Liverpool/Sefton); COVID-19 timing may not reflect normal conditions; no sociodemographic data collected; historical control design — no randomisation	• Supports: Addresses universal barriers (waiting times, access, paper-based inefficiency); digital platform model scalable; co-design methodology (Living Lab) replicable; aligns with NHS digital transformation priorities; EPR integration applicable to other NHS Trusts; multiple referral pathways adaptable • Limits: UK NHS-specific context (CCGs, NHS Trust structure); single-centre Liverpool/Sefton; COVID-19 timing; requires EPR integration infrastructure; technology access disparities • Scale-Up Needs: Staffing increases to match referral volume growth; cost-effectiveness analysis; sociodemographic analysis of reach across disadvantaged communities
Smith et al., 2025	United Kingdom	G3 (Youth)	Structural/Systemic (Supply-side)	Targeted Specialised Mental Health Services + Integrated/	• NHS--third sector partnership (SLaM CAMHS + Oval House Theatre) • Multiple referral pathways: schools (26%), CAMHS	• Multiple referral routes: schools (26%), CAMHS (43%), Social Services (19%), third sector organizations (3%)	• SDQ Impact scale reduced (mean diff=1.36, 95% CI 0.33-2.39, p=.01), perceived impact of	• NHS-third sector partnership model (specialist CAMHS + community arts organization) • Blended DBT + participatory creative	• • Success: Completion rates (57–67%) within range for community DBT (24–58%); diverse ethnic representation (76.7% racially minoritised); high satisfaction (87–91% positive); arts identified as	• Supports: Addresses universal barriers (stigma, waiting lists, cross-sector gaps); DBT has established evidence base for adolescent self-harm; arts/social prescribing

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				Multi-Sector Services	(43%), Social Services (19%), third sector (3%), direct/family (9%) • Self-referral accepted • Standardized DBT skills groups adapted for adolescents • Creative arts augmentation to increase accessibility and engagement	• Targeted recruitment in high-deprivation boroughs (Lambeth, Southwark) • Publicized via SLaM website, information sheets, videos, posters circulated to institutions • Introductory meeting: arts "taster" session + clinical screening + brief risk assessment • Screening criteria: McLean BPD score ≥4; self-harm within past 12 months; not currently in targeted mental health care	difficulties decreased • PSS Significant Other subscale improved (mean diff=−2.67, 95% CI −5.00 to −0.33, p=.03) - perceived social support • Self-harm frequency reduced (36% reporting >11 incidents pre vs 12.5% post; Fisher's p=.20) • SDQ Prosocial improved (p=.07) • WEMWBS wellbeing improved (p=.12)	arts intervention --- novel combination • Concept mapping exercise to identify thematic overlaps between DBT skills and arts practices • Community arts venue (Oval House Theatre) - less stigmatizing than hospital/clinic settings	crucial engagement factor; improved completion in year 2 despite COVID-19; trusted relationships with practitioners; no significant ethnicity differences between completers/non-completers • Challenges: 38% overall non-completion; "Looked After" children did not complete (n=2, both dropped out); non-completers had significantly higher baseline emotional difficulties; familial difficulties associated with dropout; COVID-19 caused 5-month delay • Limits: No control group — cannot infer effectiveness; underpowered for clinical changes; women-only design; no measure of deprivation; missing data precluded ITT analysis	gaining international policy traction (WHO, NICE); NHS–third sector partnership model replicable; ethnically diverse sample supports applicability; completion rates comparable to international benchmarks • Limits: UK NHS context specific; requires DBT-trained psychologist + professional artists; women-only design; did not retain care-experienced children; English proficiency required • Scale-Up Needs: Adaptations for young men who self-harm; adaptations for "Looked After"/care-experienced youth; standardised outcome measurement and deprivation indices; training/competency frameworks for arts-psychology practitioners
Carballeira Carrera et al., 2020	Multiple (UK, France, USA, Canada, Australia, Nordic countries, etc)	G1 (Migrants/ Refugees)	Mixed: Structural + Cultural	Targeted Specialised Mental Health Services	• Interpreters and cultural mediators > linguistic and symbolic function • Cultural competence training and > supervision for professionals • Ethnic matching of therapist and patient • Cultural Consultation Services (CCS) \ consultation-liaison model (McGill, UK adaptations) • Ethno-specific clinics (USA, Canada)	• Ethnic matching: patients matched with therapist of same ethnicity/language • Cultural Consultation Services: referral by > professional when cultural > factors compromise evaluation/treatment • Ethno-specific clinics: direct access for > specific ethnic communities • French TPT: referral from medical, social, educational institutions after failure of standard management	• 29 papers included; quality globally good except international policy context description • Models grouped by country history, migration patterns, citizenship model • Most initiatives focus on training/supervision (indirect approach) or ethnic matching • French TPT unique as complete psychotherapeutic method making culture integral to therapy • UK: Specialized services for ethnic minorities; CCS adaptations; transcultural mental health workers	• French TPT as complete psychotherapeutic method (vs. framework adaptation) • Multicultural therapy group embodies > otherness as therapeutic lever • Dual complementary interpretation: anthropological + clinical psychoanalytic • Indirect communication style (addressing principal therapist) enables emotional containment	• Success: Models adapted to national contexts, migration histories, citizenship models; Australia achieved nationwide network with public funding and workforce training focus; Canada's "reasonable accommodation" legal framework supports pluralism; French TPT rooted in ethno-psychoanalytic theory (Devereux) and evolved since 1980s; group format congruent with collective care approaches in traditional societies • Challenges: No overall consensus on single good practice model (UK); cultural competence training limited by adaptability of standard treatments; ethnic matching conflates language, ethnicity, culture; sustainable changes require national plan and strategy • Limits: Scoping review with heterogeneous articles; no existing quality checklists for conceptual articles; custom	• Supports: Multiple adaptable models identified across different healthcare systems; core principles applicable (interpreter use, cultural competence training, consultation services); CCS model (McGill) successfully adapted to UK context; French TPT therapeutic processes theory-based and manualised; positive health framework concepts (transitional space, decentring) cross-culturally relevant • Limits: Models strongly shaped by national migration histories and citizenship models; French TPT requires trained multicultural co-therapist group; training requirements substantial • Scale-Up Needs: National policy frameworks to support sustainable change; long-term funding, research, guidelines, staff training;

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									quality appraisal tool created; limited to English, French, Spanish publications	integration of cultural psychiatry into general healthcare facilities
Van Everdingen et al., 2021	Netherlands	G8 (Homeless)	Structural/ Systemic (Supply-side)	Targeted Specialised Mental Health Services + Community-Based Mental Health Services	• HOP-TR comprehensive assessment approach with 6 fundamentals: user perspective primary; transdiagnostic mental health • InterRAI CMH questionnaire + custom Homelessness Supplement (71 items) • Clinical integrating assessments for physical health, mental health, concurrent problems • Mental Health Related Care Needs decision tree based on Dutch SMI/EPA consensus definition • Healthcare ecosystem approach for dialog at nano/micro/meso/ macro levels • Positive health framework: 6 domains (physical, mental, daily functioning, social participation, QoL, meaning)	• Homeless Service (HS) access typically > requires valid residence permit • Entry via night shelters (67.4%), crisis shelters, daytime shelters, protected living facilities • 8 participants without valid residence permit included via open daytime shelter • Naturalistic recruitment: researcher participated in program activities (meals, opening sessions) to lower contact • Snowball sampling: original subjects > introduced researcher to network	• Mean Mental Health Problems (MHP): 5.3 > (range 0-10, SD 1.9) • Mean Physical Health Problems (PHP): 1.1 > (range 0-7, SD 1.2) • Mean Concurrent Health Problems (CHP): 2.8 > (range 0-4, SD 0.84) • Mean Mental Health Related Care Needs (MHRCN): 1.7 (range 0-2, SD 0.6) • 95% had CHP affecting 2+ domains	• Transdiagnostic mental health strategy \ identifies 12 features across/beyond DSM diagnoses • Positive health framework integration \- 6 domains mapped to 3 recovery dimensions • Healthcare ecosystem approach \ dialogs at nano/micro/meso/ macro levels • Rights-based assessment codes: Future Living Status (optimal residence based on needs); Care-Needs Appraisal	• Success: Saturated sample achieved (436 HS users); high participation rates in most facilities (44–76% of caseload); comprehensive data across multiple domains enables pattern analysis; local reports responded well to municipal information needs; transparent results stimulated multi-stakeholder dialogue; some regions forged long-term commitment for care improvement • Challenges: Single assessor (single MD researcher) — potential bias; medical records unavailable in most settings; 4/5 subjects had not visited physician in past 3 months; cross-sectional design overrepresents complex cases • Limits: Data quality limited to single encounters; no control group; cannot estimate prevalence in broader homeless population; generalisability limited by facility-based recruitment	• Supports: Assessment approach highly manualised — replicable; InterRAI CMH internationally validated instrument; positive health framework applicable across contexts; transdiagnostic approach addresses universal limitations of categorical diagnoses; healthcare ecosystem framework adaptable; rights-based assessment principles universally applicable; supplementary materials provide complete variable overview • Limits: Dutch healthcare/welfare system specific; requires interviewer with medical background; Dutch language instruments; urban Western European context only • Scale-Up Needs: Training programmes for interviewers with various backgrounds (nursing, psychology, social work); staged approach option with basic interviews by trained social workers + clinical reinterviews; public health oversight within research team
Adriaenssens et al., 2019	Belgium (primary), England, France, Net	G5 (Older adults)	Structural/Systemic (Supply-side)	Integrated / Multi-Sector Services + Community-Based Mental Health Services	• CARITAS principles: Comprehensive, Accessible, Responsive, Individualised, Transdisciplinary, Accountable, Systemic • Chronic Care Model (CCM): community, health	• GPs as first-line contact -- well-positioned due to long-lasting bond with patients, holistic view, low-threshold access • Elderly preference for primary care over specialised mental health institutions • Mobile crisis teams for acute care	• Collaborative care: effective for major depression, suicidal ideation, behavioural symptoms in Alzheimer's • Stepped care embedded in collaborative care: effective for major depression,	• England: IAPT services providing first-line psychotherapy access; mobile crisis teams; liaison MH teams in hospitals • Netherlands: Mental health nurse or psychologist supporting GPs in primary care • Canada: Geriatric emergency nurses for acute somatic	• Success: Collaborative care with case manager coordination effective; multidisciplinary teams systematically present in effective services; GP involvement with specialist support (psychiatric nurses, psychologists); national/regional guidelines support implementation (England, Canada); anti-	• Supports: CARITAS principles and CCM provide universally applicable frameworks; evidence for collaborative care effectiveness across multiple conditions; international comparison identifies transferable models (IAPT, mobile teams, GP support); common barriers identified across countries (stigma,

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	herlands, Canada)				system, care team, and patient levels • Collaborative Care: multi-facetted intervention, case manager coordination, enhanced inter-professional communication • Stepped Care: least intensive intervention first, stepping up/down based on need • Indicated Prevention: early intervention > for those showing risk signs	(identified in England, Netherlands, Canada) • Community mental health centres with > specialist elderly teams • Liaison mental health teams in general > hospitals	depression/anxiety in residential care • Indicated prevention + stepped care: effective for minor/sub-threshold depression • Watch-and-wait embedded in stepped care: effective for depression/anxiety in residential care • Watch-and-wait alone: not effective for > major depression	conditions (delirium); multidisciplinary day hospital teams • France: Old-age psychiatrists with specific training to identify somatic problems	stigma awareness campaigns contribute to access • Challenges: Fragmentation of care; rigid referral systems; lack of communication and data sharing between providers; stigma and wrong beliefs about mental health in elderly; GP knowledge/skill gaps; competition between care providers; funding constraints • Limits: Only 4 countries in international comparison; purposive survey sample — may not represent entire Belgian MHCE landscape; narrative review rather than systematic review; 2016 data	training gaps, fragmentation) • Limits: Belgium-specific policy context and 2010 mental health reform structure; healthcare financing systems vary by country; international comparison limited to 4 high-income Western countries; 2016 data • Scale-Up Needs: Expand Belgian 2010 mental health reform to include elderly; develop national guidelines for MHCE; training programmes for all healthcare providers on elderly mental health
Venkataraman et al., 2024	United Kingdom	G5 (Older adults)	Structural/Systemic (Supply-side)	Targeted Specialised Mental Health Services + Digital Mental Health Interventions	• Remote Brain Health Clinic model within > NHS mental health trust • Satellite biomarker assessments (lumbar puncture at BRC Clinical Research Facility) • Comprehensive biomarker panel: CSF, genetics, blood, automated MRI • Standardised remote cognitive assessment > battery • Two online psychological intervention > groups	• Referral from three SLaM memory services after initial clinical assessment and MCI/mild dementia diagnosis • Remote assessment via Microsoft Teams > video or telephone • Satellite lumbar puncture at BRC Clinical > Research Facility • Cognitive assessments emailed to > participants (self-administered) • SLaM Digital Inclusion Team support > available	• 86% very satisfied/satisfied with overall > remote service • 95% very satisfied with lumbar puncture procedure; 0% significant complications • 93% found saliva genotyping very > easy/easy; 100% instructions clear • 93% found cognitive assessment (ICA) > instructions clear • 98% satisfied with Cognitive Wellbeing > Group	• First remote biomarker-enhanced memory clinic within UK NHS mental health trust • Satellite lumbar puncture service with > rapid CSF turnaround (1 day) • Saliva-based polygenic risk scoring for Alzheimer's disease (genoSCORE) • AI-based cognitive assessment (ICA) -- 5-minute, language-independent, self-administered	• Success: High acceptability (86% satisfied with remote service; 95% satisfied with lumbar puncture); safe lumbar puncture — no significant complications; fast biomarker turnaround (1 day CSF results); ethnically diverse and representative cohort (42% minoritised vs 13% nationally); effective intervention groups (98% satisfied; 90% goals achieved) • Challenges: Digital exclusion — 27% telephone only; considerable proportion did not complete digital set-up; limited capacity constrained recruitment (only 68/146 enrolled in research); Digital Inclusion Team support only available for limited time • Limits: Small sample size (n=68 research, n=146 total); participants may be more engaged than typical population; single NHS trust — generalisability uncertain; no controlled comparison	• Supports: Remote model addresses universal challenges (travel, capacity, waiting times); ethnically diverse cohort (42% minoritised) demonstrates feasibility in diverse populations; uses validated cognitive assessments; aligns with emerging disease-modifying therapy requirements globally; addresses European task force recommendations for brain health services • Limits: UK NHS-specific context; requires biomarker infrastructure (CSF, MRI, genetic testing); digital inclusion support needed; urban London setting • Scale-Up Needs: Expand to other memory clinics in South London and beyond; integrate with primary care for earlier MCI detection; implement blood-based biomarkers when validated to reduce need for lumbar puncture
Price et al., 2019	United Kingdom	G3 (Youth)	Transition Gaps (Supply-side)	CAMHS / Youth Mental Health Services + Transition	• Parents as essential navigators: seeking, translating, and	• Referral from CAMHS/paediatrics to adult > services (where available) • Parents persistently seeking information	• Parent support essential for transition regardless of young person's age	• First UK in-depth exploration of information role in ADHD transitions from young person/parent perspective	• Success: Information provided early and repeated over time gave stability; parent involvement in information communication essential; knowing what to	• Supports: Large qualitative sample (n=92) across diverse service configurations; three transition stages enable understanding of full

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				to adult services	managing information • Parents coaching young people in > information management skills • Support workers helping young adults > re-access services • Provide information early (ideally from diagnosis) that ADHD may persist into adulthood • Include parents in communication of key information (with young adult consent)	and service access on young person's behalf • GPs as gatekeepers -- but often unable to provide appropriate information or signposting • Young adults attempting to re-enter via GP referral (often unsuccessful) • Support workers (e.g., hostel staff) helping young adults access services	• Without parent advocacy, many would > not have transitioned • Young adults without parent support reported multiple failed attempts to access services 2. Information on ADHD • Basic understanding that ADHD may persist related to understanding need to remain engaged • Many misinformed that 'you definitely > grow out of it'	• Large qualitative sample (n=92) across 10 NHS Trusts with varying service models • Three groups at different transition > stages enabling comparison • Part of CATCh-uS national surveillance > programme • Digital/technological solutions for > information sharing	expect reduced anxiety and enabled preparation; even knowing there was no service was better than finding out after leaving child services • Challenges: Majority received limited or no transition information; child clinicians often unaware of adult service availability; GPs frequently unable to provide appropriate information; chaotic service structures — 'juggled round departments'; adult services exclude parents • Limits: NHS recruitment only — could not reach those disengaged from all services; limited information on those who fail to transition; self-selected sample	pathway; findings align with NICE guidelines — provides evidence base; information needs likely generalisable to other long-term conditions; specific ADHD-related barriers identified for tailored approaches • Limits: UK NHS-specific context and service structures; CAMHS/AMHS split may differ in other countries; patchy adult ADHD provision UK-specific • Scale-Up Needs: National digital resources on ADHD and transition; GP training on adult ADHD and local service availability; clear service mapping
Parr et al., 2024	United Kingdom	G3 (Youth)	Structural/Systemic (Supply-side)	CAMHS / Youth Mental Health Services + Targeted Specialised Mental Health Services	• Pre-appointment information gathering (70.3% of teams improved this) • Digital technology introduction (43.9% of > teams) • Single pathway for autism and ADHD > assessment • Adapting professionals' roles and skill > mix • Reducing assessment steps when sufficient > evidence available	• Referral to diagnostic pathway (various > routes depending on locality) • Pre-assessment information collection (reports from professionals, questionnaires) • MDT assessment (composition varies by > service type) • Paediatrics: most assess 0--18 years; all > assess age 4+ • CAMHS: most assess 8--18 years; \~50% > assess from age 4--5	• Referrals increased 115% (2015--2019); completed assessments increased 68% • Waiting times: paediatrics 9 months, CAMHS 10 months (vs 3-month NICE target) • 76% of assessed children received autism > diagnosis (both settings) • Only 17.9% always meet NICE guidance; > 67.2% meet most/all of time • Only 26.4% paediatrics, 34.8% CAMHS start assessment within 3 months	• Digital technology adoption (43.9% of > teams) • Pre-appointment information gathering > improvements (70.3%) • Single integrated pathway for ASD + ADHD > assessment • Adapting professionals' roles to address > skill gaps	• Success: Pre-appointment information improves assessment speed (69.5%), quality (85.2%), satisfaction (78.9%); integrated services better able to meet NICE guidance; 70.3% of teams improved referral information gathering within existing resources; teams motivated to improve — identified multiple adaptations • Challenges: 115% referral increase with static/decreased funding (75.8%); incomplete MDTs with critical gaps in key professionals; CAMHS and paediatrics working in isolation; many unable to assess/diagnose co-occurring conditions; 35.9% report increased case complexity • Limits: No central record of UK autism diagnostic teams (unknown denominator); non-validated survey questionnaire; self-reported data; limited responses from Scotland, Wales, Northern Ireland; survey during COVID-19	• Supports: Large sample (128 teams) across UK NHS providing comprehensive picture; identifies universal challenges (workforce shortages, funding constraints, rising demand); NICE guidance provides transferable quality standards framework; solutions identified (pre-appointment information, digital technology) applicable to other contexts • Limits: UK NHS-specific context and commissioning structures; NICE guidance UK-specific; paediatrics/CAMHS organisational split UK-specific; survey conducted during COVID-19 • Scale-Up Needs: Investment in MDT expertise and specialist clinicians; integrated service models bridging paediatrics and CAMHS
Lelutiu-Weinberger et al., 2023	Romania	G4 (LGBTQIA+)	Acceptability/Trust/Stigma	Targeted Specialised Mental Health	• Two-day LGBTQ-affirmative mental health > training	• Recruitment via advertisements to mental health organizations,	• Explicit bias reduction (d=0.35, p<0.01)	• RCT comparison of in-person vs online training modalities (first	• Success: High training attendance (94%) and acceptability (92% informative; 98% would	• Supports: Evidence-based curriculum (minority stress theory, LGBTQ-affirmative principles, APA guidelines);

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			(Demand-side)	Services Capacity Building	• Evidence-based curriculum: minority stress theory, LGBTQ-affirmative therapy principles, APA guidelines • CBT integration with minority stress approach (case conceptualization, techniques) • Optional monthly online supervision for 8 > months • Online delivery modality enabling > geographic reach • Information-motivation-behavioural skills > model framework	university psychology departments • Online screening survey for eligibility • Proof of professional qualifications > required via email • Randomization to in-person or online arm > (stratified by location) • In-person trainees received travel > stipends to Bucharest	• Implicit bias reduction (d=0.25, p<0.05) • LGBTQ-affirmative clinical skills > increase (d=1.12, p<0.001) • Practice beliefs increase (d=0.38, p<0.05); behaviours increase (d=0.54, p<0.001) Online training: • Explicit bias reduction (d=0.31, p<0.05); implicit bias reduction (d=0.64, p<0.01)	for LGBTQ-affirmative training) • 15-month longitudinal follow-up (longest to date for LGBTQ-affirmative provider training) • Implicit Association Test (IAT) to measure unconscious bias (less susceptible to social desirability) • Optional supervision component with > demonstrated added benefit	recommend); sustained effects at 15 months across both modalities; equivalent efficacy of online vs in-person delivery (average d=0.04); large effect sizes for clinical skills (d=1.12–1.45); added benefit of supervision for explicit bias reduction and behaviour change • Challenges: Self-selected motivated providers — may not generalise to less motivated; 76% had no LGBTQ clients at baseline; client numbers did not change post-training; practice intentions did not change despite improved competence • Limits: No non-active control group — cannot rule out naturally occurring attitudinal changes; provider-level outcomes only — no client mental health outcomes; IAT only measures sexual minority bias	RCT design demonstrates efficacy with 15-month sustained effects; online modality equivalent to in-person — enables geographic scale-up; implemented in high-stigma context applicable to similar global settings; large sample (n=113) • Limits: Romania-specific context; training in English with live translation; self-selected motivated providers; Western-developed curriculum may need cultural adaptation • Scale-Up Needs: Strategies to engage less motivated providers; governmental and professional association collaboration for wider reach
Baleige et al., 2022	France	G4 (LGBTQIA+)	Structural/Systemic (Supply-side)	Primary Care-Based Mental Health; Community-Based Mental Health Services	• Free and informed consent as basis for transition care • Self-diagnosis assisted by primary care provider • Primary care coordination replacing psychiatric gatekeeping • No mandatory mental health involvement in transition pathway • Harm reduction perspective • Development of informal care networks through organizations	• Self-referral to MDS primary care centre • Primary care provider coordination (replacing psychiatric gatekeeping) • Self-diagnosis assisted by primary care provider • Access to secondary mental health care through mainstream system (not specialized transgender clinics) • Peer support networks and user organizations	• Multi-stakeholder collaborative structure established • MDS operating since 2011 providing informed consent- based transition care • CUT developed with regional health agency for user empowerment • Local network initiated including two additional medical centres • Research team established for ICD-11 field study	• First implementation of ICD-11-aligned de-psychopathologized transgender care model • Informed consent model replacing psychiatric gatekeeping - operating since 2011 • Integration of transgender persons as co-researchers and service designers • WHO Collaborating Centre involvement in model development	• Success: Bottom-up initiatives from field operators and transgender persons; established since 2011 — mature model; WHO Collaborating Centre legitimacy and support; socialised healthcare removes cost barrier; regional health agency engagement (CUT development); co-construction approach avoids new parallel specialised system • Challenges: No consensus on implementing human rights for transgender persons internationally; transgender needs in secondary mental health care "remains marginal worldwide"; current system "still far from ideal community model" • Limits: Descriptive field report — no quantitative outcomes; need for tools to assess organisational transformations; need for consensual indicators for evaluation	• Supports: ICD-11 provides international policy justification; WHO/Wonca community mental health model applicable globally; Yogyakarta Principles as shared human rights standards; informed consent model documented for replication; four development axes provide transferable framework • Limits: French socialised healthcare removes cost barrier — major barrier elsewhere; free public mental health care France-specific; regional/local structures context-specific; requires established transgender user organisations • Scale-Up Needs: Tools to assess organisational transformations and health/social inclusion impact; consensual indicators for evaluation; documentation of implementation in other

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										contexts; action research to create feedback loops
McDermott et al., 2024	United Kingdom	G4 (LGBTQIA+) & G3 (Youth)	Acceptability/Trust/Stigma	Community-Based Mental Health Services; Targeted Specialised Mental Health Services	• Intersectional youth-rights approach - uphold right to non-discrimination; enable informed independent decisions • Non-pathologising framework - LGBTQ+ identity and difficult emotions not signs of psychological abnormality • Youth-centred support - anti-paternalist; advocacy; collaboration; subjective self-assessment • LGBTQ+ affirming environment - affirmation of plurality/fluidity of gender and sexual identity; recognition • Connection and belonging - relationality; peer support; trusted adults; 'mutual care' not just self-care • CAMHS partnership model -collaboration between NHS and voluntary sector	• Self-referral to community/voluntary LGBTQ+ organisations • Peer support groups and youth group activities • Online support and self-care resources • Referral from schools/education settings • NHS CAMHS referral (limited LGBTQ+ specific provision)	• Theoretical framework for non-pathologising LGBTQ+ youth mental health support (Stage 1) • UK service mapping: 111 services identified; 5-category typology produced (Stage 2) • 13 principles model for 'what works' in early intervention mental health support (Stage 3) • Intersectional youth-rights approach validated through case study evaluation • 73% services provided by community/voluntary sector	• First large-scale theory-led evaluation of early intervention mental health support for LGBTQ+ young people in UK • Meta-narrative review methodology synthesising heterogeneous literature across psychology, sociology, public health • Non-pathologising theoretical framework placing LGBTQ+ youth at centre of own mental health care • 13 principles model operationalising intersectional youth-rights approach	• Success: CAMHS partnership model offers promising bridge between NHS and voluntary sector; voluntary sector has LGBTQ+ expertise; extensive PPI with LGBTQ+ Young People's Advisory Group throughout; integration of LGBTQ+ young person as research team member • Challenges: NHS Trusts often misunderstand need for LGBTQ+-specific support; voluntary sector has precarious funding; rural areas significantly underserved; trans-specific support severely lacking (only 12.6%); staff training essential but insufficient alone — need organisational/structural change • Limits: No control group — theory-building not efficacy testing; case study methodology generalises to theory not population; COVID-19 disrupted data collection; limited trans-specific findings; predominantly urban sample	• Supports: Theory-driven model applicable across settings (education, clinical, community); 13 principles can be operationalised in various ways; intersectional framework addresses multiple identity characteristics; aligns with UN/WHO rights-based approach; non-pathologising approach applicable internationally; service typology provides template for mapping • Limits: UK-specific service landscape and funding structures; NHS-specific organisational context; urban bias in service provision studied; cultural/legal context for LGBTQ+ rights varies • Scale-Up Needs: Implementation research on intersectional youth-rights approach; NHS commissioning guidance development; staff training programmes; sustainable funding models for voluntary sector; rural service provision strategies; trans-specific service development
Edge et al., 2018	United Kingdom	G2 (Ethnic minorities)	Acceptability/Trust/Stigma	Targeted Specialised Mental Health Services	• CaFI -- culturally adapted evidence-based FI • Family Support Members (FSMs) as "proxy families" for those without family contact • Cultural competency training for therapists (2 days)	• Referral from clinical teams (care coordinators, community mental health teams) • Recruitment across acute wards (9.7%), rehabilitation (22.6%), community (67.7%) • Community launch events and outreach • Research Advisory Group networks	• Recruitment: 31/74 eligible (42%) consented • Retention: 24/31 (77.4%) completed treatment • Session completion: 24/26 (92%) who started completed all 10 sessions	• First culturally adapted FI specifically for African- Caribbean people with schizophrenia • Family Support Members (FSMs) as "proxy families" - novel solution enabling participation without biological family • Systematic cultural adaptation framework	• Success: High recruitment (42% of eligible) despite "hard to reach" population; excellent retention (92% of starters completed all 10 sessions); strong community engagement and trust-building; co-production with stakeholders throughout; FSMs enabled 50% without families to participate; cultural competency training for	• Supports: Based on NICE-recommended evidence-based FI; systematic cultural adaptation framework applicable to other groups; FSM model addresses universal barrier (family unavailability); participants recommended "culturally adaptable" model for all ethnic groups; addresses inequalities relevant across healthcare

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					• CaFI therapy manual developed • Fidelity measure developed	• Posters and information sheets	• Mean sessions attended: 7.90 (SD 3.96) out of 10 • Data completion: PANSS 96% baseline, 100% post- intervention, 100% follow-up	derived from literature review • Co-production with African-Caribbean stakeholders at all stages	therapists; good fidelity to manual • Challenges: Non-psychologist therapists less confident despite training; therapist workloads led to some breaching 20-week therapy window; NHS restructuring created organisational challenges; accurate ethnicity data not available in services • Limits: No control group — cannot assess efficacy; small sample size — limited power; single region (Manchester); self-selected sample may not represent all African-Caribbean service users	systems; MRC complex interventions framework used • Limits: Specific to African-Caribbean population and UK context; requires cultural competency training infrastructure; requires paired therapist delivery; NHS-specific organisational context • Scale-Up Needs: Multicentre RCT to establish effectiveness; cost-effectiveness analysis; develop "culturally adaptable" version for multiple ethnic groups; cultural competency proficiency framework
Alfayumi-Zeadna et al., 2025	Israel	G2 (Ethnic minorities)	Acceptability/Trust/Stigma	Peer-Delivered/Lay Worker Services + Community-Based Mental Health Services	• M2M peer-support program culturally adapted for Bedouin • First M2M Center in Bedouin village (co-located with MCHC/Early Childhood Center) • Professional and paraprofessional Bedouin staff • Partnerships with hospitals, gynecologists, psychiatrists, community clinics • Referral pathway to mental health services (28.8% referred; 23.4% received care)	• Referral from healthcare professionals (75%): nurses, physicians, social workers • Self-referral via friends, family, internet (25%) • Initial intake meeting with project leader (phone or face-to- face) • Online questionnaire completion via project website • Choice of contact mode: phone, home visit, Zoom, in- person at MCHC/community center	• EPDS ≥10 decreased from 45% (Time-1) to 19.8% (Time- 2) at one-year follow-up • EPDS ≥13 (moderate-severe) decreased from 45% to 19.8% • Mean EPDS at Time-2: 7.2 (SD=5.1) vs Time-1: 9.7 (SD=5.9) • Self-harm ideation: 8.1% at Time-1; 0% at Time-2 • Childbirth complications: OR=3.4 (95% CI 1.24--9.40, p=0.018)	• First culturally adapted M2M program for Arab Bedouin population • First M2M Center established within Bedouin community (co-located with MCHC/Early Childhood Center) • Bedouin female professional and paraprofessional staff • First-ever engagement with male religious leaders on women's mental health	• Success: Culturally concordant staffing (Bedouin women); trust-building with community and healthcare professionals; flexible delivery modes accommodating preferences; Arabic-language materials and communication; co-location with existing trusted services (MCHC, Early Childhood Center); high retention rate (89.2%); strong professional referral pathway (75%) • Challenges: Cultural norms around privacy, honour, stigma; geographic barriers (unrecognised villages, rural areas); COVID-19 required adaptation to Zoom delivery; variable exposure (individual vs group; dose varied) • Limits: No control group — cannot establish causality; selection bias possible (voluntary participation); self-reported measures may not reflect true status; EPDS is screening not diagnostic; no qualitative data to confirm mechanisms	• Supports: Peer-support model validated in multiple contexts (Boston, Jewish Israeli); EPDS widely validated including Arabic version; cultural adaptation framework applicable to other minority/indigenous populations; flexible delivery modes adaptable; addresses universal barriers (stigma, access, cultural competency) • Limits: Specific to Bedouin cultural context in Israel; requires culturally concordant staff; Arabic-language specific; no control group limits causal inference; Israeli healthcare system specific • Scale-Up Needs: Establish additional M2M centres in other Bedouin communities; train more Bedouin paraprofessionals; integrate into routine maternal-child health services
Keogh et al., 2020	Ireland	G2 (Ethnic minorities)	Acceptability/Trust/Stigma	Targeted Specialised Mental Health Services	• TMHLN specialist nursing role • Integration within Traveller Health Unit infrastructure • Collaboration with existing	• Traveller Health Project staff suggestion when distress observed • Word-of-mouth from other Travellers • Traveller Wellbeing Groups (met TMHLN,	• Factors affecting Traveller MH: accommodation, unemployment, alcohol/drug misuse, patriarchal	• Culturally targeted specialist mental health nursing role for ethnic minority • Embedded within existing trusted	• Success: TMHLN's interpersonal skills (warm, kind, understanding, non-judgmental); trust and confidentiality emphasised from onset; cultural congruency of approach;	• Supports: Addresses universal barriers (trust, stigma, cultural competency); interpersonal skills framework applicable across contexts; recovery-oriented approach aligns

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					trusted services (PHN, Community Health Projects) • Four intervention types: therapeutic, liaison, educative, follow-up • Traveller Wellbeing Groups • Word-of-mouth referrals from other Travellers	then made one- to-one appointment) • Direct self-referral after initial contact • Home visits or community locations offered	gender roles, suicide • Accessing the TMHLN: multiple pathways; minimal waiting time; variety of presenting issues (depression, anxiety) • Experiences/ perceptions of TMHLN: extremely positive; no negative comments; trust, confidentiality, privacy valued • Therapeutic interventions (relationship building, talking therapy) • Liaison interventions (signposting, advocacy, appointments)	Traveller health infrastructure • Association with known/trusted Public Health Nurse enhanced credibility • Recovery-oriented rather than clinical/symptom-focused approach	embedded within established trusted infrastructure; minimal/no waiting time; flexibility in location and approach; association with trusted PHN enhanced credibility • Challenges: Limited to one healthcare region; building trust takes time; complex social factors underlying MH issues require multi-faceted response; single practitioner model • Limits: Small sample size (n=10) — cannot be generalised; cross-sectional design (not longitudinal); no pre/post intervention comparison; limited diversity (e.g., few young people)	with contemporary MH policy; intersectionality framework transferable to other marginalised groups; responds to WHO and national suicide prevention strategies • Limits: Specific to Irish Traveller community and culture; requires established community health infrastructure; requires culturally competent/trained staff; small-scale regional implementation • Scale-Up Needs: Expansion to other regions with Traveller populations; training more culturally competent MH nurses
Hassan et al., 2020	United Kingdom	G7 (Socioeconomic)	Structural/Systemic	Community-Based Mental Health Services / Integrated Multi-Sector Services	• Life Rooms social prescribing model • Recovery College with free courses • Pathways advice service (housing, debt, employment) • Employment and volunteering support • Peer tutors and trained mental health staff	• Self-referral (open to all without formal requirements) • Clinician referral from primary/secondary care • Informal "drop-in" access for pathways advice • Welcome by staff with informal discussion of support options • No bureaucratic administrative processes	• Social belonging: safe environment, approachability, non- judgmental culture, sense of community and validation • Resourceful and accessible: all-encompassing hub, free access to resources, choice and control, flexible engagement • Social inclusion and connectedness: reduced isolation and loneliness, relationship building, improved family relations • Moving forward: self-development, independence, coping mechanisms, confidence,	• Co-production principle at all levels (development, delivery, evaluation) • Mental health-specific social prescribing focus (distinct from general wellbeing SP) • Recovery College model with peer tutors • Pathways advice service addressing social determinants (housing, debt, employment)	• Success: Non-clinical welcoming environment enhanced help-seeking; co-production with service users at heart of delivery; free access to multiple resources in one location; flexibility in engagement (user choice and control); peer support and shared experience environment; local remit with community knowledge • Challenges: Limited to two locations (Liverpool, Sefton); study only included Mersey Care service users (not wider public); potential need for broader implementation infrastructure • Limits: Qualitative design limits generalisability; sample limited to NHS Trust service users only; cannot quantify outcomes or cost-effectiveness	• Supports: Addresses universal social determinants of mental health; aligns with NHS priorities (Five Year Forward View, Long Term Plan); co-production model adaptable to other contexts; elements common to effective SP approaches (local knowledge, integrated care, holistic approach) • Limits: Specific to UK NHS Trust context (Mersey Care); requires organisational infrastructure for co-production; local community resources and partnerships needed; free access model requires funding sustainability • Scale-Up Needs: Implementation plan for larger scale rollout; cost-effectiveness analysis

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							working toward employment goals			
Saillant et al., 2020	Switzerland	G6 (Rural)	Acceptability/Trust/Stigma (Demand-side)	Community-Based Mental Health Services (Suicide Prevention)	• Sentinel/gatekeeper training program for agricultural workers • Multi-sector collaboration (health, agriculture, chaplaincy) • Role-play exercises for skill development • Psychoeducation on suicide warning signs • Information on local care resources and pathways	• Invitations sent via email by agricultural departments and professional organizations • Flyers distributed to: farmers, veterinarians, milk controllers, peer controllers, accountants, technical advisors • Self-registration with agricultural department • Training sessions held in agricultural schools and agriculture- related buildings (familiar settings) • Half-day format accessible for working professionals	• 220 participants across 9 sessions (mean 24.4 per session) • Canton Vaud: 154 participants, 6 sessions • Canton Neuchâtel: 66 participants, 3 sessions • Sentinelle:worker ratio = 1.45% (1.2% Vaud, 2.92% Neuchâtel) • 50% female participants SATISFACTION (Neuchâtel, n=64/66):	• Sentinel/gatekeeper model adapted specifically for agricultural population • Based on Quebec "Sentinelle agricole" model (2016) • Multi-sector collaboration: health + agriculture + religious (chaplaincy) • Agricultural chaplain (former farmer) as key facilitator bridging sectors	• Success: Contrary to expectations of emotional reticence, participants expressed emotions freely; role-play exercises facilitated emotional expression through identification; peer support model valued; testimonials from lived experience appreciated; multi-sector collaboration (health, agriculture, chaplaincy) enabled reach; familiar agricultural settings reduced barriers • Challenges: Suicide remains taboo — many don't know when/how/to whom to speak; competition between farmers may limit disclosure; limited rural mental health access; single half-day intervention may be insufficient; intergenerational farm succession difficulties contribute to suicidal ideation • Limits: Possible selection bias — email invitations may exclude older/less digitally connected; no validated outcome tools; no control group; no medium/long-term follow-up; heterogeneous participant group	• Supports: Based on Quebec "Sentinelle agricole" model — demonstrates cross-national adaptation; addresses internationally recognised risk group (farmers studied in India, England, New Zealand, Australia, France); simple gatekeeper model adaptable; multi-sector collaboration replicable; GRPS approach based on LivingWorks ASIST recommendations • Limits: French-speaking Swiss context (2 cantons); agricultural chaplaincy may not exist elsewhere; small sample (220); no validated outcome measures • Scale-Up Needs: "Refresher" modules (planned for 2020); validated outcome tools; medium/long-term follow-up; sociodemographic data collection; comparative studies with control groups
Gire et al., 2017	Multiple (UK, Netherlands, Finland, Spain, USA, China)	Multiple (socioeconomically disadvantaged/ rural)	Structural/Systemic (Supply-side)	Digital Mental Health Interventions (mHealth)	• SMS text message medication reminders (Montes et al., Kauppi et al.) • SMS goal-achievement prompts for cognitive compensation (Pijnenborg et al.) • Smartphone app for real-time symptom assessment via ESM (Ainsworth et al.) • iPad cognitive training games for working memory (Dang et al.)	• SMS text messages (most common - 4 studies) • Smartphone applications (1 study) • Tablet devices/iPad (1 study) • Handheld telehealth device "Health Buddy" (1 study) Key insight: 96% global mobile phone penetration	• Montes et al.: Significant improvement in IG vs CG (MAQ change - 1.0 vs - 0.7, P=0.02) • Kauppi et al.: Medication most commonly selected message type (175/562 participants) • Kasckow et al.: Participants reported Health Buddy effective for adherence (qualitative) • Pijnenborg et al.: No improvement in medication adherence (but	• Experiential Sampling Methodology (ESM) -- real-time/real-place symptom assessment constructing daily profiles • ITAREPS system -- SMS-based early warning signs questionnaire with automated alerts to clinicians • User-defined message timing and content selection (Kauppi et al.) • iPad cognitive training using commercially available games (Mahjong, math games, brain teasers)	• Success: High feasibility and acceptability across studies; basic SMS functionality accessible and effective; user-defined timing increased engagement (preferred early week/morning); high monthly adherence rates (83–92% for Health Buddy); 70% positive evaluation of SMS intervention; smartphone apps preferred over SMS when available (67% vs 13%) • Challenges: Heterogeneity of interventions/outcomes prevented meta-analysis; ITAREPS largely unsuccessful due to poor protocol adherence by investigators (only 39% followed alerts); follow-up showed decline in gains;	• Supports: 96% global mobile phone penetration makes mHealth widely applicable; basic SMS functions work on simple phones — no smartphone required; applicable to low-resourced settings; medication adherence interventions showed consistent positive results; feasibility demonstrated across multiple European countries, USA, and China • Limits: Most studies from HICs — only 1 from China, none from Africa/South Asia; cultural adaptation not addressed; language considerations not discussed

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					• Health Buddy telehealth device for suicidal ideation monitoring (Kasckow et al.)		improvement in leisure activities and appointments) • Ainsworth et al.: Smartphone app faster than SMS (68.4s vs 325.5s, P\<0.001); more data points completed		some barriers to device setup (landlord permission, substance misuse, cognitive impairment) • Limits: Only 7 studies identified — limited literature; small sample sizes; only 1 study rated low risk of bias; most studies from HICs; no studies combined assessment AND treatment	• Scale-Up Needs: Larger well-designed RCTs; studies combining assessment AND treatment; LMIC-specific studies; teleconsultation models for remote specialist access; public health applications (e.g., stigma reduction campaigns via SMS)
Burbach & Stiles, 2021	United Kingdom	G3 (Youth)	Structural/Systemic (Supply-side)	Digital Mental Health Interventions + CAMHS/Youth Mental Health Services	• Healios digital platform (Panacea) - secure, ISO 27001 certified • Multiple interconnected services (mental health + neurodevelopmental) with internal referral pathways • NICE-endorsed CBT with BABCP-accredited therapists • Gold-standard autism/ADHD assessment tools (ADI-R, ADOS, Conners-3) • Structured slide decks ensuring fidelity with flexibility for adaptation	• NHS referral to Healios (via NHS portal for secure referrals and progress monitoring) • Web-based scheduling via family portal (flexible hours 9am--8pm, 7 days/week) • Sessions scheduled to accommodate work commitments (parents) and school (young people) • Option to have sessions during school hours (with school support) or evenings/weekends • Multiple service lines accessible via internal referral if needs change during treatment	• Referral to first appointment: 4--51 days (mean 22.67, SD 14.59) • Comparison: NHS autism 352 days; NHS CAMHS 56-182 days • Between-service waiting (within Healios): mean 34 days (SD 30.39) • Total referral to discharge: 18-51 weeks (mean 26.35, SD 11.56) therapeutic alliance (HPSR): • Mean overall score 92.72/100 (SD 12.63; range 68.53-100)	• Fully remote \"digitally native\" service operational since 2015 (pre- pandemic) • Bespoke secure platform (Panacea) - ISO 27001 certified, cloud- based, Ruby on Rails • Split-screen videoconferencing with interactive slides during sessions • Structured slide decks ensuring fidelity to NICE-endorsed protocols while allowing adaptation	• Success: Flexible delivery (9am–8pm, 7 days) valued by families; timely response reduces escalation of problems; personalised care adapted to individual needs; multiple interconnected services allow comprehensive care; digital platform facilitates routine outcome measurement; family involvement from different locations; multi-agency integration via digital reports/portals; young people felt at ease in familiar home surroundings • Challenges: Some missing ROMs data (system failures, parental non-involvement); technical hitches with questionnaires; delays when awaiting school input (e.g., during holidays); study does not explore non-engagement or dropout • Limits: Convenience sample — not representative; cannot be generalised to other platforms; CYP cases only; no control group; both authors employed by Healios (conflict of interest)	• Supports: Pre-pandemic evidence demonstrates digital viability before COVID-19 forced adoption; 10 key elements provide framework for other digital services; addresses common concerns (therapeutic alliance, risk management); NICE-endorsed protocols ensure fidelity; outcomes comparable to or better than in-person services (waiting times, alliance, satisfaction) • Limits: Specific bespoke platform (Panacea) may not be replicable; UK NHS commissioning context; requires secure IT infrastructure; internet access and digital literacy required • Scale-Up Needs: Platform development and IT infrastructure investment; clinician training for digital delivery; integration with local NHS pathways and referral systems
Leijdesdorff et al., 2021	Netherlands	G3 (Youth)	Acceptability/Trust/Stigma (Demand-side)	Community-Based Mental Health Services + CAMHS/Youth Mental Health Services	• \@ease walk-in centers (free, anonymous, peer-to-peer) • GP in-house psychologists with smooth referral • University psychological services • GP weekly counselling to bridge waiting periods	• Walk-in options (@ease centers, GP in-house psychologists) • GP as gatekeeper with referral function • University psychological services • Online searching for services • School/teacher referral	• Negative cognitions: problems seen as weakness, own fault, something to fix alone • Multiple layers of stigma: on disorders, on seeking help, on asking assistance to find help • Feeling unentitled due to	• Walk-in format -- no appointment needed • Free and anonymous • Peer-to-peer support by trained young volunteers • Professional backup available on-site	• Success: Walk-in options reduce barriers to initial contact; free services reduce financial uncertainty; anonymity valued by young people; peer support normalises experiences; professional objectivity appreciated vs friends/family bias; personalised care with autonomy preferred over strict protocols; positive GP relationships facilitate ongoing	• Supports: Barriers identified (stigma, waiting lists, financial uncertainty) common across international contexts; aligned with international youth mental health reform movement (headspace Australia, Jigsaw Ireland); @ease model adapted from Australian headspace — demonstrates cross-national transferability;

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					• Friends, parents, partners, teachers, deans, church community recognizing problems and encouraging help-seeking		"privileged circumstances" • Belief mental health problems are for older people • Extensive comparison to peers who "seem fine"		help-seeking; once in system, navigation becomes easier • Challenges: Stigma persists despite awareness campaigns; multiple layers of stigma (disorder, help-seeking, asking for assistance); waiting lists deter initial help-seeking (anticipation alone is barrier); uncertainty about costs worse than actual costs; frequent therapist changes damage trust; transition at age 18 poorly managed (only 5% satisfied) • Limits: Sample from @ease centres — not generalisable; limited diversity (immigration, LGBTQ+, intellectual disabilities underrepresented); Dutch healthcare context specific; research team involved in @ease (potential bias)	young people's suggestions universally relevant • Limits: Dutch healthcare system specific (GP gatekeeper, insurance structure); sample recruited from walk-in centres (selection bias); cultural context of stigma may differ • Scale-Up Needs: More funding for low-threshold/walk-in initiatives; evaluation of effectiveness and reach of existing awareness campaigns; integration of walk-in options into standard care pathways
King & Said, 2019	United Kingdom	G1 (Migrants/ Refugees)	Acceptability/Trust/Stigma (Demand-side)	CAMHS/Youth Mental Health Services + Targeted Specialised Mental Health Services	• CBT-informed psychological skills group • Trauma-informed stabilization approach • Professional interpreter provision (5 interpreters for group) • Phased model beginning with physical health needs • Integration with broader service offering individual work and systemic approaches	• Referral by clinicians within the service • Open group -- young people can join at any time regardless of language • Pre-group individual meeting to assess needs and concerns about attending • Group described as supporting overall wellbeing in informal environment with peers from similar backgrounds • Interpreters provided based on language needs analysis (preferred language and dialect)	• Mean attendance 65% (SD 18.04) over 35 weeks • High return attendance once young people started attending • Non-attendance reasons: conflicting appointments, withdrawn travel funding, Ramadan requirements • Listening: 97% (SD 4.73) • Topic importance: 95% (SD 6.03)	• Open group format allowing flexible joining regardless of language spoken • Multi-language delivery with up to 5 interpreters simultaneously • Beginning with physical health needs to reduce stigma and match somatic presentations • Scaffolded CBT delivery informed by Vygotsky\'s Zone of Proximal Development	• Success: High return attendance once engaged; collaborative stance addressed power imbalances; beginning with physical health reduced stigma; scaffolding made CBT accessible; interactive delivery (games, acting out) increased engagement; open group format accommodated chaotic circumstances • Challenges: Incomplete outcome data; SDQ may not capture PTSD symptoms; interpreter costs significant; conflicting appointments; travel funding withdrawn • Limits: No control group; small sample (n=14 referred, n=11 attending); single UK service; incomplete outcome data	• Supports: CBT evidence-based approach with established efficacy; detailed cultural adaptations replicable elsewhere; feasible in routine NHS practice — delivered by trainees with interpreter support; addresses universal UASC needs (trauma, sleep, peer connection); open group format adaptable • Limits: UK NHS context specific; requires interpreter access and funding; specific to UASC population • Scale-Up Needs: Interpreter funding secured; training for clinicians in cultural adaptations; referral pathway development from social services
Spaas et al., 2022	Belgium	G1 (Migrants/ Refugees)	Acceptability/Trust/Stigma (Demand-side)	Integrated/ Multi-Sector Services + School-Based Services	• School-based collaborative mental health care networks (CCRC) • Interdisciplinary team: transcultural trauma consultant + multilingual	• School partners typically initiate referral based on developmental concerns (concentration, withdrawn behaviour • Can also be initiated by refugee children,	• Enhancing family-school interactions through contextualization • Negotiating cultural difference and shaping	• Integration of multilingual/academic development with psychosocial/mental health support in single collaborative framework • Systemic assessment model embedding child	• Success: Trust-building through validation of parental care and protection; cultural broker involvement enables intercultural dialogue; psycho-education normalizes trauma responses; municipal policy support provides sustainability; case-based	• Supports: Model based on established Canadian collaborative mental health care approach; systemic/transcultural framework broadly grounded; four-level intervention structure adaptable; addresses

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					development consultant • Interpreters/cultural brokers integrated into care network • Multi-level intervention framework (school-family, classroom, school policy, external referral) • Explicit informed consent process with leaflet in 6 mother tongues	families, or network members • Explicit parental consent required before network formation • Information leaflet provided in 6 mother tongues • CCRC supervises school actors in sensitive communication with parents about consent	cultural identifications • Psycho-educative normalization and validation of parental strategies • Locating linguistic development within migration stressors and mental health • Mobilizing school as vehicle for restoring safety and stability post-trauma |	development within: family relations, cultural meaning systems, migration • Municipal policy partnership (Education Council/SOM) enabling sustainable implementation • Inter-organizational collaboration: university clinical centre + language centre + municipal services + regional partners	expertise building empowers school teams • Challenges: Stigma not automatically reduced by school setting; power disparities persist; parents may feel coerced; different timeframes between school needs and mental health assessment • Limits: Clinical case analysis based on only 3 cases; analysts from same team — potential bias; specific to Leuven context; no outcome data	universal challenges (stigma, school-family communication, cultural differences) • Limits: Specific Belgian/Leuven policy context; requires university partnership and trained transcultural consultants; resource-intensive model • Scale-Up Needs: National policy anchoring for sustainability; training of school systems and mental health professionals; broadening to other geographic regions
Schoenmakers et al., 2017	Netherlands	G1 (Migrants) + G5 (Older adults)	Health Literacy/Navigational (Demand-side)	Community-Based Mental Health Services	• No formal intervention evaluated -- exploratory study • Children (especially daughters) provide instrumental support: transport, appointments, translation, internet navigation • Positive initial experiences with services lead to independent attendance • Bilingual psychologists when available	• GP as gatekeeper to specialist mental health services • Social network provides instrumental support at all stages: recognizing need, seeking services, arranging access • Children most frequently facilitate access (daughters more than sons) • Translation provided by family members (not professional interpreters) • Computer/phone navigation done by children Key insight: Social network involved in all 4 help-seeking stages	• Social network (mainly children/daughters) crucial for navigating all 4 stages of help-seeking • Social networks often unable to provide adequate support due to: lack of mental health literacy, shame/taboo • Children often have dismissive/constraining attitudes toward parental mental health problems • Elderly fear burdening children; adopt wait-and-see attitude; expect children to initiate contact • Spouses rarely supportive (often have own health issues or lack knowledge)	N/A — exploratory qualitative study; standard exploration of existing service access patterns; no novel intervention evaluated	• Success: Daughters most available and engaged network members; positive initial experiences lead to independent attendance; bilingual psychologists reduce linguistic barriers; community centres reduce loneliness • Challenges: Low mental health literacy in elderly AND social networks; stigma/taboo constrains help-seeking; children's busy lives limit support; elderly fear being a burden; family translation may filter sensitive information • Limits: Secondary data analysis; small sample sizes per ethnic group; data from 2012 — policy context may have changed	• Supports: Addresses universal barriers (stigma, health literacy, language) common across migrant populations; four-stage help-seeking framework applicable across contexts; findings consistent with international literature; recommendations widely applicable • Limits: Dutch healthcare system specific (GP gatekeeper); specific ethnic groups may not generalise; urban settings only; data from 2012 • Scale-Up Needs: Mental health literacy programmes for social networks; professional interpreter services in primary care; outreaching/proactive healthcare services for elderly migrants
Freţian et al., 2023	Germany	G3 (Youth)	Acceptability/Trust/Stigma (Demand-side)	School-Based Services	• Mental Health Literacy curriculum (MHC) delivered in schools • Teacher training (one-day) for curriculum delivery	• Universal school-based delivery -- all 10th grade students in participating school • Embedded in school curriculum (project day format)	• Mental Health Knowledge (MHK): Large effect size (Cohen's f = 0.574, p \< 0.001, partial η2 = 0.25)	• First German translation, adaptation, and evaluation of Canadian MHC • Cross-national adaptation of evidence-based curriculum	• Success: Large effect on mental health knowledge; medium effect on help-seeking efficacy; Results consistent with international MHC evaluations (Canada, Nicaragua, Wales)	• Supports: Evidence-based curriculum with international validation (Canada, Nicaragua, Wales, Germany); universal school-based approach applicable across contexts; modular

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					• Local cooperation group (school board, mental health coordination, NGO, foundation) • Lived experience presenters from NGO with training and peer support • Lived experience sharing (in-person or video)	• Delivered by existing school staff (religion teachers, school counselor) • No individual screening or referral required • Parental consent obtained; student assent for those under 16	• Intervention group: 56.9% correct at pre-test → 69% correct at post-test • Control group: no significant change (17.1 → 17.3) • Help-Seeking Efficacy (HSE): Medium effect size (Cohen's f = 0.311, p \< 0.001, partial η2 = 0.09) • Intervention group: 26.1 → 28.4 points	• One-day implementation format (vs. 6--12 hours over multiple weeks) • Local cooperation group model (school board, mental health coordination, NGO, foundation)	• Challenges: COVID-19 disrupted implementation at other schools (incomplete modules, extended post-test timing); Only one lived experience presenter available for 5 classes -- 2 classes received video instead • Limits: Convenience sampling; no random allocation; Single school; partial sample from larger study	structure allows adaptation; teacher-delivered model scalable; one-day or multi-week implementation options • Limits: German adaptation — language/cultural specificity; single school in Bielefeld; requires teacher training and local partners; long-term effectiveness confirmed only for weekly implementation • Scale-Up Needs: Broader roll-out across German schools; teacher training infrastructure; network of trained lived experience presenters
Pryjmachuk et al., 2024	United Kingdom	G3 (Youth)	Structural/Systemic (Supply-side)	Community-Based Mental Health Services + Third sector/NGO	• Self-referral pathways (avoids gatekeepers, valued by CYP) • Single Point of Access (SPoA) -- may help direct to appropriate service • Brief intervention services for managing waiting lists • Collaborative care models (strongest effectiveness evidence) • Outreach approaches (school, A&E, community)	• Self-referral (online form, telephone) -- valued by CYP; avoids disclosure concerns • Professional referral (GP, school, CAMHS) -- predominant in NHS services • Single Point of Access (SPoA) -- may help navigation but can create bottlenecks • School-based screening (some services) • Open access particularly in third/private sectors	• 310 documents met inclusion criteria; 154 services mapped in England/Wales • 17 service model types identified across 7 groups • Effectiveness evidence only for: collaborative care (strongest), outreach approaches, brief interventions • Cost-effectiveness evidence very limited (3 papers); only robust evidence for collaborative care • No service model appeared more acceptable than others • Three themes: pathways to support, service engagement, learning and understanding	• Comprehensive service model typology (17 models across 7 groups) synthesised from international literature • Co-produced evidence-based model of high-quality service design • Young co-researchers (6) with lived experience involved in data collection • Mixed-methods integration using 'weaving' approach	• Success: Self-referral improves access and quality of assessment information; Extended contact hours and direct staff contact improve availability • Challenges: No single service model clearly superior to others; Professional referral requires CYP/parents to advocate and use 'right language' • Limits: Defining 'service model' was challenging; Some initiatives too new for literature/service map	• Supports: Model designed to be transferable across services, sectors and geography; evidence-based components applicable regardless of specific service model; international literature synthesis provides broad evidence base; model components (access, information, personalisation, aftercare) universally applicable • Limits: UK NHS-specific context (tiers, CAMHS, commissioning); collaborative care evidence from USA — health system differences; English language literature only • Scale-Up Needs: Dedicated recruitment team for face-to-face engagement; school network partnerships via academies; Clinical Research Network support for GP recruitment
Smith et al., 2024	United Kingdom	G3 (Youth)	Structural/Systemic (Supply-side)	Community-Based Mental Health Services / Integrated	• Group exercise intervention (high/low intensity) with behaviour change component	• Multiple referral routes: NHS Single Point of Access (SPA), CAMHS (tier 2/3), GP practice record searches, schools	• 321 referrals; 173 assessed for eligibility; 14 randomised (8.1% of eligible)	• Exercise as treatment for youth depression -- addressing evidence gap • REP and MHSW co-delivery model combining exercise	• Success: High retention rate (71.4%) once engaged; High session attendance (78.7%) among those who started • Challenges: Severe recruitment failure: 14 randomised vs target of 81	• Supports: Universal issue — youth depression globally prevalent; evidence gap for exercise interventions; community-based delivery model adaptable; REP/MHSW co-

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				Multi-Sector Services	• REP and MHSW co-delivery model • Multiple referral pathways (NHS SPA, CAMHS, GPs, schools, self-referral) • Hybrid online/face-to-face delivery options • Young People's Advisory Group (YPAG) for ongoing consultation • Parent/carer involvement in consent and study assessments	• Screening: CDI-2 score 17--36 (mild-moderate depression); DAWBA; PAR-Q • Informed consent meeting (assent if \<16 years with parent/carer consent) • Cluster randomisation once group of 9 formed • Interventions delivered in community venues or online	• Recruitment rate: 0.31 participants per month per site • Retention: 71.4% (10/14) at study end • GP practice letters most effective: 40% referral-to-recruitment conversion • Schools: 11% conversion; Referral agencies: 4% conversion • Session attendance: 78.7% overall (range 66.7--90.5% by week)	expertise with mental health support • Partnership with football club community trusts for delivery • Embedded behaviour change techniques in exercise sessions	(later 27); COVID-19 pandemic disrupted face-to-face recruitment and delivery • Limits: Small sample (n=14) precludes conclusions on feasibility; COVID-19 confounded assessment of recruitment strategies	delivery model replicable; multiple referral pathways transferable; strong PPI methodology for youth engagement • Limits: UK NHS-specific referral structures (SPA, CAMHS tiers); COVID-19 context may not reflect normal implementation; requires partnership with community sport providers Scale-Up Needs: Dedicated recruitment team for face-to-face engagement; school network partnerships via academies; Clinical Research Network support for GP recruitment
Gilmour et al., 2022	United Kingdom	G3 (Youth)	Structural/Systemic (Supply-side)	CAMHS / Youth Mental Health Services	• Dedicated suicide and self-harm team (Site B) -- enabled 82% assessment rate vs 31% • Multiple referral pathways (GP, A&E, teachers, other healthcare professionals) • Direct Tier 4 referrals from A&E prioritized for immediate assessment • Face-to-face assessment with risk assessment and safety planning • Not reported • Specialist team structure for suicidal CYP	• Referral required from healthcare professional, GP (majority \~51--87%), A&E, teacher, or other source • Clinician screening of referrals to determine pathway • Assessment offered based on referral source, reason for referral, and service capacity • Multiple pathways: waiting list, immediate treatment, signposting to primary mental health worker	• 25% of all CAMHS referrals were for suicidality (Site A 26%; Site B 24%) • 33% of suicidality referrals were for children aged ≤12 years • Assessment offered: Site A 31% vs Site B 82% (FET p\<0.001) • Treatment offered: Site A 8% vs Site B 48% • Rejection rate: Site A 57% vs Site B 21% (vs 20% national average) • A&E referrals prioritized, >85% assessed	• Notable service model: Site B's dedicated suicide and self-harm team as structural innovation • Comparison of different CAMHS organizational models and their impact on access |	• Success: Dedicated suicide/self-harm team improved assessment (82% vs 31%) and treatment rates (48% vs 8%); A&E pathway ensures priority access for acute presentations • Challenges: High rejection rates in generalist CAMHS (57% Site A); Capacity constraints across CAMHS nationally • Limits: Small sample size; two sites only; Single 6-month period; pre-COVID data	• Supports: Universal issue — child/adolescent suicidality globally recognised; NHS-based model applicable across UK health boards; demonstrates clear benefit of dedicated team structure; referral pathways (GP, A&E, schools) common across healthcare systems • Limits: Scottish CAMHS-specific tier system and NHS context; regional variation in geography and service configuration; dedicated team subsequently restructured — sustainability concerns; no cost data • Scale-Up Needs: Resource allocation for dedicated suicide/self-harm teams; telehealth solutions for rural areas
Wilson et al., 2018	United Kingdom	G3 (Youth)	Transition Gaps (Supply-side)	Integrated/ Multi-Sector Youth Mental Health Services	• Extended age range service (14--25) transcending CAMHS-AMHS boundary • Four-tier integrated service model (detection → wellbeing → specialist → intensive)	• Referrals from any source including self-referral • Direct referrals accepted (bypassing traditional gatekeeping) • Consultation and signposting available • In-reaching into community and local	• EIP sub-team pilot (2008): significant changes after 12 months for social and symptomatic outcomes • Pilot service (2012): positive initial outcomes in service	• UK adaptation of Australian ORYGEN/headspace model • Extended age range (14-25) bridging CAMHS-AMHS transition • Four-tier integrated service structure within single management	• Success: Young people consulted and listened to -- service model feels genuine; Development alongside young people, stakeholders, third sector Challenges: High volume referrals, waitlists, overwhelming caseloads; Maintaining principles consistently under pressure	• Supports: Explicitly designed as exemplar for other areas; based on internationally recognised model (ORYGEN/headspace Australia); addresses universal CAMHS-AMHS transition challenges; core principles (youth-oriented, recovery-focused) widely

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					• Direct referrals including self-referral accepted • Assertive outreach and pragmatic approach • Consultation and signposting to transcend commissioning constraints	services to identify young people • Youth-friendly assessment team as accessible "front door"	engagement, global and social functioning • Service cited as example of good practice by Social Care Institute of Excellence (SCIE) • Referrals peaked at 18 years • Contact rates almost halved between 17 and 18 years -- identified "cliff edge"	• Philosophy of diagnostic uncertainty rather than labeling	• Limits: Service model case study - no controlled evaluation; Limited outcome data presented (references separate publications)	applicable; clinical staging and AMBIT models have evidence base • Limits: UK NHS context specific; built on existing well-established EIP services; requires single management structure; high resource demands at times • Scale-Up Needs: Wider youth mental health pathway including social care, education; continued commissioner engagement; IT and virtual platform development
Notredame et al., 2018	France	G3 (Youth)	Acceptability/Trust/Stigma (Demand-side)	Targeted Specialized Mental Health Services (Suicide Prevention)	• Surveillance and Brief Contact Intervention Systems (SBCIS/DVR) adapted for youth • Algorithmic recontact protocols based on risk level (first-time vs multi-attempters) • Resource cards provided to all patients • Multiple contact modalities: phone calls, SMS, postcards • Assigned referent/coordinator for each patient	• Enrolment at hospital discharge following suicide attempt • Emergency department or psychiatric service as entry point • Patient consent required to enter program • Resource card provided with phone number to call in crisis • Proactive outreach: systematic recontact calls at defined intervals (day 10/15, month 3/6)	• Day 10 calls successful: 49.2% vs 54.4% (p=0.042) -- significantly lower for youth • Mean unsuccessful calls at day 10: 2.18 vs 1.99 (p=0.013) -- more attempts made for youth • Month 6 calls successful: 15.0% vs 17.4% (NS) • Calls received from entourage: 0.09 vs 0.04 (p\<0.001) -- more for youth • Calls made to entourage: 0.09 vs 0.04 (p\<0.001) more for youth	• Adaptation of adult SBCIS model specifically for child and adolescent population • Algorithmic approach with differentiated protocols by risk level (first- time vs multi-attempters) • Multi-modal contact: phone calls, SMS, postcards, resource cards • City-hospital network integration	• Success: SBCIS complement and potentiate existing prevention resources; more call attempts made for youth suggests operator solicitude; spontaneous algorithm adaptation (6→3 month recall) demonstrates flexibility; integration with network of professionals around youth • Challenges: Lower successful contact rates for youth vs adults (49.2% vs 54.4%); adolescent ambivalence and help-negation bias; practical barriers (school, phone availability); parental mediation adds complexity • Limits: Effectiveness data still preliminary; comparative data descriptive only; no controlled comparison; French context specific	• Supports: SBCIS model has strong international evidence base for adults; adolescent help-seeking barriers universal; connectedness framework applicable across settings; multiple modalities (phone, SMS, postcards) adaptable; low-cost intervention with scale potential • Limits: French healthcare system specific; Regional Health Agency funding model; effectiveness evidence still preliminary • Scale-Up Needs: VigilanS already multi-regional — demonstrates scalability; adaptation of algorithms for local context; training for operators in youth-specific challenges
Marchini et al., 2021	Belgium	G3 (Youth)	Transition Gaps (Supply-side)	CAMHS / Youth Mental Health Services (Targeted Specialized)	• TAY-specific outpatient psychiatric program bridging CAMHS- AMHS interface (ages 16--24) • Multi-site implementation across CAMHS and AMHS services • Multiple referral pathways: GPs, child/adolescent psychiatrists, adult psychiatrists,	• Referral by healthcare professionals: GPs, child/adolescent psychiatrists, adult psychiatrists, psychologists, paediatricians • Self-referral: Belgian system permits direct access to specialists without GP coordination • Family/entourage request on behalf of youth	• 243 patients assessed over 20 months • Referral sources: GP 18.9%; child/adolescent psychiatrist 18.1%; psychologist 11.5%; adult psychiatrist 7.4%; • Requesters: youth 47.3%; family 39.1%; other (school, justice, social) 13.6%	• First TAY-specific outpatient psychiatric program in French-speaking Belgium • Age range 16--24 explicitly bridges traditional CAMHS-AMHS boundary (18 years) • Multi-site implementation across both CAMHS and AMHS services • Trans-diagnostic dimensional approach (internalizing/externalizing/psychotic) rather	• Success: High follow-up rate (81.5%) after initial assessment; Multiple referral pathways including self-referral • Challenges: 19.8% dropout before care pathway established; Transition to AMHS remains difficult and time-consuming • Limits: Retrospective design limits causal inference; Single region (Brussels urban area) - may not generalize	• Supports: TAY-specific approach addresses universal CAMHS-AMHS interface challenge; trans-diagnostic dimensional approach applicable across settings; multi-site model demonstrates cross-service collaboration feasibility; age range 16–24 aligns with international youth mental health models (headspace, Jigsaw) • Limits: Belgian health system specific — direct specialist access without GP referral; urban Brussels

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					psychologists, other specialists • Self-referral permitted (Belgian system allows direct specialist access) • Trans-diagnostic assessment approach	• Other requesters: school, justice, social workers • No formal referral required (37.4% had no defined healthcare referral)	• Leading symptoms: internalizing 67.5%; externalizing 21.8%; psychotic 10.7% • Internalizing more frequent in females (77.1% vs 53.5%, p≤0.001)	than categorical diagnoses		setting; tertiary hospital-based; foundation/philanthropic funding model • Scale-Up Needs: Specific training programmes for psychiatry trainees in youth mental health; expansion beyond Brussels to other Belgian regions
Holmen et al., 2023	Norway	G3 (Youth)	Structural/Systemic (Supply-side)	Integrated/ Multi-Sector Services	• 14 ICMs identified addressing various integration needs • Low-threshold access models: walk-in, phone access, short waiting times, limited assessment forms, no referral requirements • Multidisciplinary /intersectoral teams sharing expertise and clarifying roles • Flexible outreach models: staff visiting users in home/environment • Physical co-location of services (one-stop shop models)	• Low-threshold access: phone, short waiting times, limited paperwork • Walk-in/drop-in services (e.g., Youth Arena Oslo) • No referral required for some services • Alternative referral pathways: professionals other than GPs can refer; family members can initiate • Flexible outreach: staff visit users at home or in their environment	• 14 promising ICMs identified and characterized • 11 ICMs from literature review; 4 additional from expert suggestions (34 suggested, 27 excluded) • 12 models piloted or implemented recently (2015--2020) • 3 models adapted from international examples (Australia, Netherlands, Denmark) • Top-down mandate combined with bottom-up local ownership	• Horizon scanning methodology to identify emerging ICMs before widespread implementation • Application of integration frameworks (degree + dimensions) to systematically characterize models • Models bridging age 18 transition gap (5 models serving up to ages 23--26) • Integration beyond health: housing, child welfare, education, crime prevention	• Success: Top-down central mandate combined with bottom-up local ownership and adaptation; Intersectoral/ multidisciplinary teams enhance understanding of roles and shared expertise • Challenges: Gatekeeping system and referral process limit access to specialized care; Separate legislation and financial flows create silo structures • Limits: Low participation rate (26%; 9 of 34 invited) -- data saturation may not have been reached; Study conducted during COVID-19 pandemic national lockdown	• Supports: Integration frameworks (degree/dimensions) applicable across healthcare systems; three ICMs already adapted from international models (Australia, Netherlands, Denmark); principles of low-threshold access, multidisciplinary teams, outreach widely applicable; child/youth-specific needs universal • Limits: Norwegian healthcare system specific (semi-decentralised, tax-funded); gatekeeping system not universal; high health spending context; COVID-19 pandemic timing • Scale-Up Needs: Central mandate/national push combined with local ownership; adaptation to local resources and user demographics; clear organisational frameworks
Bechdolf et al., 2025	Multiple (Australia, Canada, Ireland, Netherlands, New Zealand, France, Denmark,	G3 (Youth)	Structural/Systemic (Supply-side)	Integrated/ Multi-Sector Services	• IYMHS based on World Economic Forum principles (Table 1 in original) • Low-threshold access: walk-in, no referral required, no health insurance card for initial contact • Youth-friendly design: community locations outside hospitals, youth participation in design • Transdiagnostic services	• Walk-in: no appointment or referral required • Self-referral by young person • No health insurance card required for initial advisory contact (soulspace transit) • Community-based locations outside hospitals • Online access: chats, group chats, online therapy (eheadspace, Foundry Virtual)	• High uptake: headspace Australia 106,574 (2020--2021); Jigsaw Ireland >44,000 since 2008; @ease Netherlands • Higher utilization by females than males • Higher utilization by older young adults • Proportionally high use by underserved groups: migrants, low- income,	• World Economic Forum expert commission principles for youth mental health services • Low-threshold "one-stop shop" model combining multiple services • Transdiagnostic approach rather than disorder-specific pathways • Youth participation in service design and delivery (co-design)	• Success: High utilization including underserved/vulnerable groups; Reaching young people who would not otherwise seek help • Challenges: Germany far behind internationally - only one active centre (soulspace) and one in development (ancora); Cross-sectoral funding coordination required (health insurance + state/foundation funds) • Limits: Only uncontrolled pre-post studies available; no completed RCTs; Ethical concerns about randomizing	• Supports: WEF principles provide internationally applicable framework; multiple successful implementations across diverse high-income countries; soulspace demonstrates IYMHS feasibility within German healthcare system; core components (low-threshold, youth-friendly, transdiagnostic, peer involvement) adaptable; digital components support scalability • Limits: Most IYMHS in high-income countries only; funding structures differ

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	Germany, Singapore, Israel, South Korea, Hong Kong, Japan, USA, Iceland)				addressing multiple presenting problems • Integration of mental health with social/vocational support		unemployed/NEET, LGBTQ+ • Soulspace reaches more first-time help-seekers than conventional hospital-based early detection • Users report benefit and high satisfaction		first-time help-seekers to no-treatment control	substantially; Germany lacks national policy framework; requires cross-sectoral coordination • Scale-Up Needs: National IYMHS establishment programme for Germany at federal/state level; pooling of health insurance and public funding mechanisms
Eilert et al., 2022	Multiple Sweden, Australia, Netherlands, Canada, China, Denmark, Iran, New Zealand, USA)	G3 (Youth)	Structural/Systemic (Supply-side)	Digital Mental Health Interventions	• Internet-delivered interventions to address access barriers (scalability, efficiency, personalization) • iCBT as primary intervention modality (strongest evidence base) • Supported/guided delivery models (75% of included studies) • Multi-modal support: email, platform messaging, phone calls • Parental involvement/support in 9 studies (active participation or behind-the-scenes support)	• Referral from GPs, mental health professionals, clinics (11 studies) • School-based recruitment (multiple studies) • Self-referral via advertising (media, social media, websites) • Flyers, youth centres, parent groups • Eligibility screening via clinical interviews or self-report measures	• Anxiety: Small effect favouring treatment (Hedges g=−0.25, 95% CI −0.38 to −0.12, P<.001; 20 comparisons, 15 studies) • Anxiety (outlier removed): Moderate effect (g=−0.50, 95% CI −0.40 to −0.20, P\<.001) • Impaired functioning: Moderate effect (g=0.52, 95% CI 0.24--0.80, P<.001; 9 comparisons) • Depression-focused interventions only: Large effect (g=−0.68, 95% CI −1.10 to −0.27, P=.001; 4 studies) • Overall depression: Small non-significant effect (g=−0.27, 95% CI −0.55 to 0.01, P=.06; 13 comparisons)	• First comprehensive meta-analysis focused specifically on internet-delivered (not all technology-delivered) interventions • Strict inclusion criteria: current symptoms required (not prevention- only) • Outcome hierarchy established a priori for measure selection • Subgroup analysis by intervention focus (anxiety, depression, transdiagnostic)	• Success: Support provision in 75% of studies (associated with larger effects in adult literature); iCBT most common and best-evidenced approach Challenges: Effect sizes smaller than adult equivalents (g=0.25 vs 0.45--0.68 in previous reviews); non-significant depression effects overall • Limits: Small number of studies; limited depression-focused interventions; Could not evaluate all moderators due to insufficient data	• Supports: Multi-country evidence base (Europe, Australia, North America, Asia); iCBT evidence translatable across settings; internet delivery inherently scalable; addresses universal barriers (workforce, access, stigma) • Limits: Effect sizes too small for confident endorsement in routine care; insufficient customisation for CYP developmental needs; evidence base lags behind adult equivalents; internet/device access required • Scale-Up Needs: Development of CYP-specific interventions (not adapted adult programmes); specialist training for CYP delivery; integration of caregivers
Michaud et al., 2020	Multiple	G3 (Youth)	Structural/Systemic (Supply-side)	Primary Care Mental Health Services (policy mapping)	• Ambulatory facilities for adolescents: 17/31 countries (8 countrywide)	• Primary care practitioner (PCP) as first point of contact (family doctors, paediatricians, nurses) • Ambulatory facilities dedicated to	• 17/31 (55%) had adolescent-specific ambulatory facilities (only 8 countrywide)	• Comprehensive 31-country policy mapping using standardized scenarios • Part of large EU-funded MOCHA project infrastructure	• Success: National-level policies with countrywide implementation; co-payment-free mental health care for adolescents; inter-professional collaboration structures; integration of	• Supports: Standardised framework enables cross-country comparison; identifies evidence-informed policy domains; highlights successful country examples (Czech Republic,

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					• PCP screening recommendations: 15/31 countries • Suicide/self-harm prevention programs: 18/31 countries • Same-day referral to psychiatrist: 21/31 countries • Specialist support nights/weekends: 17/31 countries	adolescents (available in 17/31 countries) • School-based services (nurses, doctors, psychologists) -- variable availability • Emergency referral pathways to child/adolescent psychiatrists • Hospital/emergency units for mental health crises	• 15/31 (48%) had PCP screening recommendations • 22/31 (71%) had co-payment-free mental health care for adolescents • 18/31 (58%) had suicide/self-harm prevention programs Access in emergencies: • 21/31 (68%) had same-day referral to psychiatrist possible	• Focus on vulnerable adolescents (migrants, dropouts) as distinct policy domain • Assessment of both availability AND accessibility dimensions	mental health in school settings • Challenges: Large within-country regional variation; policies often limited to larger cities; schools rarely equipped for mental health emergencies; minimal multi-cultural expertise • Limits: Country expert reports — potential variation in accuracy; assesses policy existence not implementation quality; no outcome data	Denmark, Portugal, Slovenia, Switzerland); part of larger MOCHA project • Limits: Health system structures vary greatly across countries; policy existence ≠ implementation quality; no outcome data to demonstrate effectiveness • Scale-Up Needs: Implementation monitoring systems; youth-friendly service quality standards; multi-cultural workforce development; school-based mental health infrastructure; PCP training curricula
Porter et al., 2022	United Kingdom	G3 (Youth)	Structural/Systemic (Supply-side)	Digital Mental Health Interventions	• Video Conferencing Therapy (VCT) via secure online portal • NHS-commissioned service free at point of delivery • Accredited CBT therapists with weekly supervision • NICE-endorsed standardized CBT manual • Routine outcome monitoring (ROMs) integrated into sessions	• Referral from 23 NHS CAMHS services • Online access via computers, tablets, or mobile phones • Sessions accessed from home or school • Inclusion: internet access; conversational English (or translator arranged); age 7+ years • Exclusion: active self-harm requiring medical intervention; suicidal intent (last 3 months); psychosis; eating disorders	• RCADS-25: pre 66.88 to post 60.33 (d=0.48, medium) • RCADS-47: pre 72.39 to post 66.13 (d=0.45, medium) • YP-CORE: pre 22.12 to post 16.35 (d=0.70, medium-large) • GBO: pre 2.64 to post 6.99 (d=−1.39, large) • RCADS-25: 31%; RCADS-47: 35%; YP-CORE: 38%; GBO: 80%	• Video conferencing delivery of manualised CBT for CYP at scale (n=989) • Interactive multimedia \"decks\" designed specifically for online delivery (whiteboards, emojis, sliding scales) • Digital completion of all ROMs enabling high paired data completion (46-96%) • Session-by-session outcome monitoring integrated into clinical process	• Success: High paired ROM completion rate (74%); high acceptability (92% would recommend); effect sizes comparable to in-person CBT; goal-based outcomes showed largest effect (d=−1.39) and 80% reliable improvement; digital ROMs preferred by young people; interactive materials engage CYP who struggle with verbal communication • Challenges: 272 cases with missing paired data; variability in baseline ROM collection timing; COVID-19 may have limited achievable improvement • Limits: No control group; self-report only; authors employed by Healios (conflict of interest)	• Supports: VCT evidence base growing internationally; NICE-endorsed standardised CBT manual; NHS-commissioned model replicable in public health systems; addresses universal barriers (geography, transport, time, cost); effect sizes comparable to routine care benchmarks • Limits: UK NHS commissioning context specific; requires internet access and device; exclusion criteria limit applicability to complex cases; accredited CBT therapists required • Scale-Up Needs: Integration of parent/clinician outcome measures; training on collaborative ROM use; protocols for engaging non-completers
Lamotte d\'Incamps & Rizzi, 2024	France	G1 (Migrants/ Refugees)	Structural/Systemic (Supply-side)	Primary Care Mental Health Services	• Trained GP as first-line psychotrauma care provider • PTSD screening using validated scale (PCLS) • Pharmacological treatment for sleep and anxiety • Body-focused interventions (relaxation, cardiac	• Direct consultation at GP clinic for somatic complaints (headaches, insomnia, abdominal pain, fatigue, malaise) • CADA medical centre access • Somatic presentation as culturally acceptable entry point to care	• Strong therapeutic alliance established through somatic care • Symptom improvement; patient recognizes psychosomatic link • Refugee status obtained; resumed activities	• Conceptualization of GP as psychotrauma care provider (not just gatekeeper) • Body as transcultural mediator for mental health care entry • Complementarist method integrating cultural context into standard primary care • "Resource place" model - GP clinic as	• Success: Somatic care legitimizes follow-up and builds trust; frequent accessible appointments match patient needs; continuity of care prevents traumatogenic ruptures; body-focused work (relaxation, cardiac coherence) accessible and acceptable; cultural humility enhances alliance • Challenges: CMP waiting times incompatible with close	• Supports: GP role as first-line contact universal in European health systems; patient-centred care widely taught; body-focused techniques widely available; addresses universal barrier of specialist service shortage; somatic presentation common across migrant populations • Limits: French healthcare system specific (CMPs,

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					coherence, osteopathy) • Referral pathways to CMP/psychologists when available	• Frequent accessible appointments (contrast with CMP long waits) • No formal referral required	• GP clinic became stable resource point after CMP dropout Case 2 • First contact via somatic presentation (malaise/asthenia)	stable anchor for mobile/precarious population	follow-up; high dropout from psychiatric care (67% at 3 months); polymorphic presentation leads to diagnostic wandering • Limits: Three clinical vignettes only — no systematic evaluation; single clinician perspective; no outcome measures; generalizability unknown	CADA); requires GP training in transcultural psychiatry; time-intensive consultations may not be feasible • Scale-Up Needs: GP training programmes in psychotrauma and transcultural care; integration of GPs into migrant health structures; vulnerability screening grids for primary care
Bajbouj et al., 2021	Germany	G1 (Migrants/ Refugees)	Language/ Cultural (Supply-side)	Targeted Specialised Mental Health Services	• Central Clearing Clinic with low-threshold access • Native Arabic-speaking psychiatrist present daily • Professional interpreters (in-person for Arabic/Farsi; video-based for other languages) • Triage/prioritization system based on case severity (nurse-led initial assessment) • Emergency slots for suicidal patients, acute deterioration, medication continuity	• Appointments via telephone and email • Self-referral by refugees or referral by social workers, volunteers, physicians • Nurse-led initial severity triage to adjust waiting time and prioritize severe cases • Emergency slots for urgent cases (suicidal ideation, acute deterioration, medication continuity) • Central location near former registration authority (familiar landmark)	• 4,635 contacts with 3,096 refugees over 18 months • Referrals from all 12 Berlin districts, 165/182 subdistricts • 63 nationalities, 36 languages served DIAGNOSTIC DISTRIBUTION (n=3,096): • Unipolar depression: 40.4% (47.1% F, 36.9% M) • PTSD: 24.3% (23.9% F, 24.5% M)	• Central clearing/triage model adapted from emergency medicine (\"priorisation\") for mental health • Native Arabic-speaking psychiatrist ensuring daily language-concordant care for largest language group • Video-based interpreter service for less common languages (36 languages total) • Integration of child/adolescent and adult psychiatry in single low-threshold facility	• Success: City-wide reach achieved (all 12 districts, 165/182 subdistricts); large volume served (3,096 cases in 18 months); native Arabic-speaking psychiatrist critical; central familiar location reduced navigation barriers; triage system enabled efficient resource allocation; stable contact point for mobile population • Challenges: Waiting times increased over time; low-threshold interventions not broadly available; medical attestation requests may have influenced symptom reporting • Limits: Retrospective observational design — no control group; no systematic use of validated questionnaires; pre-selected population	• Supports: Addresses universal barriers (language, system navigation, capacity); scalable model for high-stress migrant populations; triage concept adaptable from emergency medicine; large sample demonstrates feasibility; multi-language video interpretation model replicable • Limits: German healthcare system specific; requires native-speaking psychiatrists or interpreter infrastructure; centralised model may not suit rural contexts; required substantial dedicated funding • Scale-Up Needs: Integration into regular mental health care; development of local service sector networks; low-threshold interventions for less severe cases
Surkan et al., 2024	France	G1 (Migrants/ Refugees)	Language/ Cultural (Supply-side)	Peer-Delivered / Lay Worker	• PM+ intervention adapted for Arabic speakers • 80-hour helper training programme • Weekly 2-hour supervision by psychologists/psychiatrist • Delivery in accommodation centres (reducing stigma vs mental health facilities) • Native Arabic-speaking helpers	• Recruitment via flyers, oral communication, snowball sampling in accommodation centres • Sessions delivered on-site in accommodation centres (not mental health facilities) • Arabic-speaking research assistant for screening and contact • Written informed consent prior to screening	• Implementation feasible with predominantly positive reactions • 70% eligible (14/20 recruited) • 1 lost to follow-up (COVID-19 hospitalization) • All intervention components considered beneficial • Breathing exercises: easy to implement, often sustained,	• First PM+ study with Arabic-speaking migrants in France • Systematic qualitative evaluation of each PM+ component (not reported in other PM+ studies) • Diverse helper ethnic backgrounds (not same ethnicity as participants) -- may mitigate distrust issues seen elsewhere • Delivery in accommodation	• Success: Breathing exercises easy, well-liked, sustained; Helper-participant rapport critical (60-70% of improvement goes back to talking to someone who understands) • Challenges: Problem selection and follow-through difficult; Poor Arabic translation of PM+ materials (too literal) • Limits: Small sample (n=14 intervention; n=15 interviews); Only 2 women in participant interviews	• Supports: WHO PM+ protocol with established evidence base; consistent with PM+ findings in Netherlands, Switzerland, Turkey; breathing exercises universally effective; helper-participant rapport valued across all PM+ studies; accommodation centre delivery model replicable • Limits: French healthcare context specific; Arabic-speaking migrants only — other language groups need adaptation; poor translation

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					bridging cultural/linguistic gaps	• Inclusion screening: K10≥16 + WHODAS 2.0>16	extended to multiple life contexts (stress, interviews	centres for asylum seekers/homeless		quality limits direct material use; diverse Arabic dialects • Scale-Up Needs: Extension to other languages; improved translation with dialect considerations; linkage to social service organisations; psychological support for helpers
Karaoğlan Kahiloğulları et al., 2020	Turkey	G1 (Migrants/ Refugees)	Workforce Capacity/ Training	Primary Care Mental Health Services	• WHO mhGAP training programme adapted for Turkey • 5-day structured training with standardized modules • Train-the-trainer model (5-day ToT + mhGAP training) • Network of Refugee Health Training Centres with Syrian health professionals • Integration of MHPSS into primary care services	• Free primary care services through Turkish family physician network • Refugee Health Training Centres with Syrian health professionals • Temporary protection status entitles free services and medications • Syrian and Arabic-fluent Turkish staff for patient communication • MHPSS integrated into general primary care consultations	• Turkish doctors (n=388): 5% increase in correct answers (81.7% to 86.9%), p<0.000, t=7.16 • Syrian doctors (n=207): 9% increase (40.1% to 48.7%), p<0.000, t=12.94 • All mental health cases: 139→177 per doctor/year, p<0.000 • Depression: 75→96, p<0.000 • Dementia: 7.6→10.8, p<0.000	• Largest mhGAP training programme globally (1,468 doctors, 2016--2019) • Dual workforce training: both Syrian refugee doctors and Turkish doctors • National-scale integration of mental health into primary care for refugees • Hiring refugee health professionals to serve own community	• Success: Statistically significant knowledge increase for both Syrian and Turkish doctors; 38 additional mental health cases identified per doctor annually post-training • Challenges: Child/ adolescent cases did not increase post-training; Self-harm identification unchanged • Limits: No control group; Online survey response <50% of trained Turkish doctors	• Supports: WHO mhGAP is standardised, evidence-based, globally applicable; task-shifting model addresses universal specialist shortages; train-the-trainer approach enables scale-up; context adaptation process replicable; multi-component evaluation framework transferable; demonstrated at unprecedented national scale • Limits: Turkey-specific healthcare infrastructure (family physician network); unique scale of refugee population (3.6 million); temporary protection policy context; legislative context for psychiatric prescribing • Scale-Up Needs: Additional 500 doctors planned for training; refresher courses; enhanced child/adolescent psychiatry modules; pharmacological treatment training
de Graaff et al., 2023	Netherlands	G1 (Migrants/ Refugees)	Structural/ Systemic (Supply-side)	Peer-Delivered / Lay Worker	• PM+ brief psychological intervention • Task-shifting to non-specialist peer helpers • 8-day structured training (CMDs, counselling skills, intervention strategies, self-care) • Weekly group supervision by mental health professionals • Fidelity monitoring (helper	• Recruitment via community centres, NGOs, reception centres, language schools, social media • Arabic-speaking research assistants for screening and assessments • Online questionnaires (Survalyzer) with phone-based assistance for lower literacy • Inclusion screening: K10 + WHODAS 2.0 • Sessions delivered in community settings	• HSCL-25 total (PRIMARY): MD −0.25 (95% CI −0.385 to −0.122), p=0.0001, d=0.41 • Depression subscale: MD −0.28, p=0.0002, d=0.42 • Anxiety subscale: MD −0.23, p=0.001, d=0.35 • PCL-5 (PTSD): MD −6.49, p=0.0005, d=0.39 • PSYCHLOPS: MD −1.34, p=0.03, d=0.26	• First full RCT of individual PM+ for refugees in a high-income country • Task-shifting/peer delivery model validated in HIC context • COVID-19 adaptation demonstrating online/hybrid feasibility • Part of 8-country STRENGTHS consortium enabling cross-context comparison	• Success: High adherence (84.5% completed ≥4 sessions); High fidelity (97.5% self-report; 77.4% independent rating) • Challenges: COVID-19 required protocol deviation to online/hybrid delivery; Online/hybrid delivery less effective than in-person at 3-month (d=0.21 vs d=0.54) • Limits: Predominantly residence permit holders (72.8%) -- limits generalizability to asylum seekers; Relatively high educational level in sample	• Supports: First HIC effectiveness evidence for PM+ with refugees; WHO-developed scalable intervention with LMIC evidence base; peer/task-shifting model addresses universal workforce shortages; effect sizes consistent with psychotherapy in HICs; flexible delivery format (in-person/online) demonstrated • Limits: Netherlands healthcare context specific; Syrian refugees only; sample predominantly

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					checklists + independent audio recording assessment)	(Zurich, Bern, St. Gallen area equivalent locations)	• WHODAS 2.0: MD −1.64, p=0.08, d=0.21 (but significant average effect over time p=0.02) • 85.4% retention at 3-month follow-up			residence permit holders with higher education; requires trained bilingual helpers and supervision infrastructure • Scale-Up Needs: Sustainable financing mechanisms; policy enabling non-specialist helpers as providers; resource/knowledge centre for quality assurance
Spaaij et al., 2022	Switzerland	G1 (Migrants/ Refugees)	Mixed: Structural + Stigma	Peer-Delivered / Lay Worker	• PM+ intervention with trained non-specialist helpers • Task-shifting model from specialists to lay providers • 8-day helper training (basic counselling, PM+ strategies, GCP, PFA) • Continuous supervision by PM+ master trainer • EQUIP competency rating scale for fidelity assessment	• Self-referral via social media (Arabic/German), flyers, community events • Recruitment through refugee/asylum centres, community settings • Syrian community key informants and stakeholders • Word-of-mouth/personal recommendations most effective (83% joined after personal contact) • Phone/email contact with Arabic-speaking research assistant	• Retention: 67.8% baseline to 3-month follow-up • Adherence: 74.2% attended all 5 PM+ sessions; M=3.94 sessions • Screening-to-inclusion: 80.8% eligible after screening • No SAEs related to intervention • 83% would recommend programme to others • PMLDC (post-migration difficulties): d=0.88 (large)	• Task-shifting from mental health specialists to trained non-specialist helpers • WHO-developed scalable intervention tested in high-income context • Bilingual/bicultural helpers bridging formal healthcare and community care • Mixed-method evaluation combining quantitative and qualitative data	• Success: No intervention-related SAEs -- safe delivery confirmed; All PM+ participants reported subjective benefit • Challenges: Initial very slow recruitment (<15% at 4 months); Mental health stigma major barrier • Limits: Small sample -- not powered for effectiveness; Syrian refugees only -- limits generalizability	• Supports: WHO-developed intervention with evidence base across LMICs; task-shifting model addresses workforce shortages universally; nationwide interest suggests scalability; culturally adaptable framework (manual, training, supervision); part of multi-country STRENGTHS consortium enabling cross-context learning • Limits: Swiss healthcare context specific (mandatory insurance, formal entitlement); Syrian refugees only; requires trained bilingual/bicultural helpers; requires supervision infrastructure; PM+ not integrated into standard care • Scale-Up Needs: Identify implementing agencies and sustainable funding; clarify role of helpers within healthcare system; develop stepped-care integration model
Meurling et al., 2023	Sweden	G1 (Migrants/ Refugees)	Language/ Cultural (Supply)	Digital Mental Health	• i-TAP online tiered screening procedure • Culturally adapted scales (RHS-13 developed for refugees) • Multi-language delivery (Arabic, Dari, Farsi, English, Swedish) • Validated gateway	• Anonymous online questionnaire • Five language options selected by user • Multi-channel recruitment (social media, asylum housings, schools, refugee meeting points) • Self-completion at own pace, time, and place • Healthcare professional contact	• Sensitivity 94.6% for any moderate symptoms • Specificity 62.6%; Effectiveness 86.2% • 76.8% screened positive for emotional distress • PHQ-2: AUC .909; cut-off ≥3 (sens 85%, spec 83.2%)	• Tiered/adaptive screening reducing item burden while maintaining accuracy • Multi-symptom simultaneous screening (depression, anxiety, PTSD, insomnia) • Culturally adapted entry screener (RHS-13) developed specifically for refugees	• Success: Substantial item burden reduction (up to 70%); Culturally sensitive design with refugee-specific instruments • Challenges: High comorbidity limits item reduction for symptomatic individuals; Item burden increases for those with symptoms across all categories • Limits: Convenience sampling; self-identified	Supports: Uses validated, cross-culturally adapted scales; applicable in multiple settings (primary care, schools, asylum housing); online format crosses geographic barriers; tiered model adaptable to available resources; translation procedure replicable for additional languages • Limits: Swedish context and refugee population

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					instruments for efficient screening • Not reported • Three-tier adaptive structure reducing item burden	provided for distressed individuals	• GAD-2: AUC .919; cut-off ≥3 (sens 86%, spec 85.8%)	• Rigorous collaborative iterative translation procedure	refugees; No clinical interview validation (Tier 3 only)	specific; five languages may not cover all refugee groups; requires digital literacy and internet access; cut-offs may need recalibration • Scale-Up Needs: Validation with clinical diagnostic interviews; adaptation to additional languages and refugee populations
Elbert et al., 2017	Germany	G1 (Migrants/ Refugees)	Workforce Capacity/Training (Supply-side)	Peer-Delivered / Lay Worker Services	• Cascade model complementary to existing healthcare system • Health Navigators (Gesundheitslotsen) trained in health system knowledge and screening • Trauma Counsellors (Traumaberater) delivering manualized NET under supervision • Screen-and-treat approach using RHS-13, PROTECT or similar instruments • Narrative Exposure Therapy (NET) as primary intervention	• Health navigators embedded in refugee communities offer screening • Screen-and-treat using validated instruments (RHS-13, PROTECT) • Positive screens referred to trauma counsellors for structured diagnostic interview • Supervising psychotherapist reviews case and sets indication • Treatment delegated to trauma counsellor if appropriate	• Hensel-Dittmann et al., 2011: RCT comparing NET vs. stress inoculation training • Neuner et al., 2010: RCT pilot with asylum seekers in Germany • Stenmark et al., 2013: RCT in Norwegian general healthcare NET effectiveness with trained lay counsellors (crisis resolution) • Neuner et al., 2008: RCT in Ugandan refugee settlement -- trained lay counsellors achieved significant PTSD reduction • Ertl et al., 2011: RCT with former child soldiers in Uganda - community-implemented NET effective	• Adaptation of crisis-region cascade model to high-income country context • Task-shifting: trained lay counsellors (Traumaberater) deliver manualized trauma therapy • Bilingual community members as primary workforce - addresses language barrier structurally • Screen-and-treat public health approach for refugee mental health	• Success: NET robust across diverse settings and populations; lay counsellors achieve comparable outcomes to licensed therapists in crisis regions; local therapists can be trained as trainers/supervisors; manualized approach enables quality control; no special pre-requisites for patients; evidence from multiple independent RCTs • Challenges: Requires significant training and supervision resources; German regulatory framework may need adaptation for non-licensed providers; supervision capacity still a bottleneck • Limits: Conceptual paper — proposed model not yet empirically tested in German context; based on extrapolation from crisis regions; regulatory and funding pathways unclear	• Supports: Based on WHO-recommended principles (task-shifting, screen-and-treat, stepped care); evidence from multiple RCTs across diverse settings; NET validated cross-culturally and with lay counsellor delivery; addresses universal workforce capacity mismatch; model explicitly designed as complement to existing systems • Limits: German regulatory context specific; may require legal/policy changes for non-licensed providers; proposed model not yet evaluated in German context • Scale-Up Needs: Regulatory framework for trauma counsellor role; sustainable funding for training and supervision; quality assurance and outcome monitoring systems; integration with existing healthcare structures
Trilesnik et al., 2019	Germany	G1 (Migrants/ Refugees)	Language/ Cultural (Supply-side)	Integrated/ Multi-Sector Services	• RefuKey stepped-care model integrating PCCs and psychiatric clinics • Professional interpreter provision funded by project • Academic refuKey staff	• Low-threshold entry via PCCs near reception centres (open counselling hours) • Referral between PCCs and psychiatric clinics within stepped-care network • Professional referral or self-referral to PCCs	• 76% sleep problems; 57.3% depression; 54.2% anxiety; 44.8% posttraumatic symptoms; 43.7% psychosomatic problems • 74.8% reported strong to extreme symptom severity	• Need-adapted stepped-care model specifically designed for refugee mental health • Integration of psychosocial counselling centres with psychiatric clinics as competence centres • Professional interpreter provision	• Success: Significant symptom improvements with moderate-high effect sizes (d=0.487–0.952); prevalence of clinically relevant symptoms reduced across all domains; multi-language questionnaire administration feasible; partnership model (NGO + professional association + state government) secured funding; similar symptom	• Supports: Uses validated, internationally used instruments; stepped-care models have proven effectiveness internationally (NICE recommended); addresses universal barriers (language, cultural competence, workforce capacity); partnership model replicable; aligns with national recommendations

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					embedded in clinics and PCCs • Transcultural competence training for mental health professionals • Low-threshold psychosocial counselling at PCCs	• Interpreter-assisted consultations in both settings • RefuKey staff facilitate navigation and reduce bureaucratic barriers Key insight: Stepped-care model enables access	• Main post-migration stressors: fear of deportation (M=4.63), inability to return home in emergency (M=4.09), loneliness • General well-being: t=−2.644, p\<.05, d=0.499 • Depression: t=3.902, p\<.001, d=0.613	funded and coordinated by project • Academic refuKey staff (psychologists, psychiatrists, psychotherapists, social workers) with transcultural training.	severity in PCCs and clinics supports appropriate stepped-care triage • Challenges: Low return rate in clinic survey (7/32 clinics); lack of systematic refugee documentation; post-migration stressors did not decrease; quality of life did not improve • Limits: Small paired sample (n=27–28); no control group comparison yet; help-seeking population only — not generalisable to all refugees	• Limits: German legal context specific (AsylBLG restrictions); state-funded pilot — sustainability unclear; requires professional interpreter infrastructure; regional coordination structures needed • Scale-Up Needs: Standardised documentation systems for refugees across psychiatric services; control group comparison to establish effectiveness; long-term follow-up; cost-effectiveness analysis
Schmidt et al., 2023	Germany	G1 (Migrants/ Refugees)	Language/ Cultural (Supply-side)	Targeted Specialised Mental Health Services + Integrated / Multi-Sector Services	• Bielefeld Screening Approach integrated into mandatory initial medical examination • Refugee Health Screener (RHS-15/RHS-13) as validated instrument • Intercultural Therapy Assistants (ITAs) as trained multilingual lay workforce • Psychologist/ psychotherapist supervision and coordination • Three-tier traffic light classification system	• Screening offered as part of mandatory initial medical examination at reception centre • Voluntary participation following informed consent • GP refers to ITA if no crisis detected during medical exam • Direct referral to psychologist if GP detects crisis signs • Language-matched ITAs conduct screening in shared language	• 82.5% positive screening rate (RHS-15 standard cut-off) • 56.6% positive screening rate (RHS-13 elevated cut-off ≥21) • 6.6% (n=11) identified as severe psychological crisis (red flags) • Crisis types: suicidal risk (n=7), acute psychotic symptoms (n=3), high distress/self-injury (n=1) • Safety measures initiated for all crisis cases validation (n=48):	• Screen-and-treat public health approach adapted for refugee reception context • Intercultural Therapy Assistants (ITAs) as trained multilingual lay workforce • Three-tier traffic light classification system (red/yellow/green) with differentiated response • Integration with mandatory GP health check-up (complementary model)	• Success: Feasible integration into existing health check-up procedures; no significant disruption to reception centre operations; ITAs facilitated communication during medical check-up; higher crisis detection rate than standard procedures; strong correlation between screening and diagnostic interviews (r=.64–.84); safe implementation — no safety concerns • Challenges: Only 29% of eligible adults screened due to resource constraints; standard RHS cut-offs produce excessive false positives (82.5%); limited referral success post-screening • Limits: Convenience sampling — not consecutive arrivals; small validation sample (n=48); no gold standard diagnostic instruments in participants' languages	• Supports: Uses widely validated instrument (RHS-15/RHS-13); screen-and-treat is established public health approach; addresses universal barriers (language, cultural competence, workforce); lay interviewer model scalable; integration with existing procedures minimises implementation burden • Limits: German reception centre context specific; requires trained ITA workforce; cut-off calibration needed for specific contexts; dependent on supervision capacity; EU-funded — sustainability unclear • Scale-Up Needs: Develop complementary healthcare structures for successful referrals; establish follow-up contact mechanisms; train and maintain multilingual ITA workforce; standardise multilingual feedback materials
Harty et al., 2023	Ireland	Multiple (older adults)	Structural/ Systemic	Digital Mental Health	• National digital CBT service through HSE with supported/guided model • 5 referral pathways including GPs as primary source	• Referral required from GPs or other healthcare sources • Email invitation following referral • Online sign-up with consent and baseline measures (NB. no alternative access routes for digitally	• Large effect sizes overall (depression d=0.85; anxiety d=0.99) • 61% activation rate; 94% user satisfaction; 49.7% recovery rate • Older adults underrepresented,	• National scale implementation of supported digital CBT • Multi-pathway referral system across 5 healthcare sources • Embedded outcome monitoring with risk management protocol	• Success: High activation rate (61%); large effect sizes (d=0.85–0.99) for depression and anxiety; high user satisfaction (94%); nationwide reach — all 26 counties represented; recovery rates consistent with IAPT (49.7% vs 50.2%)	• Supports: Evidence-based CBT programmes with RCT validation; model replicates successful services (IAPT UK, MindSpot Australia); nationwide reach demonstrates scalability; large effect sizes comparable to face-to-face therapy

Ref.	Country	Pop. (primary)	Barriers (primary)	Service Type	Solutions (F9)	Access (F11)	Outcomes (F10)	Innovation (F12)	Implementation (F13)	Transferability (F14)
					• Asynchronous written support via platform messaging	excluded older adults; no telephone or in-person options documented)	only 2.3% of users aged 65+ versus 14.8% of population;	Nationwide geographic reach (all 26 counties)	• Challenges: Older adults severely underrepresented (2.3% users vs 14.8% population aged 65+); potential digital exclusion and internet/computer accessibility issues for older adults; 39% did not activate after referral • Limits: Observational design — no control group; cannot determine barriers specific to older adult non-engagement; no subgroup analysis by age	• Limits: Irish healthcare system specific; requires digital infrastructure — potential barrier for older adults; no self-referral option; older adults' underrepresentation suggests digital format may not suit this population without adaptation • Scale-Up Needs: Targeted awareness campaigns for older adults; age-appropriate digital literacy support; alternative access pathways for digitally excluded older adults
Gee et al., 2024	United Kingdom	G3 (Youth)	Structural/ Systemic	Digital Mental Health	• Lumi Nova digital therapeutic app delivering graded exposure therapy • Psychoeducation component embedded in game • Parent/caregiver involvement and notification • Dual access: practitioner referral or self-sign-up option (from April 2022) • CE marked medical device with NICE recommendation	• Practitioner referral (screening in person/telephone or during treatment) • Self-sign-up option (from April 2022) parent/caregiver accesses independently • Game key activation by parent/caregiver completing baseline CORS • Mobile app download (iOS 66%, Android 34%) • No waiting list once offered access	• 62.58% (644/1029) activated game key • 58.1% (374/644) completed ≥1 challenge • Median 6 unique sessions (IQR 3--12) • Median 42 minutes total engagement (IQR 15--79) • Only 17.7% completed ≥4 challenges • GBO scores improved (n=224; t 223=5.78, p<.001; d=0.37, 95% CI 0.25--0.52)	• Immersive gaming technology to deliver graded exposure therapy for children • Human-centred co-design involving multiple stakeholders including children • Personalized goal selection with in-app and real-world challenges • Parent verification of real-world challenge completion	• Success: High initial activation rate (62.58%); outcomes comparable to routine CAMHS despite brief intervention (median 42 min); small-medium effect sizes (d=0.37–0.46); graded exposure mechanism operating as expected; children from deprived areas engage well once accessed (66.4% vs 53.8% challenge completion) • Challenges: High attrition — only 17.7% completed ≥4 challenges; ethnic minorities underrepresented (Asian 1.7% vs 11.2%; Black 1.3% vs 5.5%); children with disabilities less likely to complete (42.7% vs 59.6%) • Limits: No control group; substantial missing outcome data; concurrent treatments unknown; disability captured as binary only	• Supports: Addresses universal barriers (access, workforce shortages); CE marked medical device with NICE recommendation; app-based delivery scalable; dual access routes (referral or self-sign-up) adaptable; graded exposure cross-culturally validated • Limits: UK NHS commissioning specific; English only; smartphone/internet required; parent involvement essential; may not reach marginalised groups without equity measures • Scale-Up Needs: Accessibility adaptations for disabled children; equity-focused implementation strategies for ethnic minorities and deprived areas; improved data collection
Koet et al., 2024	Netherlands	G3 (Youth)	Structural/ Systemic	Primary Care Mental Health	• YMHPN integrated into general practice -- low-threshold access point • No waiting list for YMHPN consultations • Short-term treatment capacity within primary care • Liaison function between GP,	• GP referral within general practice (primary pathway) • Self-referral or caregiver-initiated contact with GP • No waiting list for YMHPN -- immediate/rapid access • Integration within familiar general practice setting	• Median 4 consultations (IQR 2--7) per treatment trajectory • 51.7% received one or more external referrals • Referral destinations: mental health services (42.4%), other services (17.3%)	• New professional role (YMHPN) specifically designed for youth mental health in primary care • Integration of child mental health expertise within general practice structure • Bridging function during waiting times for specialized care	• Success: Low drop-out rate (13.3%) suggests good treatment adherence; 22.4% successfully managed without needing specialised referral — fills treatment gap; high external collaboration (50.2% contact with schools, mental health services, support teams); growing number of YMHPNs since 2015 indicates model acceptability	• Supports: Addresses universal barriers (waiting lists, access to specialised care); model aligns with international evidence on integrated primary care mental health; role-based innovation replicable; low-threshold no-waiting-list model broadly applicable • Limits: Dutch healthcare system specific (GP gatekeeper, municipal

Ref.	Country	Pop. (primary)	Barriers (primary)	Service Type	Solutions (F9)	Access (F11)	Outcomes (F10)	Innovation (F12)	Implementation (F13)	Transferability (F14)
					families, schools, and specialized services • Referral coordination to mental health services or community support teams	• YMHPN as first point of contact before specialized care	• Of first referrals: 44.3% accepted, 26.8% rejected, 28.9% unclear • 22.4% successfully managed without referral (YMHPN + family decided no additional help needed)	• Use of E-health interventions (17.0% of cases)	• Challenges: High adolescent drop-out (more than twice rate of younger groups); 26.8% of initial referrals rejected; 44.8% had missed appointments; limited evidence-based treatment use (CBT only 13.4%) • Limits: Routine data — documentation often limited; no validated outcome measures recorded; no control group; urban low-SES population — may not generalise	financing post-2015 Youth Act); urban low-SES Rotterdam context; requires multi-stakeholder financing; dependent on existing general practice infrastructure • Scale-Up Needs: Standardised documentation protocols; outcome measurement integration; improved referral coordination with specialised services
Santa et al., 2024	United Kingdom	G3 (Youth)	Structural/ Systemic	Digital Mental Health	• Digital single-point referral platform replacing paper-based systems • Self-referral option for CYP (non-face-to-face, reducing stigma) • Integrated access to 9 mental health partnership services • Administrative triage and forwarding system • Professionally validated self-help resources during waiting times	• Web-based platform (https://www.seftonliverpoolcamhs. com/) • Self-referral by CYP (aged 14+) • Parent/carer referral for children \<16 • Health service provider referral • No prior registration required	• 7 themes identified: (1) CYP as One vs. Traditional Referrals, (2) Gender and Language Dynamics, (3) Digital Empathy • Digital referral perceived as easier and more straightforward than paper forms • Self-referral valued for efficiency and independence • Mixed preferences: some CYP prefer in-person/phone contact • Empathetic wording critical for engagement	• Single-point digital referral replacing multiple paper-based forms across 9 services • Living Lab co-customisation methodology with iterative cycles • Quadruple Helix stakeholder model (CYP, parents, providers, researchers) • Self-referral capability for CYP reducing threshold and stigma	• Success: Co-design with diverse stakeholders ensured real-world relevance; high male participation attributed to Living Lab methodology; ethnic diversity in participants; platform already live and serving Liverpool/Sefton; iterative feedback loops allowed continuous refinement • Challenges: COVID-19 required shift to online focus groups; digital literacy varies — some prefer traditional methods; cultural diversity unbalanced in provider group (90% White-British); incomplete referrals remain an issue • Limits: Online-only focus groups limited observation; no demographic data from platform feedback respondents; focus group guide not pilot tested	• Supports: Addresses universal barriers (stigma, fragmentation, waiting times); Living Lab/co-design methodology replicable; high smartphone/internet penetration supports digital approaches; framework applicable to other regional CAMHS partnerships; themes (empathy, age-sensitivity) generalisable • Limits: UK-specific NHS context and CAMHS structure; regional partnership model specific; high digital infrastructure assumed; English-language platform; high deprivation context specific • Scale-Up Needs: Multi-language functionality; school system integration; platform-based CYP engagement history database
Bechdolf et al., 2024	Germany	G3 (Youth)	Transition Gaps (Supply-side)	Integrated / Multi-Sector	• Low-threshold, no-cost access without referral requirement • Self-referral plus referral by parents/teachers accepted • Multi-professional team including peer support workers • Staged care model: transit (counselling) for stage 1a; FIT	• Internet/website (primary pathway) • Walk-in during opening hours • Toll-free telephone • Flyers distributed in catchment area • Referral by family/friends (transit: 46.6%; FIT: 17.3%)	• Mean age 24.7 years (transit), 23.6 years (FIT) -- older than international comparators • Gender: Transit 57.4% female, FIT 63.7% male • Education (FIT): 36% university qualification, 7.6% did not finish school • Internet primary pathway	• Clinical early intervention (FIT) nested within community counselling (transit) -- reduces threshold • Seamless transition across age 18 with same multidisciplinary team • Youth co-design of service model and physical space • Staged care aligned with transdiagnostic clinical staging	• Success: Low-threshold access demonstrated — 53.5% transit users had no prior mental health contact; alignment with World Economic Forum's 8 principles; multi-stakeholder collaboration (hospital trust, community organisation, district health planning); predominantly common mental disorders — reaching intended early-stage population • Challenges: Older user age (24 years) than international models (17–19 years); no	• Supports: Based on internationally validated model (headspace, Jigsaw); follows World Economic Forum 8 principles — framework applicable across contexts; addresses universal barriers (transition gaps, stigma, threshold); staged care model replicable • Limits: German healthcare system specific (outpatient AMHS/CAMHS structure); urban inner-city setting with high service density; requires multi-stakeholder

Ref.	Country	Pop. (primary)	Barriers (primary)	Service Type	Solutions (F9)	Access (F11)	Outcomes (F10)	Innovation (F12)	Implementation (F13)	Transferability (F14)
					(clinical) for stages 1b–2 • Continuity of care across age 18		• Transit: 53.5% no prior mental health contact (vs. 15.1% FIT) - supports low-threshold hypothesis	framework (Shah et al., 2020)	integrated substance use disorder service despite high prevalence (28.8%); funding dependency (recovery college discontinued) • Limits: No control group comparison; anonymous data collection reduced sample completeness; single-site study; Germany lacks national youth mental health strategy	cooperation; older age range (15–35) differs from most services • Scale-Up Needs: National youth mental health strategy in Germany; integration of substance use services

Population codes: G1=Migrants/Refugees/Asylum seekers; G2=Ethnic/Religious minorities; G3=Children/Adolescents/Youth; G4=LGBTQIA+; G5=Older adults; G6=People with disabilities; G7=Socioeconomically disadvantaged; G8=Homeless; G9=Disaster-affected
Field codes: F9=Solutions Identified; F10=Reported Outcomes; F11=Access Mechanisms; F12=Innovation Features; F13=Implementation Insights; F14=Transferability

Appendix B: Catalogue of solutions in the wider screened literature

Reference	Country	Cluster	Pop. (primary)	Barrier (primary)	Solution (primary)	Solution (secondary)	Brief Description
Graef-Calliess et al., 2023	Germany	C1	G1	Stigma & trust	S1		Naturalistic study of RefuKey stepped-care mental health programme for asylum seekers and refugees in Germany; found significant improvement in mental health outcomes despite ongoing stressors.
Camacho-Rubio et al., 2025	Spain	C2	G3	Stigma & trust	S1	S3	Service description of school-based Mental Health Clinical Liaison Programme for children and adolescents in Spain; identified 876 cases across 53 schools with 122 specialist referrals.
Edge et al., 2020	UK	C1	G2	Structural barriers	S2	S5	Co-production study of Culturally adapted Family Intervention (CaFI) for African-Caribbean communities with psychosis in the UK; achieved high engagement from communities often labelled 'hard-to-reach'.
Cockersell et al., 2016	UK, Ireland	C1	G8	Workforce gaps	S6		Evidence review of Psychologically Informed Environments (PIEs) for homeless people in the UK and Ireland; found the approach effective in reducing social exclusion and improving mental health.
Kumar et al., 2025	UK	C1	G1	Structural barriers	S1	S2	Service description of collaborative CAMHS pathway for unaccompanied asylum-seeking young people in the UK; most referrals resulted in partnerships with specialist organisations.
Hameed et al., 2023	UK	C1	G1	Workforce gaps	S2	S3	Service description of dedicated mental health clinic for asylum seekers and refugees in the UK; served 40 referrals using trauma-informed, community-based approaches.
Graaff et al., 2022	Netherlands	C1	G1	Workforce gaps	S5	S6	RCT of peer-delivered Problem Management Plus (PM+) for Syrian refugees in the Netherlands; preliminary results showed effectiveness for depression, anxiety, and PTSD symptoms.
Pejovic-Milovancevic et al., 2025	Serbia, US	C6	G3	Workforce gaps	S3	S4	Service description of youth mental health centre (CEZAM) established following mass shootings in Serbia; provides free psychosocial support for ages 10-30 with online booking.
Bremmers et al., 2025	Netherlands	C1	G3	Structural barriers	S6		Validation study of 7-item Decision Tool Youth for identifying children needing specialist mental health care in the Netherlands; early feedback indicates improved referral efficiency.
Sjoblom, 2024	Sweden, US	C6	G3	Structural barriers	S4		RCT of digital emotion-regulation intervention (POET) for adolescents in Swedish primary care; found greater symptom reductions than control, maintained at 3-month follow-up.
Griffiths et al., 2021	UK	C1	G3	Structural barriers	S4		Service description of HappyMaps web-based resource hub for children's mental health in the UK; achieved 60,000 users since 2019, addressing gaps in overstretched CAMHS.
Chadha, 2019	UK	C1	G3	Stigma & trust	S4	S3	Evaluation of Afloat mobile app for youth mental health service access in the UK; 50% of users aged 16-25 reported increased likelihood and confidence to seek help.
Dubicka, 2018	UK, US	C6	G3	Workforce gaps	S1	S6	RCT (IMPACT trial) of Brief Psychosocial Intervention for adolescent depression in the UK; found BPI as effective as specialised CBT with minimal therapist training required.
Mirizio et al., 2016	Italy	C2	G3	Structural barriers	S1		Service description of 'Quadrilatero' coordinated early intervention network for young adults in Italy; preliminary data showed reduced age at first contact with mental health services.
Hubler et al., 2025	Croatia	C4	G4	Workforce gaps	S1	S6	Service description of BOJE mental health programme for LGBTQIA+ individuals in Croatia; served 50 participants with counselling, outpatient care, and group workshops.
Morton et al., 2025	UK	C1	G5	Stigma & trust	S1	S6	Quality improvement study of waiting time reduction initiative for mental health services in the UK; achieved 67% reduction in older adult service waiting lists.
Koks-Leensen et al., 2019	Netherlands	C1	G6	Structural barriers	S6		Pilot study of mental health nurse practitioners in out-of-hours GP services in the Netherlands; aimed to provide timely care for people with intellectual disabilities.
Suresh, 2025	UK	C1	G5	Structural barriers	S1		Service description of integrated dementia care pathway for older adults in the UK; improved diagnosis rates through shared responsibilities between primary and secondary care.
Davies et al., 2021	UK	C1	G3	Digital exclusion	S4		Pilot study of digital mental health intervention in a primary school in the UK; found high acceptability and feasibility but significant implementation barriers.
Perry et al., 2024	UK	C1	G1	Cultural barriers	S2		Feasibility study of culturally adapted ACT group intervention for Vietnamese refugees in the UK; found preliminary support for acceptability and improved psychological flexibility.
Es et al., 2023	Netherlands	C1	G1	Structural barriers	S6		Mixed-methods evaluation of trauma-focused treatment for unaccompanied refugee minors in the Netherlands; found high satisfaction though quantitative symptom measures were variable.
Boge et al., 2022	Germany	C1	G1	Affordability	S1	S5	Multicentre RCT of Stepped Care and Collaborative Model for refugees in Germany; found significantly greater reduction in depressive symptoms and cost-effectiveness versus usual care.
Mewes et al., 2021	Germany, Austria	C6	G1	Language barriers	S2	S3	Feasibility study of 'Tea Garden' low-threshold psychoeducational intervention for asylum seekers in Germany and Austria; found high acceptability across nationalities and education levels.
Leiler et al., 2020	Sweden, Switzerland	C1	G1	Workforce gaps	S6		Pilot study of AMIN psychoeducational group intervention for asylum seekers in Sweden; showed potential effectiveness in reducing distress and insomnia.
Jumaa et al., 2020	Germany	C1	G1	Structural barriers	S5		Pilot study of peer-to-peer counselling groups for Arabic and Farsi-speaking refugees in Germany; participants valued social support and recommended programme expansion.

Reference	Country	Cluster	Pop. (primary)	Barrier (primary)	Solution (primary)	Solution (secondary)	Brief Description
Learman et al., 2019	UK	C1	G1	Language barriers	S5		Qualitative study of triadic therapy relationships with interpreters for asylum seekers in the UK; found interpersonal attunement achievable with skilled interpreters enhancing therapy.
Lahuis et al., 2019	UK, Netherlands	C1	G1	Legal barriers	S6		Service description of tailored PTSD treatment programme for undocumented asylum seekers in the Netherlands; demonstrated feasibility of specialist care despite legal complications.
Potter et al., 2023	Germany	C1	G1	Workforce gaps	S5	S6	Qualitative study of therapists' experiences delivering trauma therapy to refugees in Germany; found work enriching with recommendations for reduced bureaucracy and organisational support.
Spaaij et al., 2023	Switzerland	C1	G1	Structural barriers	S1	S5	Qualitative study of implementation factors for scaling Problem Management Plus (PM+) for refugees in Switzerland; identified need for stepped care integration and sustainable funding.
Qureshi et al., 2022	Spain	C2	G1	Stigma & trust	S3	S5	Service description of peer counsellor training programme for unaccompanied migrant youth in Spain; aimed to bridge mental health services and marginalised communities.
Park et al., 2022	Turkey, US	C6	G1	Affordability	S1	S5	Cost-utility analysis of WHO Self-Help Plus (SH+) for Syrian refugees in Turkey; found guided self-help intervention highly cost-effective compared to enhanced usual care.
Burian et al., 2019	Germany	C1	G1	Language barriers	S1		Service description of culturally adapted mental health services for Vietnamese migrant women with depression in Germany; addressed language barriers through Vietnamese-background professionals.
Hughes et al., 2016	Turkey	C4	G1	Workforce gaps	S3	S6	Evaluation of mhGAP training for healthcare professionals working with Syrian refugees in Turkey; found improved knowledge and skills for managing mental health in primary care.
I et al., 2025	Italy	C2	G1	Structural barriers	S2		Service description of Transcultural Psychiatric Unit for migrants in Italy; illustrated through case studies how ethnopsychiatric services facilitate recovery and integration.
M et al., 2017	Multi-country	C6	G1	Structural barriers	S6		Programme overview of STRENGTHS project adapting Problem Management Plus (PM+) for Syrian refugees across Europe; described rationale for scalable interventions by non-specialists.
Priebe et al., 2016	Multi-country	C6	G1	Workforce gaps	S3	S6	Systematic review (WHO) of mental health among migrants and refugees in Europe; found higher PTSD in refugees with recommendations for outreach, coordination, and professional training.
In et al., 2025	Portugal	C2	G1	Language barriers	S2		Qualitative study of migrant families' access to child mental health services in Portugal; identified bureaucratic, economic, and language barriers with NGOs as key facilitators.
Serneels et al., 2017	Belgium	C1	G1	Structural barriers	S6		Service description of contextual intervention methodology for refugee children and families in Belgium; addressed multiple risk factors through improved mental health care access.
Fazel et al., 2016	UK	C1	G1	Geographic barriers	S3		Qualitative study of school-based mental health services for refugee adolescents in the UK; two-thirds preferred school-based care with teachers playing important mediating roles.
Pollard et al., 2021	UK, Ireland	C1	G1	Structural barriers	S2		Scoping review of mental healthcare for asylum seekers and refugees in the UK; identified communication difficulties and resource gaps, calling for culturally appropriate approaches.
Eruyar et al., 2022	UK, Turkey	C6	G1	Stigma & trust	S6		Comparative qualitative study of refugee mental health support systems in Turkey and the UK; identified common barriers including stigma and language with schools central to intervention.
Griffiths et al., 2017	Italy	C2	G1	Workforce gaps	S6		Qualitative study of mental health workers providing care to migrants in Italy; identified barriers including cultural knowledge gaps and recommended competence training.
Moustafa et al., 2016	Turkey	C4	G1	Structural barriers	S4		Feasibility study of telepsychiatry for Syrian refugees in Turkey; examined how videoconferencing can bridge mental health care gaps in humanitarian settings.
Harerimana et al., 2025	Multi-country	C6	G1	Workforce gaps	S2	S3	Scoping review of mindfulness-based interventions for refugees and migrants internationally; found significant benefits for PTSD and depression but implementation barriers.
Robinson et al., 2024	Multi-country	C6	G1	Stigma & trust	S2	S5	Qualitative study of mental health services for forced migrants in Belgium and the UK; identified successful practices including 'micro-flexibility' and engaging peers in care roles.
Denkinger et al., 2024	Multi-country	C6	G1	Stigma & trust	S4		Service description of German programmes for refugee mental health including treatment for Yazidi women and psychoeducational film to address self-stigma.
Gottlieb et al., 2021	Germany	C1	G1	Legal barriers	S6		Cross-sectional survey of asylum seekers' health service utilisation in Germany; found high depression/anxiety rates but low mental health service use.
Carrera et al., 2020	France	C2	G1	Workforce gaps	S2	S6	Systematic review of transcultural psychotherapy approaches for migrants in France; compared training-focused approaches with French transcultural psychotherapy model.
M et al., 2025	Germany, US	C6	G9	Digital exclusion	S4		Qualitative study of mental health specialist video consultations for elderly and rural populations in Germany; found largely positive acceptance with primary care embedding.
Mucic, 2017	Sweden, Denmark	C1	G1	Geographic barriers	S2	S4	Review of e-mental health and telepsychiatry developments for underserved populations in Europe; proposed scaling up to serve diverse refugee populations in their mother tongues.
Creswell et al., 2024	UK, Ireland	C1	G3	Affordability	S4		Multisite RCT of digitally augmented parent-led CBT for child anxiety in the UK and Ireland; found non-inferiority to treatment-as-usual with potential cost savings.
Radley et al., 2024	UK	C1	G2	Digital exclusion	S3	S4	Survey evaluation of myHealthE digital platform for CAMHS waiting list families in the UK; found household income predicted platform use and comfort with technology.
Oliveira et al., 2022	UK, Netherlands	C1	G5	Structural barriers	S2	S4	Feasibility RCT of adapted video-feedback intervention for foster children with reactive attachment symptoms in the UK; found high acceptability but recruitment barriers.

Reference	Country	Cluster	Pop. (primary)	Barrier (primary)	Solution (primary)	Solution (secondary)	Brief Description
V et al., 2023	Norway	C1	G3	Geographic barriers	S4		Mixed-methods study of video consultations for young people's mental health in Norwegian child welfare; found many experienced video therapy as more superficial.
AP et al., 2021	UK	C1	G3	Affordability	S6		Feasibility trial (MAPS) of psychological interventions for adolescents with first-episode psychosis in the UK; demonstrated feasibility with adaptations needed for full trial.
Ahmed et al., 2022	UK	C1	G3	Geographic barriers	S4		Service evaluation of telerehabilitation during COVID-19 for paediatric services in the UK; found comparable outcomes to face-to-face rehabilitation.
Grootheest et al., 2025	Netherlands	C1	G3	Structural barriers	S6		Survey of mental health professionals on family-focused care for children in the Netherlands; found collaboration occurs mainly through interventions and 'child checks'.
Serkowska et al., 2025	Multi-country	C6	G3	Affordability	S3	S6	Service mapping study of child and adolescent mental health provision across Poland; found significant regional disparities in waiting times (mean 257 days) and workforce shortages.
Reed et al., 2025	UK, Australia	C6	G3	Transition gaps	S5		Qualitative study of extended-age youth mental health services (up to age 25) in the UK; identified facilitators including clear rationale, co-production, and leadership.
Stevens et al., 2022	UK	C1	G3	Digital exclusion	S4	S5	Pilot evaluation of Kooth online mental health platform for young people in the UK; found improvements in distress and loneliness, suggesting cost-effectiveness for prevention.
Marinova et al., 2022	UK	C1	G3	Digital exclusion	S4	S5	Retrospective analysis of Togetherall digital peer-support platform for UK adolescents; found baseline symptoms and usage patterns predicted engagement and anxiety reduction.
Everts et al., 2022	Netherlands	C1	G3	Structural barriers	S6		Implementation evaluation of mandatory COPMI screening in Dutch mental healthcare; found the tool underutilized and often focused narrowly on safety rather than support.
Hoter-Ishay et al., 2022	Israel, Australia	C6	G7	Cultural barriers	S6		Service description of first Headspace youth mental health centre in Israel; found high distress at entry with school counsellors as main referral source.
Lidchi et al., 2021	UK	C1	G3	Structural barriers	S6		Service description of redesigned UK CAMHS for vulnerable children using THRIVE framework; achieved increased capacity by building on family resilience and front-line worker skills.
Vusio et al., 2021	UK, Australia	C6	G3	Stigma & trust	S3		Service description of Solar integrated 0-19 mental health model in the UK; designed to provide inclusive, stigma-free, youth-friendly environment with early intervention emphasis.
Shah et al., 2021	UK	C1	G6	Stigma & trust	S1		Service evaluation of pharmacist prescribers in CAMHS in the UK; found high acceptability with pharmacists contributing 322 documented care activities including ADHD clinics.
Staite et al., 2021	UK	C1	G3	Stigma & trust	S6		Service evaluation of CAMHS Crisis Team in the UK; found 15% of young people showed significant improvement in functioning, with service stabilizing outcomes.
Burn et al., 2020	UK	C1	G3	Workforce gaps	S6		Implementation evaluation of CYP-IAPT programme in UK CAMHS; found low coherent understanding of programme aims affecting sustainability.
Pile et al., 2020	UK	C1	G3	Structural barriers	S6		Epidemiological analysis of youth depression treatment in UK CAMHS; found only a quarter of expected cases accessed services.
Goicolea et al., 2018	Sweden	C1	G3	Stigma & trust	S1	S3	Qualitative comparative study of youth health centres in Sweden; found trust necessary but insufficient for mental health accessibility without multidisciplinary teams.
Jolstedt et al., 2018	Sweden	C1	G3	Digital exclusion	S4		RCT of internet-delivered CBT for paediatric anxiety in Swedish CAMHS; found ICBT superior to control with 48% remission and cost-saving of €493 per participant.
Sever et al., 2024	Netherlands	C1	G3	Stigma & trust	S2		Service description of culturally adapted Problem Management Plus (PM+) for young refugees in the Netherlands; developed new emotional processing module through qualitative research.
Ishay et al., 2024	Israel, Australia	C6	G3	Cultural barriers	S6		Dissertation evaluating Israel's Headspace model for youth mental health; examined pathways to care and how policy influences clinical judgments.
Johansson et al., 2023	Sweden	C1	G3	Structural barriers	S6		Cohort study of brief self-referral admissions for adolescents with self-harm in Sweden; found 78% reduction in emergency visits and 74% reduction in admissions.
Goodyear et al., 2022	Austria	C3	G3	Workforce gaps	S5	S6	Co-development study of family-focused service model for children of parents with mental illness in Austria; used co-design to create context-specific solutions.
Jolstedt et al., 2021	UK, Sweden	C1	G7	Geographic barriers	S4	S1	Effectiveness study of internet-delivered CBT (BiP Anxiety) for children in Swedish CAMHS; demonstrated effectiveness and cost-effectiveness in specialist and rural settings.
Brett et al., 2020	UK	C1	G3	Structural barriers	S3		Case study of Brief Behavioural Activation for adolescent depression in UK schools; demonstrated successful adaptation of evidence-based treatment to school settings.
Wright et al., 2019	UK	C1	G3	Affordability	S1	S4	RCT pilot comparing computerised CBT (Stressbusters) with self-help websites for adolescent depression in UK CAMHS; both groups improved with 65% probability of cost-effectiveness.
Lindkvist et al., 2025	Sweden	C1	G3	Structural barriers	S6		Qualitative study of Brief Admission by Self-referral for adolescents with self-harm in Sweden; professionals perceived approach as promoting autonomy while relieving families.
Simplicio et al., 2020	Multi-country	C6	G3	Workforce gaps	S4	S6	Feasibility study of Functional Imagery Training for young people who self-harm in Europe; found moderate reductions in self-harm frequency with good acceptability.
Isa et al., 2024	UK, Ireland	C1	G3	Structural barriers	S6		Pilot study of 'The Happiness Toolkit' for paediatric mental health inpatients in Ireland; 13 patients received evidence-based self-care techniques with promising initial results.

Reference	Country	Cluster	Pop. (primary)	Barrier (primary)	Solution (primary)	Solution (secondary)	Brief Description
Ferrara et al., 2018	Italy	C2	G3	Structural barriers	S1		Feasibility study of Early Intervention Services for psychosis in Italy; 689 patients enrolled with 67% showing improvement at 6 months, including 23% migrants.
Parabiaghi et al., 2016	Italy	C2	G3	Structural barriers	S6		Feasibility study of ultra-high risk psychosis model in Italian community mental health departments; developed integrated actions between child and adult services.
Karagianni et al., 2015	Greece	C2	G7	Structural barriers	S6		Service description of integrated child mental health care in primary care in rural Greece; psychologists and visiting psychiatrist served 346 children since 2010.
De et al., 2015	Spain	C2	G6	Workforce gaps	S6		Service description of psychodynamic group therapy for adolescents with intellectual disabilities in Spain; 12 participants showed clinically significant improvement.
R et al., 2023	UK	C1	G3	Digital exclusion	S4	S6	Cross-sectional surveys of UK clinicians and young people on digital technology and mental health; found over a third of youth not asked about digital use.
D et al., 2022	Austria	C3	G3	Structural barriers	S6		Position paper on day-care clinics in Austrian child psychiatry; recommended transdisciplinary treatment and local access, noting gap between need and planning.
S et al., 2023	Germany	C1	G3	Cultural barriers	S3		Multisite evaluation of school-based 'ProfScreen' intervention across 11 European countries; found only 10% of at-risk students engaged in treatment.
F et al., 2022	UK	C1	G3	Structural barriers	S3		Qualitative study using Lego Serious Play methodology exploring young people's experiences of UK mental health service; identified barriers including location and waiting times.
F et al., 2018	Ireland	C1	G3	Cultural barriers	S6		Mixed-methods study of eating disorder services in Ireland; found parents critical of access barriers and adolescents reluctant to seek help.
G et al., 2017	UK	C1	G3	Structural barriers	S4		Mapping survey of child and adolescent mental health services across 28 EU member states; found substantial variation in resources not matching epidemiological burden.
HG et al., 2017	Germany	C1	G3	Structural barriers	S6		RCT comparing structured case management with usual care for maltreated children in Germany; found less than 40% accessed evidence-based treatment in either group.
M et al., 2016	UK	C1	G5	Structural barriers	S6		Systematic review of interagency collaboration in children's mental health services; found mixed outcomes with communication and training facilitating collaboration.
Sayal et al., 2025	UK	C1	G3	Digital exclusion	S1	S4	RCT of standardised diagnostic assessment (DAWBA) in UK CAMHS for emotional disorders; found no evidence that the tool improved detection rates.
Rocca et al., 2025	UK	C1	G3	Digital exclusion	S4		Single-case design study of video-delivered Narrative Exposure Therapy for UK adolescents who witnessed domestic violence; three of five showed reliable PTSD improvement.
Loades et al., 2025	UK	C1	G3	Cultural barriers	S4		Single-arm pilot of Project Care UK web-based self-compassion intervention for adolescents; showed improvements in hope and reduced hopelessness.
Shaw et al., 2021	UK	C1	G3	Workforce gaps	S4		Service evaluation of UK youth eating disorder service during COVID-19; found increased pressure but maintained high satisfaction with remote delivery.
Reinauer et al., 2021	Germany, US	C6	G3	Workforce gaps	S1	S6	Cluster RCT of motivational interviewing training for German paediatricians; found no significant difference in service use but longer consultations.
Reis et al., 2021	Multi-country	C6	G6	Transition gaps	S6		Exploratory study of CAMHS to adult service transition for youth with autism in Belgium; assessed care needs and proposed strategies for optimal transition planning.
Wales et al., 2021	UK	C1	G3	Transition gaps	S6		Qualitative study of eating disorder service transition from CAMHS to adult services in the UK; identified communication and timing as key factors.
Lambert et al., 2020	UK	C1	G3	Workforce gaps	S3	S6	Qualitative study of UK GPs' perceptions of children's mental health services; found Primary Mental Health Workers in practices improved advice access.
Santosh et al., 2020	UK	C1	G3	Transition gaps	S6		Validation study of TRAM transition readiness measure for CAMHS across eight EU countries; found tool reliable for assessing young people's transition needs.
Bj et al., 2020	UK, Norway	C1	G3	Structural barriers	S6		Focus group study of user participation in Norwegian CAMHS inpatient settings; identified need for culture change and flexible approaches.
Lehmann et al., 2018	Norway	C1	G3	Structural barriers	S6		Review of mental health needs for children in alternate care in Norway; discussed official measures to improve service provision and cooperation.
Walsh et al., 2018	Ireland	C1	G3	Transition gaps	S6		Qualitative study of healthcare transition for young people with diabetes in Ireland; identified autonomy and diabetes nurse continuity as key factors.
Bell et al., 2018	UK	C1	G3	Stigma & trust	S6		Action research on youth mental health service co-design in the UK; found participatory co-making approaches reduced relational intensity and enabled openness.
Pass et al., 2018	UK	C1	G3	Structural barriers	S6		Feasibility study of Brief Behavioural Activation in UK secondary schools for adolescent depression; found high demand and successful integration.
Lenhard et al., 2017	Sweden	C1	G3	Affordability	S4		Cost-effectiveness study of internet-delivered CBT for adolescent OCD in Swedish CAMHS; found ICBT generated societal cost savings of ~$145 per patient.
York et al., 2017	UK	C1	G2	Structural barriers	S5		Qualitative study of UK foster carers' experiences accessing CAMHS for looked after children; found barriers within the system with long waiting times.

Reference	Country	Cluster	Pop. (primary)	Barrier (primary)	Solution (primary)	Solution (secondary)	Brief Description
Neufeld et al., 2017	UK	C1	G3	Stigma & trust	S6		Longitudinal cohort study of UK adolescents showing mental health service contact at age 14 reduced likelihood of depression by age 17.
Venrooij et al., 2022	Netherlands	C1	G3	Workforce gaps	S1	S4	Mixed-methods study of Dutch GPs' clinical decision-making for youth mental health; identified mechanisms related to competence and collaboration.
Somerville et al., 2019	UK, Ireland	C1	G3	Workforce gaps	S4	S6	Survey of Irish CAMHS social workers on social networking sites; found participants consider awareness important but feel insufficiently informed.
Ronis et al., 2017	Multi-country	C6	G3	Affordability	S6		Comparative review of child mental health service organization in Canada, US, and Netherlands; identified insurance and financing as system-level factors.
Anderson et al., 2017	UK	C1	G3	Structural barriers	S6		Scoping review of service-level barriers to child mental health access; found most studies from US with waiting times and ethnic minority access as focuses.
Rodda et al., 2016	UK	C1	G5	Structural barriers	S6		Survey of services for younger people with dementia in the UK; found significant gaps in mental health service provision.
Adindu et al., 2025	UK	C1	G7	Digital exclusion	S3	S4	Systematic review of AI-driven digital mental health interventions for UK adolescents; identified opportunities but barriers including data security and ethics.
Linderborg et al., 2024	Sweden	C1	G3	Structural barriers	S6		Implementation study of The Family Model across Swedish mental health services; found utility for family-focused conversations with clinicians.
O et al., 2023	France	C2	G3	Structural barriers	S1	S2	Service description of French projects to improve youth mental health care; found long duration of untreated psychosis and barriers to evidence-based care.
Shchedrinskaya et al., 2021	Russia	C5	G3	Stigma & trust	S4		Survey of Russian psychiatrists and psychologists on collaboration barriers; found most see teamwork as essential but identified organisational barriers.
Farina et al., 2021	Multi-country	C6	G3	Stigma & trust	S3	S6	Narrative review positioning Social Prescribing for adolescents within community-based mental health innovations; found unique non-clinical focus on social determinants.
McGorry, 2018	Multi-country	C6	G3	Structural barriers	S1	S6	Perspective on youth mental health reform describing Headspace Australia model serving 100,000+ young people; called for child psychiatry to lead transformational change.
JM et al., 2025	Multi-country	C6	G9	Structural barriers	S1	S3	Policy analysis of European child psychiatric hospital beds; argued increasing beds does not improve outcomes without community investment.
S et al., 2025	UK	C1	G3	Digital exclusion	S4		Scoping review of facilitators and barriers to digital mental health interventions for youth depression/anxiety; identified quality and effect as predominant factors.
Alustiza et al., 2025	Multi-country	C6	G1	Structural barriers	S1		Qualitative study of initial health assessments for asylum-seeking children across eight European countries; found considerable variation in mental health screening.
Slabu et al., 2025	UK, Ukraine	C6	G1	Affordability	S2		Feasibility study of music therapy for Ukrainian refugee families in the UK; found significant improvements in caregivers' PTSD, depression, and anxiety.
Afghan et al., 2019	UK	C1	G5	Workforce gaps	S1	S4	Survey of UK psychiatrists on primary-secondary care joint working innovations; identified themes including teaching, co-working pilots, and workforce development.
El-Guenuni et al., 2022	UK	C1	G9	Stigma & trust	S2	S5	Co-production study of therapeutic group for Moroccan-origin adolescents affected by Grenfell Tower fire in the UK; found benefits in collective memorialisation.
Alkalay et al., 2019	Israel	C1	G3	Digital exclusion	S4		Survey of online educational psychology services for children in Israel; found 82% had no website with Arab sector and periphery underserved.
Mitra et al., 2019	Multi-country	C6	G1	Cultural barriers	S6		Systematic review of protective factors for unaccompanied refugee minors in Europe; found supportive living arrangements associated with lower PTSD.
Jacobs et al., 2018	Greece	C2	G1	Stigma & trust	S2		Service description of 'Tree of Life' narrative methodology for unaccompanied refugee minors in Greece; found approach effective for trauma without retraumatisation.
Peritogiannis et al., 2017	Greece	C2	G7	Geographic barriers	S1	S3	Ten-year service description of Mobile Mental Health Unit for rural communities in Greece; found 30% reduction in hospitalisations and high treatment engagement.
Peritogiannis et al., 2016	Greece	C2	G5	Geographic barriers	S3		Service evaluation of home-based mental health care for elderly in rural Greece; found dementia patients particularly benefited from domiciliary visits.
Saumtally et al., 2024	UK	C1	G2	Geographic barriers	S1	S5	Quality improvement project at UK Mother and Baby Unit; achieved 260% increase in ethnic minority admissions through streamlined referral pathways.
Bono et al., 2023	UK	C1	G2	Workforce gaps	S1	S6	Service description of UK Advancing Mental Health Equality Collaborative; 18 organisations working on population-specific projects using co-production approaches.
LM et al., 2019	Germany	C1	G6	Structural barriers	S6		Cross-sectional study of epilepsy counselling services in Germany; found high satisfaction and disease-related job loss avoided in 72% of cases.
Roberts et al., 2016	UK	C1	G7	Affordability	S4		Discussion of socioeconomic inequalities in UK child/adolescent mental health; recommended progressive universal strategies including early intervention.
Glossop et al., 2025	UK	C1	G4	Digital exclusion	S3	S4	Mixed-methods study of UK mental health forum users; found forums provide accessible alternative support particularly for those facing discrimination.

Reference	Country	Cluster	Pop. (primary)	Barrier (primary)	Solution (primary)	Solution (secondary)	Brief Description
Isometsa, 2021	Multi-country	C6	G9	Structural barriers	S4		Nordic symposium overview on suicide prevention strategies; covered universal interventions and national strategies across Scandinavian countries.
Jovanovi et al., 2025	UK	C1	G2	Stigma & trust	S4	S5	Mixed-methods study of perinatal mental health access for ethnic minority women in the UK; found barriers including stigma and fear of child removal.
L et al., 2023	UK	C1	G2	Structural barriers	S6		Service analysis of burns psychology referrals by ethnicity in the UK; found ethnic minority patients more likely to be referred but no engagement differences.
Olafimihan et al., 2024	UK	C1	G2	Stigma & trust	S6	S2	Narrative review of cultural competence interventions in UK NHS mental health services; found culturally-adapted therapies improved BAME service user experiences.
Menon et al., 2025	Multi-country	C6	G1	Stigma & trust	S6		Scoping review of South Asian communities' mental health access in the UK and other countries; identified challenges including inflexible services and stigma.
Bhattacharya et al., 2025	UK	C1	G2	Structural barriers	S4	S5	Research impact analysis of ethnic inequalities in UK mental health care (ARIADNE project); identified need for safe spaces and diversified care.
Pau et al., 2025	Multi-country	C6	G3	Structural barriers	S2		Qualitative study of Good Lives Model for ethnically diverse forensic mental health clients in Europe; found primary goods have universal relevance.
C et al., 2017	Romania	C3	G4	Workforce gaps	S6		Pilot study of LGBT-affirmative training for mental health professionals in Romania; found significant increases in clinical skills and reduced negative attitudes.
Gava et al., 2021	Italy	C2	G4	Digital exclusion	S4		Cross-sectional survey of transgender people during COVID-19 in Italy; found telemedicine access for hormonal consultations associated with better outcomes.
Hughes et al., 2018	UK	C1	G4	Workforce gaps	S6		Survey of UK mental health staff on working with LGBTQ youth; found LGBT awareness training increased likelihood of discussing sexuality/gender identity.
BE et al., 2025	Sweden	C1	G4	Geographic barriers	S4		Multi-sample study of sexual minority youth treatment preferences in US and Sweden; found most preferred counsellor-led over self-guided treatment.
Barnes et al., 2020	UK	C1	G6	Stigma & trust	S1		Service evaluation of structured ADHD diagnostic pathway in UK CAMHS; found over 90% adherence to NICE guidelines and narrowed demographic differences.
Rajalu et al., 2023	Israel	C1	G6	Affordability	S6		Comparative analysis of psychiatric rehabilitation for people with disabilities in Israel; recommended dedicated legislation and telepsychiatry improvements.
Alves et al., 2023	Portugal	C2	G3	Workforce gaps	S1	S6	Survey of neurodevelopmental disorder services in Portugal; found only 17% of departments had subspecialised clinics with poor transition protocols.
A et al., 2022	UK	C1	G6	Transition gaps	S3		Qualitative study of ADHD transition from child to adult services in the UK; found variable access to information and need for clear protocols.
Dagnan et al., 2015	UK	C1	G6	Workforce gaps	S6		Validation study of Therapy Confidence Scale for therapists working with people with intellectual disabilities in the UK; found training increased confidence.
Reale et al., 2015	UK, Italy	C6	G6	Transition gaps	S6		Qualitative study of ADHD transition experiences in Italy and the UK; identified communication and coordination as key challenges.
Gallagher et al., 2025	Ireland	C1	G6	Workforce gaps	S4	S6	Survey of psychiatrists on autistic patient care in Ireland; found high knowledge but variable self-efficacy with need for neurodiversity-affirmative care.
Pennington et al., 2024	UK, Ireland	C1	G6	Affordability	S5	S6	Systematic review of employment interventions for people with disabilities in the UK; found Individual Placement and Support effective and cost-effective.
Shing et al., 2021	UK	C1	G3	Stigma & trust	S6		Narrative review of CAMHS access barriers for children with neurodevelopmental conditions in the UK; identified waiting times and capacity as key challenges.
Daley et al., 2020	UK	C1	G5	Workforce gaps	S6		Feasibility study of staff-level recovery intervention (OARI) in UK older people's mental health services; found significant improvements in recovery attitudes.
JS et al., 2025	Ukraine	C5	G3	Digital exclusion	S4		RCT of digital self-calming intervention for war-affected students in Ukraine; found high acceptability but no significant difference from control.
Woodward et al., 2022	Netherlands	C1	G1	Stigma & trust	S5		Qualitative study of scaling up Problem Management Plus (PM+) for refugees in the Netherlands; identified barriers including stigma and funding challenges.

Legend

Geographic Clusters

C1	Northern/Western Europe
C2	Southern Europe
C3	Central and Eastern Europe (EU Member States)

C4	Western Balkans / South-East Europe and Türkiye
C5	Eastern Europe and Central Asia (EECA)
C6	Multi-country or pan-European studies

Target Populations

G1	Migrants, refugees, asylum seekers
G2	Ethnic or religious minorities
G3	Children and young people (including students)
G4	LGBTQIA+ individuals
G5	Older adults
G6	People with disabilities (intellectual, physical, sensory)
G7	Socioeconomically disadvantaged populations
G8	Homeless populations
G9	Disaster-affected populations (including COVID-19)

Barriers Addressed

Stigma & trust	Stigma, discrimination, mistrust of services
Cultural barriers	Cultural/linguistic mismatches, interpreter needs
Structural barriers	Fragmented pathways, poor coordination
Workforce gaps	Staff shortages, training needs, burnout
Transition gaps	Poor transitions between services/life stages
Geographic barriers	Rural/remote access issues
Affordability	Cost, insurance, funding barriers
Language provision	Language barriers in service delivery
Digital exclusion	Technology access/literacy barriers
Legal status	Documentation, immigration status barriers

Solution Categories

S1	Integrated/collaborative care models
S2	Culturally adapted interventions
S3	Outreach and low-threshold services
S4	Digital/e-health interventions
S5	Peer workers and community health workers
S6	Organisational and workforce redesign

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SEERC SOUTH-EAST EUROPEAN RESEARCH CENTRE

GIVMED Share medicine Share life

AMALIPE Center For Interethnic Dialogue and Tolerance

LADAPT

LGBT IRELAND For Inclusion For Equality For Everyone

FISEVI Fundación para la Gestión de la Investigación en Salud de Sevilla

Zentralinstitut für Seelische Gesundheit

Q-PLAN INTERNATIONAL

JIGSAW Young people's health in mind

EHTEL Collaborating for Digital Health and Care in Europe

diesis network

EUCOMS The European Community based Mental Health Service Providers Network www.eucoms.net

EASPD European Association of Service providers for Persons with Disabilities

SQUAREDEV

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