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COMMUNITY-DRIVEN INCLUSIVE, EQUITABLE,
MENTAL HEALTHCARE ACCESS

D1.3 Mega-trends that have negatively affected equal access to mental health services

Q-PLAN

31/03/2026



Funded by
the European Union

Document Information

Issued by:	Q-PLAN INTERNATIONAL
Issue date:	31/03/2026
Due date:	31/03/2026
Work package leader:	KU
Dissemination level:	PU - Public

Document History

Version	Date	Modifications made by
0.1	25/02/2026	1st draft shared by Q-PLAN
0.2	11/03/2026	Review comments by KU and EUR
0.3	25/03/2026	Updated version shared by Q-PLAN
1.0	30/03/2026	Final review by WR
1.1	31/03/2026	Deliverable submission

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Executive Summary

Current deliverable presents findings from a **literature review and a Pan-European Delphi expert survey**, drawing on scientific evidence and a two-round Delphi process with EU-level experts to examine **macro-level megatrends undermining equitable access to mental healthcare for people in vulnerable situations across the European Union (EU)**, using the **updated Levesque Framework** to analyse access across five supply-side dimensions: **i. Approachability; ii. Acceptability; iii. Availability and Accommodation; iv. Affordability, and v. Appropriateness**. The study combines a scoping review of scientific and grey literature with a two-round Delphi survey involving EU-level experts, enabling the identification and forward-looking assessment of systemic megatrends affecting mental healthcare accessibility across Europe. The analysis adopts a macro-level perspective by identifying structural megatrends affecting mental healthcare systems across Europe and examines how these systemic dynamics translate into operational barriers and enabling conditions within the five supply-side access dimensions of the Levesque framework.

The Delphi exercise explored territorial disparities in mental healthcare accessibility, the intersectional needs of vulnerable populations, the anticipated multi-dimensional impacts of systemic trends up to 2040, and potential mitigation and prevention strategies, including innovative solutions that may inform subsequent project activities. Across both the literature and the Delphi findings, inequities in mental healthcare access are shown to stem primarily from **systemic and institutional conditions** rather than isolated service-level shortcomings. **High-consensus barriers** consistently cluster around workforce shortages, fragmented and poorly coordinated care pathways, administrative and legal complexity, insufficient public funding, socioeconomic inequalities, persistent stigma, and uneven digital transformation. Experts strongly converged on the view that these challenges are mutually reinforcing and will remain critical risks to equity if left unaddressed. In parallel, the Delphi process identified strong consensus around **mitigation strategies** that prioritise structural reform, including redistributive and crisis-resilient financing models, workforce redistribution and capacity expansion, integrated cross-sector governance, disability-inclusive and rights-based service design, and digitally inclusive hybrid care models.

The findings complement the outputs of T1.1 and T1.2 by contextualising identified access barriers within broader systemic trends and by informing the development of accessibility metrics and policy recommendations. In addition, they complement the meso-level analysis conducted in T1.4, which examines national healthcare system barriers through stakeholder interviews and surveys, and the micro-level investigation in T1.5, which focuses on contextual and place-based access barriers experienced by vulnerable populations in pilot sites. Taken together, the findings underscore that **advancing equity in mental healthcare requires coordinated, system-level transformation rather than incremental adjustments**. Expanding services alone is insufficient without parallel reforms in financing, governance, workforce planning, and institutional design. This deliverable concludes that future-ready mental healthcare systems must be inclusive by design, resilient to social and environmental shocks, and responsive to intersecting forms of vulnerability. By synthesising evidence and expert foresight, this analysis provides a robust foundation to inform EU and national policy development and to support the design of equitable, sustainable, and resilient mental healthcare systems across Europe.

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List of Terms and Definitions

Table 1. Terms and Definitions

Abbreviation	Definition
AI	Artificial Intelligence
COVID-19	Coronavirus Disease 2019
EU	European Union
GA	Grant Agreement
GDPR	General Data Protection Regulation
HADEA	European Health and Digital Executive Agency
ICU	Intensive Care Unit
IDD	Intellectual and Developmental Disabilities
IOM	International Organization for Migration
JBI	Joanna Briggs Institute
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual, and other identities
LIMCs	Low- and Middle-Income Countries
MGA	Model Grant Agreement
NCDs	Non-Communicable Diseases
NGOs	Non-Governmental Organisations
OECD	Organisation for Economic Co-operation and Development
PREMs	Patient Reported Experience Measures
PROMs	Patient Reported Outcome Measures
PRISMA-ScR	Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews
PTSD	Post-Traumatic Stress Disorder
SES	Socio-Economic Status
SOC	Sense of Coherence
TIC	Trauma-Informed Care
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

1. Introduction

D1.3 presents findings from a literature review and a Pan-European expert survey, using scientific evidence and a two-round Delphi process with EU-level experts to examine major megatrends affecting equitable access to mental healthcare for people in vulnerable situations across the EU. In the context of this study, macro-level megatrends refer to long-term structural developments in social, economic, demographic, technological, environmental, and governance domains that shape how mental healthcare systems are organised, financed, and delivered. These megatrends were identified through a combined methodological approach, integrating a scoping review of scientific and grey literature with a two-round Delphi exercise involving EU-wide experts, allowing both evidence-based identification and forward-looking expert assessment of systemic dynamics affecting equitable access to mental healthcare. This deliverable builds directly on the findings of Task 1.1, which mapped prevalent mental health conditions and associated access barriers across vulnerable populations, and Task 1.2, which developed the accessibility assessment framework and metrics based on the updated Levesque model. While T1.1 and T1.2 provided the conceptual and analytical foundations for understanding access barriers, T1.3 expands this analysis by examining the broader structural trends that shape these barriers over time and across Europe.

By taking a foresight perspective, the study aims to anticipate future challenges and support the development of more inclusive, resilient, and equitable mental healthcare systems. To achieve this, the study integrates evidence from grey and scientific literature with expert perspectives collected through a two round Delphi exercise. The Delphi survey, engaging 66 experts, examined territorial disparities, intersectional needs, long-term impacts in the next 15 years (2040), and possible innovative mitigation measures. Although this deliverable focuses on macro-level systemic developments, the analysis is structured using the five supply-side dimensions of the Levesque Framework as an analytical lens. In this study, macro-level megatrends are interpreted as structural drivers that influence the organisation, governance, financing, and delivery of mental healthcare systems, which in turn shape operational conditions of service accessibility. The Levesque framework therefore serves as a conceptual bridge, allowing the analysis to examine how broad systemic trends translate into concrete access barriers and enabling conditions across the Levesque dimensions.

The outcomes provide an overall picture of the key megatrends that threaten equal access to mental healthcare, ranging from demographic shifts and digital divide to socioeconomic inequalities and administrative, legal, and logistical barriers. D1.3 synthesises existing knowledge through the scientific and grey literature review but also generates forward-looking insights and policy recommendations from the Delphi Survey, aiming to support equitable, sustainable, and future-ready mental healthcare systems across the EU. In doing so, the study provides robust evidence base for shaping policies, service models, and innovations that are resilient, inclusive, and equitable.

1.1 Rationale

Mental health has long been recognised as a fundamental determinant of social inclusion and overall well-being. Nevertheless, inequalities persist for vulnerable populations across EU in accessing appropriate mental healthcare services; groups such as refugees and asylum seekers, migrants, ethnic and religious minorities, LGBTQIA+ individuals, persons with disabilities, older adults, youth, and survivors of crises are found to be disproportionately affected by systemic, policy-level, and

territorial barriers. These inequities are not only shaped by healthcare system limitations but also by broader macro-level dynamics.

Macro-level megatrends are understood as the large-scale, long-term patterns and dynamics (e.g., demographic, economic, social, technological, political) that systematically shape mental health service accessibility and create structural conditions that can affect vulnerable populations. The Levesque framework (Levesque et al., 2013) is a conceptual model that defines healthcare access as the interaction between the health system's (supply-side) five dimensions of Approachability, Acceptability, Availability/Accommodation, Affordability, and Appropriateness, and the user's (demand-side) corresponding five abilities to perceive, seek, reach, pay, and engage for healthcare services. The supply side analysis focuses on the ability of services to be approachable, acceptable, available and accommodating, affordable, and appropriate. This perspective analyses how healthcare providers and systems are structured, organised, and resourced to meet (or fail to meet) the diverse needs of vulnerable populations.

To establish a comprehensive evidence base, our research began with two complementary reviews: a review of peer-reviewed scientific literature and an analysis of grey literature sources. This phase was conducted in close synergy with the findings of T1.1 "Review of prevalent mental health conditions and related health and care services' access barriers and enablers across Europe", which provided a baseline understanding of the most prevalent mental health conditions and access barriers among vulnerable groups. Q-PLAN systematically reviewed 28 grey literature sources, such as reports from EU institutions, international organisations (e.g., WHO, UNHCR), and national government publications. In parallel, Q-PLAN initially identified and analysed 61 scientific papers, further expanding the search with 220 more papers using SciSpace¹, for additional searching and identification of relevant literature. Although the study focuses on macro-level systemic, institutional, and policy trends, the Levesque framework is used as an analytical structure to examine how these broader dynamics influence service accessibility conditions. In this approach, macro-level megatrends, such as governance structures, financing mechanisms, demographic change, digital transformation, and socioeconomic inequalities, are interpreted as structural drivers that shape the organisation, capacity and functioning of mental healthcare systems. These systemic developments are then analysed in relation to the five supply-side dimensions of the Levesque framework allowing the study to explore how macro-level trends translate into operational barriers and enabling conditions for accessing care. Each identified trend was analysed in the context of the five supply-side dimensions of the Levesque framework. This mapping process was essential for linking macro-level barriers to the specific access challenges faced by different vulnerable groups.

Building on the findings of the literature review, a comprehensive Delphi questionnaire was developed, structured into three thematic sections. The survey addressed the impact of macro-level megatrends, regional disparities, intersectional needs, mitigation strategies, and potential future policy and technological innovations. Questions were designed to capture expert insights on the evolving challenges and solutions for mental healthcare accessibility, employing Likert scale for impact assessment and for strategy selection. The mapping of barriers identified in the literature review directly informed the design of the first section of the questionnaire, where experts were asked to evaluate the projected impact of these barriers over the next 15 years. These barriers were also reframed through the Core Salutogenic Principle (Langeland & Vinje, 2022): rather than focusing on

¹ <https://scispace.com/>

what causes these barriers, the emphasis was placed on what resources and supply-side capacities of healthcare systems and service providers can be strengthened to enable vulnerable populations to navigate these challenges and access mental healthcare. This framing guided the formulation of megatrends for consideration in the second section of the survey, which also integrated the updated Levesque framework (developed under T1.2 “Development of a comprehensive accessibility assessment tool and metrics of mental health and care services accessibility” in M6), adapting its five dimensions with tailored indicators relevant to vulnerable groups. This section focused on forecasting mitigation and prevention strategies, linking systemic barriers with innovative solutions. Attention was given to embedding an intersectional perspective, ensuring that the survey captured the diverse needs of vulnerable populations across territorial contexts and marginalised communities. Finally, the 3rd section of the questionnaire invited experts to evaluate the anticipated multi-dimensional impacts of these megatrends and propose innovative strategies for improving access to mental health and care services.

In parallel with the survey design, expert recruitment was initiated. All EQUICARES partners were invited to nominate experts from across their networks, ensuring coverage from all consortium countries (Belgium, Netherlands, Greece, Bulgaria, France, Ireland, Spain and Germany), as well as from other EU countries. The goal was to secure a diverse panel of experts with complementary expertise (e.g., health policy, service delivery, mental health practice, rights-based approaches, mental healthcare innovation technologies) and geographical coverage across the EU.

Experts participating in the Delphi exercise were identified primarily through the EQUICARES consortium networks and professional contacts, enabling the recruitment of individuals with recognised expertise in mental health policy, service provision, research, social innovation, and the inclusion of vulnerable populations across Europe. From the outset, key professional domains relevant to the objectives of Task 1.3 were clearly defined, and expert recruitment focused on ensuring participation within these domains. This purposive approach allowed the study to engage specialists with direct knowledge of mental health systems, access barriers, and service innovation, while also ensuring geographical coverage and disciplinary diversity across EU contexts.

A total of 231 experts meeting the specified criteria were nominated by project partners and initially contacted to participate in the survey. Of these, 124 confirmed their willingness to take part in the Delphi process. This strong initial response reflects the level of interest and engagement in the topic, as well as the project’s reach across relevant EU networks. The Information sheet and the consent form (Annex 8.1) were distributed before the launch of the Survey. A total of 88 experts participated in the first round of the survey, while 66 experts provided feedback in the second round.

In parallel, **ethical compliance** considerations were thoroughly assessed. Given that the Delphi method does not involve experimental procedures on human subjects, nor the collection of sensitive patient data, and operates based on anonymity and confidentiality, it was determined, following consultation with the project’s External Ethics Advisor, that no formal ethical approval was required. The nature of the study based on expert opinion rather than patient intervention, substantially mitigated ethical risks. Nonetheless, all participants were required to sign the informed consent form prior to participating in the survey, ensuring that they were fully aware of the purpose of the study, the voluntary nature of their involvement, and the strict confidentiality of their responses.

The Delphi technique was used for the needs of the survey, a structured forecasting tool widely used in health research to build consensus among a panel of experts through iterative rounds of

questionnaires. A two-round Delphi process was employed; in the first round, experts were asked to assess a series of statements as developed in the Delphi questionnaire, concerning expected trends up to 2040. In the second round, the results of the first round were aggregated and shared with the same experts anonymously, and they were invited to reassess their responses across all three components of the survey considering the collective feedback, with the aim of identifying convergence or divergence of opinion on future scenarios.

To implement the Delphi survey, an assessment of various digital tools was undertaken, resulting in the selection of Welphi², an online platform designed specifically for Delphi studies. Welphi's capacity to ensure anonymity, confidentiality, and streamlined participant management made it ideal for our research context. The tool's architecture also supported two-round engagements with respondents, in alignment with Delphi methodology standards.

In conclusion, the study successfully addressed the underexplored question of how systemic and structural barriers affect vulnerable populations in accessing mental health care, both in the present and in the future. By situating its analysis within the Levesque framework and combining it with a Delphi-based foresight methodology, it delivered findings of both theoretical and practical relevance. These results are expected to inform the development of innovative, equity-driven, and sustainable solutions that strengthen access to mental healthcare for all vulnerable groups across the EU.

1.2 Objectives

The primary objective of this study was to identify and analyse the macro-level megatrends that act as systemic barriers to equitable access to mental health and care services for people in vulnerable situations across the EU. The study adopted a future-oriented approach to understanding how structural, policy-related, demographic, economic, and technological transformations influence access inequalities, particularly from the supply side of healthcare systems. Building upon the findings of Tasks 1.1 and 1.2, and using the updated Levesque Framework as a guiding analytical tool, the study pursued the following specific objectives:

- **To identify the macro-level megatrends** that are currently shaping or are expected to shape access to mental healthcare services across the EU, particularly in ways that hinder equity and inclusion.
- **To forecast the trajectory of these megatrends up to 2040**, through the implementation of a two-round Delphi survey involving a diverse panel of EU-wide experts, thereby capturing informed perspectives on anticipated future challenges and changes in service accessibility.
- To assess the **perceived magnitude of impact** of these megatrends on the five supply-side dimensions of the Levesque Framework for the next 15 years, based on expert judgement collected through the Delphi process.
- **To explore the intersectional dimensions of vulnerability**, including how specific groups (e.g., people with disabilities, migrants and refugees, ethnic minorities, LGBTQ+ individuals, and people in rural or remote areas) are disproportionately affected by the evolving megatrends.

² <https://www.welphi.com/>

- **To identify and assess potential mitigation and prevention measures**, including innovative and systemic approaches that could address the identified megatrends and promote more inclusive, sustainable, and equitable access to care.

Ultimately, this study aimed to provide a robust evidence base that informs policymaking, supports the design of targeted interventions, and lays the groundwork for the subsequent studies of the project, particularly in relation to the mapping and piloting of innovative solutions for mental health equity.

1.3 Structure of the deliverable

The study is organised as follows:

- **Chapter 2** outlines the methodological approach, including data sources, eligibility criteria, and the evidence synthesis process,
- **Chapter 3** presents the grey literature review, highlighting EU-level and national insights into systemic access barriers,
- **Chapter 4** reviews emerging scientific literature on macro-trends impacting access, structured around the five dimensions of the Levesque framework, summarises the identified megatrends and categorises them according to the five dimensions of the Levesque's framework,
- **Chapter 5** details the Delphi Survey process and results,
- **Chapter 6** summarises the main findings of the analysis,
- **Chapter 7** presents the list of references.

2. Methodology

2.1 Theoretical Framework

For the purposes of this study, the term **macro-level megatrends** refer to long-term structural developments in social, economic, technological, demographic, environmental, and governance domains that systematically influence how mental healthcare systems are organised, financed, and delivered. While the concept of megatrends is often associated with global transformations such as demographic ageing, migration, or climate change, this report uses the term operationally to capture broader systemic dynamics that affect the accessibility of mental healthcare services over time. These include structural shifts in healthcare delivery models, workforce dynamics, digital transformation, socioeconomic inequalities, and evolving governance and policy environments. The analysis focuses specifically on how these structural dynamics translate into barriers or enabling conditions for mental healthcare access within European health systems.

The Levesque framework of access to healthcare was the study's main analytical reference, applied specifically from a supply-side perspective to mental healthcare services on a macro level analysis.

The framework offers a comprehensive, system-oriented approach to understanding access, focusing on how mental healthcare services are organised, delivered, and adapted to meet population needs. By examining access five interconnected dimensions - Approachability, Acceptability, Availability and Accommodation, Affordability, and Appropriateness - the framework enables a structured assessment of how mental healthcare systems facilitate or constrain access for people in vulnerable situations. In this deliverable, the Levesque framework is applied to identify structural, organisational, and policy related factors that shape service accessibility across diverse European contexts.

Approachability refers to the extent to which services are visible, understandable, and perceived as trustworthy and relevant, enabling individuals to recognise mental health needs and seek care through effective communication, outreach, and culturally attuned engagement. **Acceptability** captures how well services align with social, cultural, and identity-based expectations, influenced by provider characteristics, service design, and institutional sensitivity to diversity and inclusion. **Availability and Accommodation** concern the presence, capacity, and distribution of services, as well as their alignment with people’s daily realities, including geographic location, mobility, work patterns, and literacy. **Affordability** reflects the balance between the costs of care and individuals’ ability to pay, shaped by financing arrangements, insurance coverage, and out-of-pocket payments. Finally, **Appropriateness** relates to the quality, coordination, continuity, and relevance of care, recognising that meaningful access depends not only on service availability, but also on whether care adequately meets individuals’ needs in a timely and effective manner.

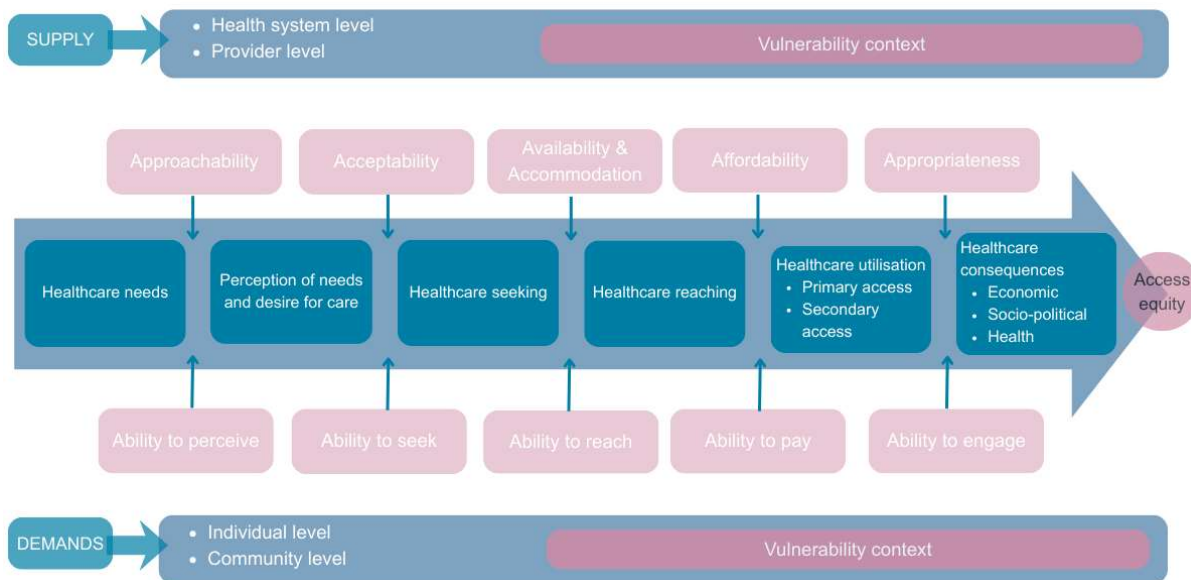


Figure 1: Levesque framework dimensions of mental healthcare services

While the analysis focuses on macro-level megatrends, the Levesque framework was employed as an analytical bridge to examine how these structural forces translate into service-level accessibility conditions. In this study, macro-level megatrends are interpreted as systemic drivers that shape the organisation, distribution, financing, and cultural responsiveness of mental healthcare systems. These systemic factors are then analysed through their impact on the five supply-side dimensions of access (approachability, acceptability, availability and accommodation, affordability, and appropriateness).

This allows for a structured examination of how broader structural developments translate into operational barriers and enabling conditions for accessing mental healthcare.

2.2 Research Design

2.2.1 Type of Study

The review followed a Scoping Review following the PRISMA-ScR guidelines (Tricco et al., 2018), utilizing a thematic analysis to synthesize the findings. This approach prioritises the mapping and interpretation of qualitative evidence, in line with Snyder's (2019) guidance on semi-systematic reviews, which emphasises thematic synthesis and knowledge mapping rather than exhaustive aggregation.

A structured search strategy was applied across multiple academic databases (PubMed³, Web of Science⁴, Google Scholar⁵) and grey literature sources (WHO⁶, OECD⁷, European Commission⁸, Mental Health Europe⁹), using predefined inclusion and exclusion criteria. Boolean operators and group-specific search terms ensured comprehensive coverage, while tools such as Zotero¹⁰ facilitated screening and data management. The review focused primarily on qualitative data, drawing on policy documents, case studies, and reports that were then categorised under the dimensions of Levesque's framework. This approach was selected over a full systematic review, as the aim was not to critically appraise or aggregate outcomes but rather to capture themes, narratives, and emerging patterns that illustrate systemic barriers. The inclusion of grey literature was essential to address gaps in the academic evidence base, particularly in relation to policy implementation, system-level constraints, and underreported populations, which are often insufficiently captured in peer-reviewed studies. The semi-systematic nature of the review allowed flexibility to synthesise diverse qualitative sources, thereby providing a robust foundation for the subsequent Delphi survey design.

2.2.2 Inclusion Criteria

The review applied specific inclusion and exclusion criteria to ensure methodological consistency and relevance. Eligible studies included articles that focused on mental health accessibility in the European Union and examined at least one of the vulnerable groups identified in the study scope. Preference was given to research employing Levesque's framework or comparable accessibility models to guide the analysis. Studies were excluded if they fell outside the EU context, unless they contributed relevant insights into the supply-side global dimensions of mental healthcare services. Articles were also excluded if they focused solely on individual-level barriers without addressing macro-level factors, or if they were not available in English.

³ <https://pubmed.ncbi.nlm.nih.gov/>

⁴ <https://clarivate.com/academia-government/scientific-and-academic-research/research-discovery-and-referencing/web-of-science/>

⁵ <https://scholar.google.com/>

⁶ <https://www.who.int/>

⁷ <https://www.oecd.org/>

⁸ https://commission.europa.eu/index_en

⁹ <https://www.mentalhealtheurope.org/>

¹⁰ <https://www.zotero.org/>

2.3 Information sources and search strategy

2.3.1 Grey Literature

In the context of this study, the term “**macro-level megatrends**” is used operationally to refer to **long-term systemic developments in healthcare systems, policy environments, and broader social dynamics that influence access to mental healthcare services**. These include, for example, trends related to service organisation and delivery (e.g., digitalisation, workforce capacity, service integration), as well as wider social and structural factors (e.g., socioeconomic inequalities, stigma, migration, and demographic change). Rather than being limited to global megatrends in the traditional sense, the concept is applied here to capture **system-level and policy-relevant dynamics that shape access conditions for vulnerable populations across EU contexts**. These macro-level trends were identified through grey and scientific literature and subsequently mapped onto the five supply-side dimensions of the Levesque framework. In this analytical approach, megatrends are treated as contextual and structural drivers, which are examined in terms of how they influence service-level accessibility conditions.

The methodology for the grey literature review followed a structured multi-source approach. First, grey literature was systematically searched from key EU institutions, including the European Commission¹¹, the European Parliament¹², and the Council of the European Union¹³, with a focus on mental healthcare access among vulnerable groups. This was complemented by a targeted search for relevant reports and policy documents issued by national governments of EU Member States addressing mental health service provision for these populations. Additionally, publications from NGOs and EU-level advocacy groups were included to capture civil society perspectives on mental health disparities. The review also incorporated reports from international organisations such as the WHO¹⁴, the United Nations High Commissioner for Refugees (UNHCR)¹⁵, and the International Organization for Migration (IOM)¹⁶, specifically those dealing with mental health access within EU territories. Identified literature was analysed to extract macro-level megatrends on the supply side of the health system that function as access barriers, using the five dimensions of the Levesque framework. Through this initial screening, **15 key barriers** were identified, with three barriers mapped under each of the five dimensions of the Levesque framework (see Section 3, figure 3).

2.3.2 Scientific Literature

The review covered EU Member States, with a specific focus on vulnerable populations including LGBTQIA+ individuals, persons with physical and mental disabilities, refugees and asylum seekers, migrants and those with a migrant background, ethnoreligious minorities, the Roma community, older individuals (including older migrants and older women), youth populations and unaccompanied minors, as well as survivors of natural disasters.

The literature search prioritised multidisciplinary and health-focused databases (PubMed, Web of Science) to ensure broad coverage of policy, health systems, and service delivery dimensions of

¹¹ https://commission.europa.eu/index_en

¹² <https://www.europarl.europa.eu/portal/en>

¹³ <https://www.consilium.europa.eu/en/council-eu/>

¹⁴ <https://www.who.int/>

¹⁵ <https://www.unhcr.org/>

¹⁶ <https://www.iom.int/>

mental healthcare access. Given the study's focus on systemic and supply-side barriers, rather than clinical or psychological outcomes, the selected databases were considered appropriate to capture the relevant evidence base.

The search strategy combined general, thematic, and group-specific search terms, using **Boolean operators** to increase precision. General search terms included combinations such as: ("*mental health access*" OR "*healthcare access*" OR "*healthcare barriers*" OR "*health service accessibility*") AND ("*vulnerable populations*" OR "*marginalised groups*") AND ("*European Union*" OR "*EU*"). To capture systemic barriers, additional queries were constructed around thematic dimensions:

- **Policy-related barriers:** ("mental health policy" OR "healthcare policy" OR "legislative barriers" OR "policy gaps") AND ("European Union" OR "EU").
- **Economic barriers:** ("mental health funding" OR "budget allocation" OR "mental healthcare costs" OR "economic inequality" OR "health disparities") AND ("European Union" OR "EU").
- **Social barriers:** ("stigma" OR "discrimination" OR "social determinants of mental health" OR "cultural competence") AND ("European Union" OR "EU").
- **Geographic barriers:** ("rural mental healthcare access" OR "urban-rural divide" OR "geographic disparities") AND ("European Union" OR "EU").

In addition, group-specific search strings were applied to ensure adequate coverage of the selected vulnerable populations:

- **LGBTQIA+:** ("LGBTQIA mental health" OR "LGBTQIA discrimination in mental healthcare" OR "LGBTQIA mental healthcare barriers").
- **Disability:** ("mental health services for disabled individuals" OR "disability and healthcare access").
- **Refugees & Migrants:** ("migrant mental health" OR "refugee mental health services" OR "asylum seeker healthcare access").
- **Ethnoreligious minorities:** ("Muslim mental health access" OR "Roma health disparities" OR "ethnoreligious discrimination in healthcare").
- **Older populations:** ("geriatric mental health services" OR "older / elderly healthcare access").
- **Youth populations:** ("youth mental health access" OR "adolescent healthcare barriers").
- **Natural disaster survivors:** ("post-disaster mental health care" OR "mental health recovery after disasters").

This comprehensive strategy ensured the identification of both academic and policy-relevant sources, capturing a wide range of evidence on macro-level barriers, intersectional needs, and systemic trends affecting access to mental healthcare for vulnerable groups in the EU. To refine and expand these findings, a structured multi-step search process was applied:

AI-Assisted Search (SciSpace)

The initial findings from the literature review were used as input prompts in the SciSpace AI tool to refine and broaden the evidence base. Through this process, 173 additional papers were retrieved

and incorporated into the megatrend analysis, resulting in the identification of 33 megatrends in total. All retrieved results were systematically cross-checked to ensure thematic relevance and accuracy of the findings. Keyword search was also applied here (as described in 2.3.2). In addition, search prompts were structured to incorporate both the **Levesque framework dimension** (supply-side only, excluding demand-side/patient-level factors) and the **target vulnerable group(s)** relevant to the study. An example of the standardised prompts that were used is: *“Please search and provide papers identifying the following – or any relevant - barrier in accessing mental healthcare for vulnerable populations within the EU: [identified barrier], under the [Levesque framework dimension – supply side only], for [specific vulnerable group].”* The search incorporated broader thematic and system-level keywords related to policy, governance, financing, and social determinants to ensure the inclusion of macro-level structural factors that may not be explicitly described using Levesque terminology. The framework was primarily applied during the analysis stage, where a thematic synthesis was conducted to identify recurring patterns and systemic trends. This approach ensured that both macro-level determinants and service-level accessibility conditions were comprehensively captured and analytically integrated. This two-stage process - combining systematic literature screening with AI-assisted refinement - ensured that the identified barriers were comprehensive, supply-side oriented, and consistently aligned with the dimensions of the Levesque framework.

2.4 Synthesis of results

Data from the included studies were extracted using a structured template capturing key information such as study context, type of barrier, and alignment with the supply-side dimensions of the Levesque framework, ensuring consistency across diverse sources. The data were then thematically synthesised, with identified barriers grouped and mapped onto the five supply-side dimensions based on the primary way in which they influence access to mental healthcare services. The initial mapping of the derived trends was further informed by a salutogenic approach (Langeland & Vinje, 2022), emphasising factors that support mental health and enable access, thereby complementing the Levesque framework by highlighting system capacities, resources, and enabling conditions. The framework was applied as an analytical and organisational tool rather than to establish causal mechanisms, while patterns and overlaps across vulnerable groups and contexts were identified to consolidate findings into broader megatrends. This synthesis informed the development of the Delphi survey and guided the expert consultation process, where participants assessed the perceived magnitude of impact of each barrier on the relevant dimension. The underlying mechanisms are primarily derived from the literature review and thematic synthesis, acknowledging that several barriers are interrelated and may affect multiple dimensions simultaneously.

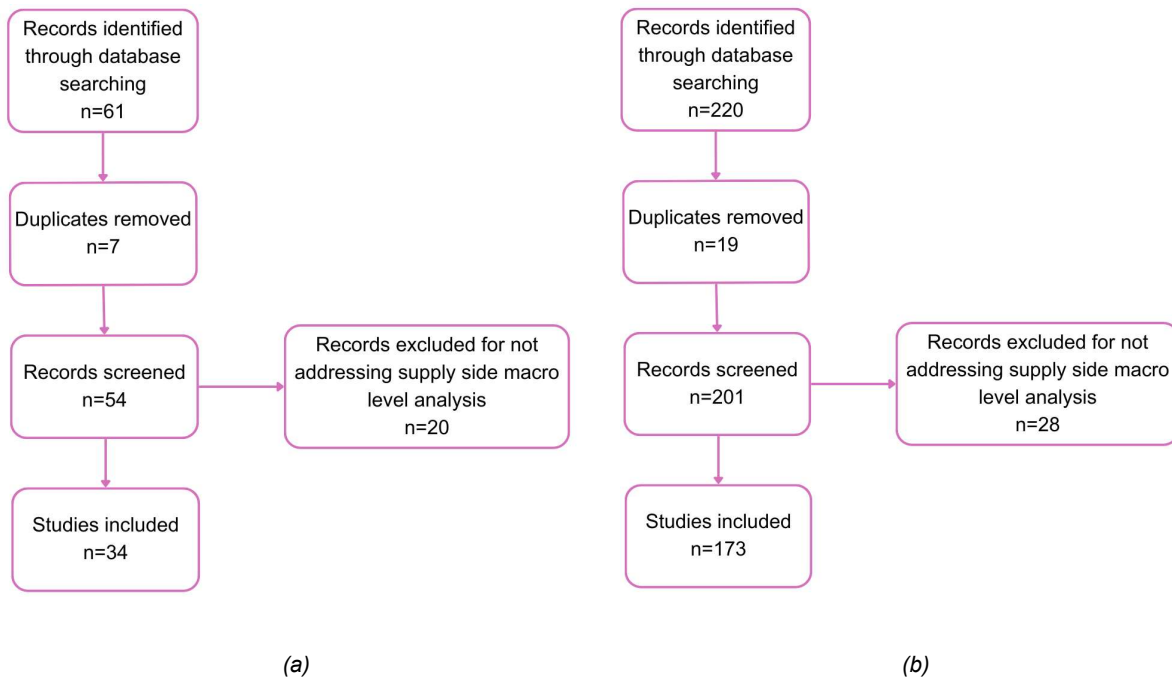


Figure 2: Study Flow Diagram representing records retrieved from (a) initial keyword research and (b) follow up SciSpace search

3. Grey Literature Review

To ensure the comprehensiveness and robustness of the evidence base, a scoping review of grey literature was conducted alongside the review of peer-reviewed scientific literature, as outlined in the methodological framework of this deliverable. The inclusion of grey literature, such as policy reports, institutional publications, and documents from EU bodies and international organisations, aimed to capture systemic and policy-level dimensions that may not be fully represented in academic publications. This dual approach was adopted to minimise the risk of overlooking relevant macro-level factors and to verify whether additional or divergent aspects emerged outside the scientific corpus. The findings indicated that the grey literature tended to describe the identified barriers and megatrends in broader, more policy-oriented terms, while the scientific literature provided more detailed empirical and conceptual analyses. Overall, the convergence between sources strengthens the validity of the identified megatrends and confirms the coherence of the analytical framework applied.

Building on this synthesis, the identified barriers were interpreted as manifestations of structural trends. These trends were analytically mapped onto the five supply-side dimensions of the Levesque framework. This approach allows for a structured interpretation of how systemic and policy-level dynamics translate into operational access barriers across the five dimensions.

Grey Literature findings were synthesised into a comprehensive summary table (Table 2), linking each trend to the associated Levesque dimensions and the supporting grey literature sources, leading to the identification of 15 megatrends, as presented below (Figure 3).

Table 2: Grey literature references

Levesque Dimension	Identified trends on structural barriers	Grey literature sources
Approachability	Insufficient Awareness and Information	(European Disability Forum, 2023), (Bioengineer.org, 2025), (European Greens, 2022)
	Administrative, Legal and Logistical Barriers	(Caldas Almeida, Mateus & Tomé, 2018), (European Parliament, 2024), (ECDC, 2021)
	Geographical Disparities	(European Commission, 2023), (Eurostat, 2025), (WHO, 2011)
Acceptability	Pervasive Stigma and Discrimination	(European Parliament, 2022), (Barbato et al., 2014), (European Parliament, 2023), (Mental Health Europe, 2024)
	Lack of Cultural Competence and Trust	(European Red Cross, 2023), (Mental Health Europe, 2024), (International Organization for Migration, 2022)
	Violation of Human Rights and Lack of Autonomy	(European Disability Forum, 2023), (European Disability Forum, 2023)
Availability & Accommodation	Shortage of Mental Health Professionals	(European Parliament, 2023), (European Red Cross, 2023), (Fundación Civio, 2021), (WHO Regional Office for Europe, 2023),

	Limited Integration of Mental Health with Other Healthcare and Social Services	(European Greens, 2022), (European Parliament, 2023)
	Uneven Distribution of Services and Resources	(European Parliamentary Research Service, 2023), (European Parliament, 2022), (European Parliament, 2022), (Fundación Civio, 2021)
Affordability	Underfunding of Mental Health Services	(European Parliament, 2023), (Foundation for European Progressive Studies, 2023), (Foundation for European Progressive Studies, 2023), (Foundation for European Progressive Studies, 2023), (European Greens, 2022)
	Lack of Comprehensive Insurance Coverage	(Mental Health Europe, 2024), (International Organization for Migration, 2022), (Fundación Civio, 2021), (WHO, 2016), (WHO, 2024), (European Observatory on Health Systems and Policies, 2016)
	High Out-of-Pocket Costs and User Fees	(European Parliament, 2023), (European Parliament, 2023), (Fundación Civio, 2021), (Bioengineer.org, 2025), (International Organization for Migration, 2023)
Appropriateness	Lack of Culturally and Linguistically Appropriate Services	(European Red Cross, 2023), (Mental Health Europe, 2024), (Migration Policy Institute, 2024), (Mental Health Europe, 2024)
	Lack of Person-Centred and Rights-Based Approaches	(International Diabetes Federation Europe, 2023), (Scholz, 2021), (Mental Health Europe, 2024), (European Greens, 2025)
	Insufficient Tailoring to Specific Needs of Vulnerable Groups	(European Parliament, 2022), (WHO, 2025), (European Parliament, 2023)

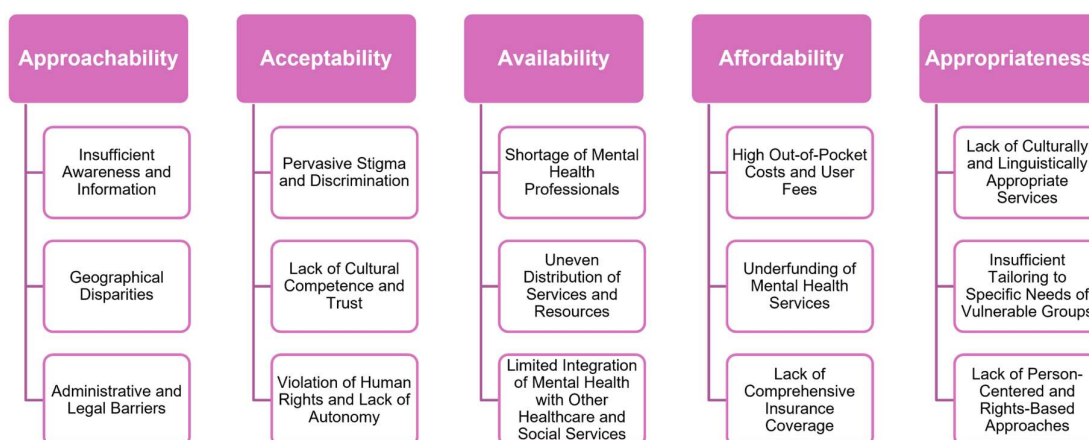


Figure 3: Structural trends affecting mental healthcare accessibility among vulnerable groups, identified through grey literature analysis

4. Literature Review - Emerging megatrends

In this section the findings of the scientific literature review, focusing on the identification and analysis of emerging macro-level megatrends that influence equitable access to mental healthcare across the EU, are being presented and analysed. Building on the barriers identified through the grey literature and structured within the Levesque framework, this section synthesises peer reviewed evidence to examine how long term socioeconomic, technological, demographic, and environmental dynamics shape each dimension of access. The analysis moves beyond descriptive barriers to articulate systemic trends, highlighting how these forces interact with health system structures and disproportionately affect people in vulnerable situations. By mapping scientific evidence onto the five Levesque dimensions, this section provides an analytically grounded basis for the subsequent Delphi survey and the identification of forward-looking mitigation and prevention strategies.

The following bar chart illustrates the number of scientific publications identified in the literature review for each dimension of the Levesque framework, highlighting the relative emphasis of existing research in relation to access to mental healthcare.

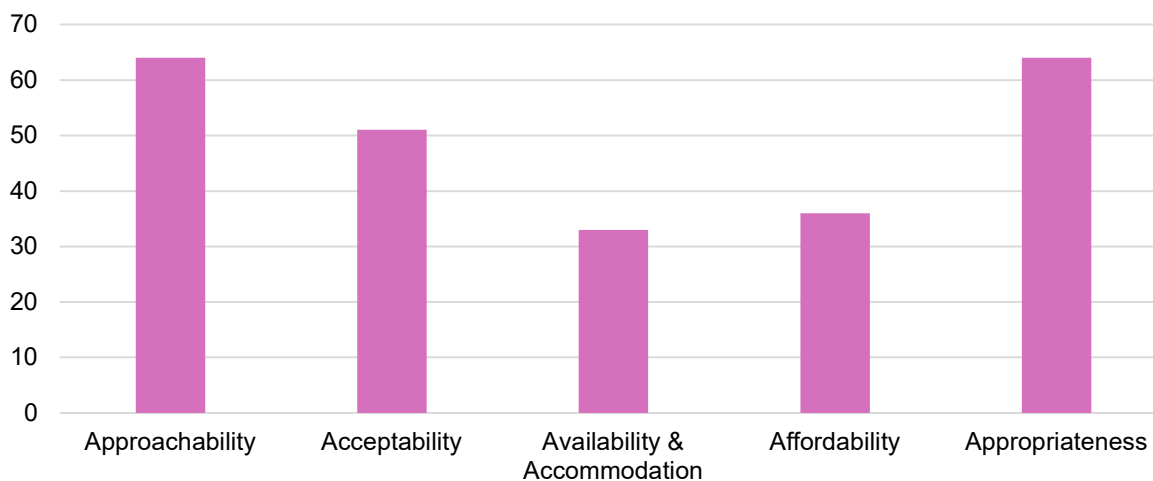


Figure 4: Distribution of scientific literature references across the Levesque dimensions.

In this section, the identified barriers are interpreted as structural trends within the scope of the analysis, reflecting broader macro-level dynamics that shape mental healthcare systems across European contexts. While the Levesque framework primarily captures service-level dimensions of access, it is used here as an operational and analytical lens to examine how these structural trends are expressed in terms of accessibility conditions. In this approach, macro-level dynamics are not analysed directly, but through their influence on the organisation, delivery, and functioning of services. **This allows for a structured interpretation of how macro-level structural trends translate into observable access barriers and enabling conditions across the five supply-side dimensions of the Levesque framework**, acknowledging that several trends are interrelated and may influence multiple dimensions simultaneously.

Across all dimensions of the Levesque framework, the identified barriers were systematically reframed into macro-level, solution-oriented approach to support a forward looking and system focused analysis of access to mental healthcare. This reframing approach deliberately shifts the analytical

lens away from individual deficits, behaviours, or capacities, and instead places responsibility on the structural, organisational, financial, and ethical foundations of mental healthcare systems. By translating barriers into megatrends, the analysis captures long term, transformative dynamics that shape how services are designed, delivered, and adapted across diverse contexts and populations. The resulting megatrends formed the subsequent Delphi survey questionnaire, allowing experts to assess their anticipated relevance, evolution, and impact on equitable access to mental healthcare over the next 15 years.

4.1 Levesque: Approachability


Approachability refers to the extent to which health services are organised and presented in ways that make them visible, understandable, and perceived as trustworthy and relevant by the populations they aim to serve. An approachable health system goes beyond simply announcing its presence, it actively supports individuals in recognising their own mental health needs through strategies like screening, culturally sensitive outreach, and community engagement. By promoting confidence in the system’s accessibility, usefulness, and ethical integrity, it encourages individuals to take the first step in seeking care (Levesque et al., 2013).

Table 3: References related to Approachability barriers

Approachability Macro-level trends affecting accessibility	References
Lack of awareness and persistent information gaps	(Baierl et al., 2024), (Barbo, 2022), (Barbo & Petrucka, 2024), (Bell & Zech, 2009), (Brown et al., 2016), (Burgess & Mathias, 2017), (Canady, 2023), (Corscadden et al., 2018), (Franks et al., 2007), (Goetz et al., 2022), (Guerrero et al., 2023), (Kirmayer & Jarvis, 2019), (Kirmayer et al., 2011), (Levesque et al., 2013), (Limiri, 2024), (Priebe et al., 2016), (Sarikhani et al., 2021), (Schouler-Ocak, 2015), (Strasmayr et al., 2012), (Sweileh, 2024)
Digital divide and unequal access to telehealth	(Kohli et al., 2024), (Kozelka et al., 2023), (Krystallidou et al., 2023), (Larsen & Guler, 2023), (Limiri, 2024), (Mejsner et al., 2023) (Noori et al., 2022), (Ogbeta et al., 2022), (Paness, 2018), (Shaw, 2022), (Sweileh, 2024)
Lack of integrated and cross-sectoral approaches	(Apers et al., 2023), (Baierl et al., 2024), (Barbo, 2022), (Barbo & Petrucka, 2024), (Franks et al., 2007), (Krystallidou et al., 2023) (Limiri, 2024), (Mejsner et al., 2023), (Ogbeta et al., 2022) (Paness, 2018), (Priebe et al., 2016), (Schouler-Ocak, 2015), (Sweileh, 2024)
Administrative, legal, and logistical barriers	(Barbo, 2022), (Barbo & Petrucka, 2024), (Cowell, 2013), (Franks et al., 2007), (Holoyda & Landess, 2024), (Sarikhani et al., 2021) (Sweileh, 2024), (Uwakwe et al., 2017), (Wahlbeck & Huber, 2009) (Zhu & Eisenberg, 2024)
Public health crises (e.g., COVID-19 pandemic)	(Crnkovič et al., 2023), (Habermann-Horstmeier, 2023), (Ladegard et al., 2022), (Mavreas & Stylianidis, 2022), (Molenaar et al., 2024) (Salerno et al., 2020)

<p>Climate change and climate related disasters</p>	<p>(Ansari & Kar, 2024), (Austin & Godleski, 1999), (Baierl et al., 2024), (Christodoulou, 2024), (Clayton & Crandon, 2024), (Craig et al., 2006), (Edwards et al., 2019), (Ghose & Ali, 2024), (Hodes et al., 2018), (Jaseema & P, 2024), (Mohammadi et al., 2023), (Oliveira et al., 2024)</p>
<p>Socioeconomic inequalities and lower education levels</p>	<p>(Berchet et al., 2022), (Damyanov, 2024), (Gil-Salmerón et al., 2021), (Henking, 2022), (Ismaili et al., 2024), (Mezzina et al., 2022), (Pfister et al., 2023), (Raj et al., 2024), (Uwakwe et al., 2017), (Wheatley, 2024)</p>

4.1.1 Healthcare system capacity for proactive, comprehensible, and inclusive mental health information dissemination



Grey literature derived trend:
“Insufficient Awareness and Information”

One of the key challenges to accessing mental health services for people in vulnerable situations across the EU is the widespread lack of awareness and insufficient dissemination of information about available support structures. Many individuals in these groups are unaware of the existence of mental health services or how to navigate the systems to access them (European Disability Forum, 2023), and this absence of clear, accessible guidance serves as a primary barrier, discouraging early engagement and preventing timely help-seeking. Moreover, when information is available, it often fails to reach all segments of the population due to issues of format, language, and accessibility, with a lack of inclusive communication strategies compounding existing inequities. As a result, large segments of vulnerable communities remain excluded from the mental healthcare system despite being in need. This underscores the urgent need for proactive, tailored outreach efforts that present mental health information in multiple languages and accessible formats to ensure services are visible, understandable, and approachable, thus reducing disparities in access. Additionally, structural factors such as education levels play a crucial role in shaping both awareness and service utilisation. Research shows that in 15 out of 26 EU countries, lower education levels are consistently linked with a weaker capacity to advocate for one’s own mental health needs (Bioengineer.org, 2025), indicating that education influences not only awareness but also the ability to engage with and navigate the healthcare system effectively. Public education efforts should therefore extend beyond traditional academic knowledge to include targeted mental health education, counselling services, and inclusive programs for migrant and refugee populations, while also providing reintegrative support for marginalised or “invisible” groups through cultural competency training and rehabilitative services that promote full social participation (European Greens, 2022).

Lack of awareness and information gaps are understood as structural trends within the scope of this analysis, reflecting broader macro-level dynamics; fragmented governance structures, limited prioritisation of mental health in public policy, and uneven development of inclusive communication strategies. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **approachability dimension**, particularly in relation to visibility, comprehensibility, and trust in mental healthcare services.

Within the Levesque Framework, the *Approachability* dimension emphasises making mental health services visible, understandable, and perceived as trustworthy and relevant. Addressing awareness and information gaps involves indicators such as the existence and reach of mental health promotion programs, culturally adapted efforts to reduce stigma, and clear, consistent outreach to enhance service visibility. It also includes ensuring comprehensible, culturally appropriate information tailored to diverse literacy levels, dispelling misconceptions, and providing transparent details about how and where to access care through multiple communication channels.

A significant obstacle in accessing mental healthcare among vulnerable populations in the EU is the **lack of awareness and persistent information gaps**, particularly from the healthcare system's supply side. To bridge the information gap and enhance approachability from the supply side, healthcare systems must prioritise making services visible and understandable through consistent communication, culturally appropriate information, and diverse, transparent channels (Kirmayer & Jarvis, 2019; Goetz et al., 2022; Corscadden et al., 2018; Sarikhani et al., 2021). Additionally, proactive awareness and promotion programs are essential to ensure that target populations are informed and encouraged to seek care (Canady, 2023). The lack of awareness and information gaps are often due to systemic issues within the healthcare system, which fail to adequately inform and engage vulnerable groups about available mental health services. This problem is prevalent across different vulnerable groups, including migrants, asylum seekers, and ethnic minorities, who face unique challenges in accessing mental healthcare. These gaps in understanding the healthcare system itself further exacerbate the problem, reinforcing the need to close these awareness and information divides (Baierl et al., 2024; Barbo & Petrucka, 2024).

In addition to communication challenges, many **migrants and refugees** are unfamiliar with the mental healthcare services available to them. Navigating a system without clear guidance often leaves individuals unaware of the support they can access, or the steps required to obtain it (Kirmayer et al., 2011). Irregular migrants also face challenges due to a lack of awareness of their legal entitlements to healthcare, which is exacerbated by administrative obstacles and fear of deportation (Strasmayr et al., 2012). Addressing these barriers requires comprehensive strategies that focus on both system-level change and community engagement. Researchers have emphasized the need for improved information dissemination tailored to the specific linguistic and cultural needs of migrant populations (Schouler-Ocak, 2015; Priebe et al., 2016). Community-based outreach has also shown promise in bridging the gap between healthcare systems and migrant communities. Initiatives that offer multilingual resources and rely on trusted community members to share information can greatly enhance mental health literacy and promote service use (Tarricone et al., 2019). **Asylum seekers** in the EU often find that their theoretical right to access mental healthcare is not matched by reality, with significant information gaps about available services and entitlements (Bell & Zech, 2009).

LGBTQIA+ individuals and **ethnoreligious minorities** face persistent and unique challenges in accessing mental healthcare, often rooted in societal discrimination and stigma. These issues are further compounded by a widespread lack of awareness and cultural understanding among healthcare providers, which undermines trust and deters individuals from seeking help. To address these disparities, there is a critical need for interventions that enhance the cultural competence of mental health services. Such improvements can help ensure these communities receive care that acknowledge and respect their identities and lived experiences (Sweileh, 2024). The situation becomes even more complex when considering **intersectionality**; **individuals who belong to multiple marginalised groups**, such as LGBTQIA+ migrants or refugees from ethnoreligious minority backgrounds, often experience **compounded barriers**. A more nuanced, **intersectional approach is therefore essential**. Research shows that community-based interventions rooted in

local knowledge and tailored cultural support can foster safer, more supportive environments. These efforts not only facilitate immediate access to care but also promote long-term integration and resilience (Burgess & Mathias, 2017). Barriers faced by LGBTQIA+ individuals and ethnoreligious minorities should be understood as systemic manifestations of broader structural and policy-level dynamics; including persistent social stigma, insufficient integration of equity and diversity considerations in healthcare policy, and gaps in institutional cultural competence. These factors are embedded within wider macro-level trends related to social exclusion, governance frameworks, and the uneven implementation of rights-based approaches across healthcare systems.

Members of the **Roma community**, particularly women, continue to encounter significant barriers to accessing mental health services. These challenges are rooted in longstanding discrimination and a widespread lack of accessible, culturally relevant information about available support options (Guerrero et al., 2023). Addressing these systemic obstacles requires a dual approach: structural reforms that promote equity and inclusivity within the healthcare system, and targeted outreach efforts that actively engage the Roma community. Such initiatives must aim to ensure that services are not only available but also welcoming, informed by an understanding of the community's specific cultural and social needs (Guerrero et al., 2023).

Young individuals often face significant gaps in information and a lack of mental health services tailored to their age group, leaving them underserved and at risk (Barbo & Petrucka, 2024; Barbo, 2022; Brown et al., 2016). Addressing these gaps requires dedicated outreach strategies and educational programs that are developmentally appropriate and culturally sensitive.

Older people and **people with disabilities** also encounter multiple layers of exclusion when it comes to mental healthcare due to information gaps. To ensure equitable access, it is vital to provide accessible information and services that are specifically designed to meet the diverse needs of these populations; adapted communication, physical accessibility, and trained personnel are key components of a more inclusive system (Limiri, 2024).

The identified barrier "**Lack of Awareness and Information Gaps**," was reframed as the macro-level megatrend: "**Strengthening the System's Capacity for Proactive, Comprehensible, and Inclusive Mental Health Information Dissemination**," shifting focus from the problem to a solution-oriented perspective, emphasizing the system's responsibility to ensure that mental health information is accessible, understandable, and culturally relevant for all individuals, regardless of background or prior knowledge. It underscores the importance of enhancing the system's capacity to deliver clear, inclusive, and contextually appropriate information across all levels of prevention—ranging from broad public health campaigns (primary prevention) to targeted early interventions (secondary), and comprehensive treatment options (tertiary).

4.1.2 Digitally inclusive and manageable telehealth system to ensure equitable approachability and engagement

The digital divide and unequal access to telehealth are understood as structural trends within the scope of this analysis, reflecting broader macro-level dynamics; uneven digital infrastructure development, socioeconomic inequalities, national e-health policies, and varying levels of investment in digital health systems. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **approachability dimension**, particularly in relation to visibility, usability, and inclusiveness of digital mental healthcare services.

Addressing the digital divide and unequal access to telehealth requires structuring mental healthcare services to be visible, comprehensible, and relevant in a digital context. Key indicators as defined in T1.2 include offering flexible appointment and contact options, including alternatives for those with limited digital access, and ensuring the availability and active use of telehealth tools such as online counselling and mental health apps. Efforts to overcome digital barriers, through initiatives like digital literacy support, provision of equipment, or financial assistance, are crucial for equitable participation. The presence of national or institutional eHealth strategies and health technology policies further signals a strategic commitment to digital care. Finally, transparent and accessible digital information channels, such as secure portals or apps for communication and test results, indicate how effectively systems facilitate digital engagement.

The **digital divide and unequal access to telehealth** pose significant barriers to mental healthcare for vulnerable populations across EU. It refers to the gap between those who have easy access to digital technologies and those who do not. This divide is particularly evident in telehealth, where access to broadband internet and digital devices is crucial for service utilization. Vulnerable populations, such as those in low-income or rural areas, often lack these resources, limiting their ability to engage with telehealth services (Kan et al., 2023; Anselm, 2023). The lack of digital literacy further compounds this issue, as having access to a device does not necessarily equate to the ability to use it effectively for telehealth purposes. This is a significant barrier for many vulnerable groups, who may not have the skills or support needed to navigate digital health platforms (Kozelka et al., 2023). The transition to telehealth during the COVID-19 pandemic has highlighted the importance of technology in healthcare delivery. However, it has also underscored the challenges faced by low-resource settings, such as community health centres, in adapting to this new mode of service delivery (Noori et al., 2022).

The integration of culturally competent care within telehealth platforms can significantly enhance engagement for **migrants and refugees**, ensuring that their unique experiences and backgrounds are acknowledged and respected. Moreover, as technology continues to advance, innovative solutions such as multilingual telehealth platforms and community-based digital literacy programs could bridge the gap created by the digital divide, fostering a more inclusive healthcare environment. This approach not only aligns with the need for improved access but also emphasizes the importance of tailoring mental health interventions to meet the specific needs of diverse populations, ultimately promoting better health outcomes across the board (Kohli et al., 2024). **Youth refugees** and **asylum seekers** often lack the necessary digital literacy and access to technology (Barbo & Petrucka, 2024; Barbo, 2022). **Ethnoreligious minorities** may face similar barriers due to the digital divide. These groups often experience systemic discrimination and may lack access to culturally competent care, which can be further complicated by limited digital access (Sweileh, 2024). The lack of culturally competent telehealth services can exacerbate feelings of isolation and hinder these populations from seeking necessary care, as evidenced by the challenges faced by refugees and asylum seekers in similar contexts (Larsen & Guler, 2023).

Addressing the digital divide requires a multi-stakeholder approach that includes improving digital health literacy, training healthcare providers in telehealth, and advocating for culturally appropriate services. Sustainable funding models and policy changes are also necessary to ensure equitable access to telehealth services (Gallegos-Rejas et al., 2022; Shaw, 2022). The implementation of digital health equity frameworks can help identify and address the factors that influence access to digital health services. These frameworks emphasize the need for universal design principles that

consider the diverse needs and abilities of all users (Kan et al., 2023). The integration of mobile health technologies, such as apps designed specifically for mental health support, can further empower these populations by providing immediate access to resources and information tailored to their unique needs (Arévalo & Aguilera, 2022).

The barrier “**Digital Divide and Unequal Access to Telehealth**” was reframed as the macro-level megatrend: ***Cultivating a Digitally Inclusive and Manageable Telehealth Ecosystem to Ensure Equitable Approachability and Engagement***. This shift highlights a systemic solution, emphasising the responsibility of the healthcare system to proactively bridge the digital divide - not only by offering telehealth services, but by ensuring they are genuinely accessible, intuitive, and supportive for individuals across diverse levels of digital literacy and access. It calls for the development of inclusive digital platforms, provision of digital assistance, and exploration of hybrid care models to accommodate diverse needs. By doing so, telehealth becomes a supportive tool for navigating care across all stages (from primary consultations to specialised follow-ups) and prevention levels (universal, targeted, and intensive), rather than a new obstacle.

4.1.3 Comprehensible and integrated mental healthcare system across health and social sectors

The lack of integrated and cross-sectoral approaches is understood as a structural trend within the scope of this analysis, reflecting broader macro-level dynamics; fragmented governance systems, sectoral policy silos, and limited coordination between health and social care sectors. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **approachability dimension**, particularly in relation to clarity of care pathways and system navigability.

A **lack of integrated and cross-sectoral approaches** significantly undermines the approachability of mental health services, limiting their visibility, comprehensibility, and perceived trustworthiness. Key indicators outlined in T1.2 include poor linkage between mental health services and general healthcare or non-health sectors, insufficient integration at primary care or community levels, and fragmented information channels that obscure care pathways. The absence of coordinated prevention and screening programs hinders early identification of needs, especially for vulnerable populations. Furthermore, without strategic policies promoting integration and the routine collection of patient-reported experiences and outcomes (PREMs and PROMs), systems fail to reflect user perspectives or build culturally attuned, approachable services.

The lack of integrated and cross-sectoral approaches is compounded by the complexity of mental health needs and the fragmented nature of healthcare systems, which often fail to provide comprehensive and coordinated care. This fragmentation is a significant barrier to service utilization among vulnerable groups (Limiri, 2024; Mejsner et al., 2023). **Migrants, refugees, and asylum seekers** face numerous barriers due to fragmented mental healthcare systems. These include language barriers, cultural differences, and a lack of understanding of the healthcare system, which are exacerbated by the lack of integrated services (Baierl et al., 2024; Franks et al., 2007; Schouler-Ocak, 2015). The need for coordinated care is emphasised, with recommendations for increasing care capacity and eliminating language and cultural barriers (Baierl et al., 2024). **Refugees and asylum seekers, particularly youth**, are highlighted as vulnerable groups who underutilise mental health services due to these systemic barriers (Barbo & Petrucka, 2024; Barbo, 2022). **LGBTQIA+** individuals and ethnoreligious minorities encounter systemic obstacles, including discrimination,

gender-specific challenges and a lack of culturally competent care. The integration of mental health services with other healthcare and social services is crucial to address these barriers and improve access for these groups (Sweileh, 2024). Moreover, the intersectionality of these barriers suggests that individuals who belong to multiple marginalised groups face compounded challenges in accessing mental healthcare. For instance, LGBTQIA+ refugees may experience unique stressors, such as discrimination based on both their sexual orientation and their immigration status, which can exacerbate mental health issues and deter them from seeking help (Krystallidou et al., 2023). **Individuals with physical and intellectual disabilities** face unique challenges in accessing mental healthcare due to the lack of integrated services that can address their specific needs (Panes, 2018). The need for a more coordinated approach that includes mental health in primary care settings is suggested as a way to improve access for these populations (Limiri, 2024) Furthermore, the integration of mental health services into community-based settings can significantly enhance accessibility for individuals with disabilities, who often encounter physical and systemic barriers that hinder their engagement with traditional healthcare frameworks. **Older individuals**, particularly those with migrant backgrounds, face barriers due to fragmented systems that do not adequately address their complex health needs (Ogbeta et al., 2022). In addition, **youth populations**, especially unaccompanied minors, are vulnerable to mental health issues and require integrated services to navigate the healthcare system effectively (Barbo & Petrucka, 2024; Barbo, 2022).

The integration of mental health services with other healthcare and social services is essential to overcome these barriers. The importance of addressing social determinants of health through intersectoral programming is significant (Apers et al., 2023). This includes policy shifts, legislative efforts, and the use of technology to create a more coordinated care environment (Ogbeta et al., 2022). Recommendations include promoting social integration, developing outreach services, and training professionals to work with vulnerable groups (Priebe et al., 2016).

The barrier, "**Lack of Integrated and Cross-Sectoral Approaches**," was reframed as the macro-level megatrend: "**Comprehensible and Seamlessly Integrated Mental Healthcare System**". This shift reframes the issue through a solution-focused lens, emphasizing the responsibility of the system to build meaningful integration between mental healthcare and related sectors such as physical health, social services, education, and employment.

4.1.4 Streamlining systemic (administrative, legal, logistical) processes to ensure manageable and approachable services



Grey literature derived trend:
"Administrative, Legal and Logistical Barriers"

Administrative complexity and legal restrictions create major barriers to mental health services for vulnerable populations across the EU. Bureaucratic requirements, including registration procedures, referral pathways, and navigating insurance systems, can discourage timely engagement or lead individuals to abandon care (Caldas Almeida, Mateus & Tomé, 2018). Legal status is particularly critical: in many EU Member States, access to comprehensive healthcare depends on residency or immigration status, leaving migrants, asylum seekers, and undocumented individuals often limited to emergency care or subject to complex administrative procedures (European Parliament, 2024). Logistical challenges, such as limited transportation and difficulties coordinating services, further impede access, leading to missed appointments and delayed care,

especially for refugees and asylum seekers (ECDC, 2021). EU and national policy reforms should therefore focus on reducing administrative barriers, revising access criteria, and addressing discriminatory practices to ensure equitable mental health care for all.



Grey literature derived trend:
“Geographical Disparities”

People in rural and remote areas face reduced access to healthcare due to fewer visible entry points, weaker local infrastructures, and limited outreach, which diminishes early recognition of healthcare needs (European Commission, 2023). EU and OECD/Observatory reports document pronounced rural shortfalls, noting tele-mental health as an uneven compensatory solution (OECD, 2025). Youth, older adults, and people with disabilities in these areas experience fewer tailored outreach or screening initiatives and less culturally or age-appropriate messaging, reducing perceived relevance and first contact. EU syntheses and Eurostat territorial analyses highlight service and information gaps outside cities (Eurostat, 2025). Community mediators, interpreters in refugee clinics, mobile/outreach teams, and proactive screening and education could enhance service visibility and trust, particularly in arrival and rural contexts (WHO, 2011). The scientific research highlighted how geographic disparities reflect broader challenges in mental healthcare: limited-service visibility, fewer tailored outreach efforts, and gaps in culturally or age-appropriate messaging in rural areas. These issues show the need for streamlining systemic processes across health and social sectors.

Administrative, legal, and logistical barriers are understood as structural trends within the scope of this analysis, reflecting broader macro-level dynamics; complex regulatory frameworks, restrictive eligibility criteria, migration and legal status policies, and bureaucratic healthcare governance structures. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **approachability dimension**, particularly in relation to transparency and ease of navigating mental healthcare services. **Administrative, legal, and logistical barriers** limit the visibility, clarity, and perceived relevance of mental healthcare services. Rigid appointment systems, inflexible contact mechanisms, and the absence of supportive policies further exacerbate access challenges by failing to accommodate diverse user needs or promote inclusive, coordinated care frameworks.

Administrative complexities, such as bureaucratic procedures and paperwork, can deter both providers and patients from engaging with mental health services. These barriers can lead to delays in service provision and discourage individuals from seeking help (Sarikhani et al., 2021). In addition, the mental health workforce often faces administrative burdens that reduce their capacity to deliver care effectively. Streamlining these processes could enhance service delivery and accessibility (Zhu & Eisenberg, 2024). Legal frameworks can also restrict the availability of mental health services. For instance, certain legal requirements may limit the ability of providers to offer timely and necessary interventions, particularly in correctional settings where involuntary treatment might be required (Holoyda & Landess, 2024). Legislation that does not prioritise mental health can result in inadequate funding and resources, further exacerbating access issues (Uwakwe et al., 2017). Moreover, logistical challenges, such as geographical distance and lack of transportation, can prevent individuals from accessing mental health services, especially in rural or underserved areas. In school settings, logistical issues like competition for space and scheduling conflicts can hinder the implementation of

mental health programs, affecting the availability of services for children (Cowell, 2013). The perceived relevance of mental health services is crucial for their utilisation; if services are not seen as relevant or beneficial, individuals are less likely to seek them out.

Migrants face numerous barriers to accessing mental healthcare, including bureaucratic processes and a lack of understanding of the healthcare system in their host countries. These barriers are compounded by language and cultural differences, which can deter initial contact with mental health services (Baierl et al., 2024; Franks et al., 2007). **Refugees and asylum seekers** often experience significant barriers due to their precarious legal status and the complexity of the healthcare system. These barriers include a lack of interpreting services, fear of authority, and previous negative experiences with healthcare providers (Franks et al., 2007). **Youth refugees and asylum seekers** are particularly vulnerable, facing additional challenges such as post-traumatic stress disorder and depression, yet they underutilise mental health services due to these systemic barriers (Barbo & Petrucka, 2024; Barbo, 2022). **Unaccompanied minors and other youth populations** face barriers related to the complexity of the healthcare system and a lack of targeted services. These barriers can prevent them from accessing necessary mental health care (Barbo & Petrucka, 2024). The **Roma community**, particularly women, face significant barriers due to systemic discrimination and social exclusion. These barriers are often legal and administrative, making it difficult for them to access mental health services (Sweileh, 2024).

Older individuals, including older migrants and women, encounter logistical barriers such as transportation issues and limited availability of services tailored to their needs. These barriers can deter them from seeking mental health support (Wahlbeck & Huber, 2009). Additionally, the intersection of age-related factors with existing barriers further complicates access to mental health services for elderly populations, particularly among those from marginalised communities. For instance, elderly individuals often experience increased isolation and cognitive decline, which can exacerbate mental health issues and make navigating the healthcare system even more challenging. Addressing these issues requires a multifaceted approach that incorporates age-friendly practices within mental health services while also enhancing community support systems to ensure that elderly individuals feel valued and empowered in their pursuit of mental well-being (Franks et al., 2007).

The barrier "**Administrative, Legal and Logistical Barriers**" was reframed as the macro-level megatrend: ***Streamlining systemic (administrative, legal, logistical) processes to ensure manageable and approachable services.*** This emphasises a shift from problem identification to solution development, placing responsibility on the system to proactively simplify administrative procedures, legal requirements, and logistical arrangements that often hinder initial access to care. It underscores the need for user-friendly intake processes and accessible appointment systems particularly for vulnerable populations across all geographic regions. By reducing procedural complexity, the system facilitates timely and approachable entry points into care across all levels, supporting primary prevention by reducing hesitation or avoidance and enabling smoother access to secondary and tertiary services.

4.1.5 Building systemic resilience and adaptability during public health crises

Public health crises are understood as structural trends within the scope of this analysis, reflecting broader macro-level dynamics; emergency governance mechanisms, health system preparedness, resource allocation priorities, and crisis response capacity. Examined through the Levesque

framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **approachability dimension**, particularly in relation to continuity, adaptability, and trust in mental healthcare services.

During **public health crises such as the COVID-19 pandemic**, the approachability of mental health services is shaped by how well systems maintain visibility, clarity, trust, and relevance under rapidly changing conditions. Key indicators outlined in T1.2 include the successful transition to remote or virtual platforms and the ability to overcome digital literacy, affordability, and privacy challenges. Ensuring continuous, clear, and culturally tailored communication is critical, especially as crisis-related stress and misinformation may reduce mental health literacy. Services must also remain accessible to linguistically diverse and marginalised groups, with outreach adapted to various communication needs. Finally, trust and confidence in services must be reinforced through transparent operations, ethical responsiveness, and routine user feedback (e.g., PREMs and PROMs), which are essential to understanding and enhancing how services are perceived in crisis contexts.

Regarding **migrants**, community-based organisations play a crucial role in addressing the mental health needs of migrants by providing culturally sensitive care and support. However, these services face challenges such as fragmentation and overload, which hindered their effectiveness (Molenaar et al., 2024). The pandemic's impact on the **older populations**, particularly those with migrant backgrounds, was profound due to increased isolation and limited access to mental health services. **LGBTQIA+** individuals face unique vulnerabilities due to social disadvantages and mental health disparities, which were exacerbated by the pandemic. The lack of culturally competent care and systemic discrimination further hindered their access to mental health services (Salerno et al., 2020). **People with intellectual and developmental disabilities (IDD)** were significantly affected by COVID-19 due to their living conditions and associated health factors. The pandemic led to higher morbidity and mortality rates among this group, and the restrictive measures further isolated them, impacting their mental health (Habermann-Horstmeier, 2023). **Youth**, especially those from minority backgrounds, faced significant mental health challenges during the pandemic. Schools, whether virtual or in-person, became crucial venues for providing mental health support, highlighting the need for culturally competent care in educational settings (Ladegard et al., 2022).

The approachability of mental health services during public health crises is significantly influenced by the systems' ability to maintain visibility, clarity, trust, and relevance amidst rapidly changing conditions. The COVID-19 pandemic has necessitated rapid adaptations in mental health service delivery, highlighting both challenges and innovations in maintaining service accessibility and quality. The pandemic has exposed vulnerabilities in public mental health systems, such as fragmented services and insufficient coverage, particularly for vulnerable groups. This has highlighted the need for systemic improvements to enhance service approachability (Mavreas & Stylianidis, 2022).

The barrier, "**Impact of Public Health Crises (e.g., COVID-19) on Mental Health Services**," was reframed as the macro-level megatrend: ***Building Systemic Resilience and Adaptability to Sustain Manageable and Meaningful Mental Healthcare Approachability During Public Health Crises***. This shift places the emphasis on the system's responsibility to proactively prepare for and respond to crises by ensuring that mental healthcare remains accessible, functional, and relevant during periods of disruption. It highlights the importance of learning from past experiences to develop flexible service delivery models, ensure surge capacity, and implement clear, reassuring communication strategies.

4.1.6 Proactive and localised systemic capacities in the face of climate change and disasters

Climate change and environmental crises are understood as structural trends within the scope of this analysis, reflecting broader macro-level dynamics; environmental degradation, disaster preparedness policies, migration pressures, and uneven resource distribution across regions. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **approachability dimension**, particularly in relation to system responsiveness and accessibility in crisis contexts.

In the context of **climate change and climate related disasters**, the approachability of mental health services depends on their ability to remain visible, comprehensible, trustworthy, and relevant under crisis conditions. Key indicators outlined in T1.2 include the integration of climate-related mental health issues, such as eco-anxiety or trauma from displacement due to natural disasters - into awareness campaigns. Services must maintain robust, disaster-resilient communication strategies to ensure visibility, including mobile or low-tech outreach methods. Information must be culturally and contextually appropriate, accessible to displaced or vulnerable populations, and tailored to varying literacy levels. Early screening initiatives should be embedded in community outreach and disaster response to identify and support at-risk groups. Trust is further strengthened through transparency, ethical conduct, and accountability, especially for those previously underserved. Finally, linkage with emergency services and the development of climate-sensitive mental health policies and holistic service models are essential to ensuring that mental health care remains approachable during and after climate-related crises.

Climate change-induced disasters often lead to forced migration, significantly impacting refugees and asylum seekers' mental health. These individuals face increased risks of depression, anxiety, and post-traumatic stress disorder (PTSD) due to the compounded stress of displacement and inadequate access to mental health services in host countries (Ghose & Ali, 2024; Mohammadi et al., 2023). In case of climate crises, **migrants** often face barriers such as language differences, cultural misunderstandings, and discrimination, which hinder their access to mental health services. Services need to be culturally sensitive and linguistically accessible to be effective (Baierl et al., 2024; Edwards et al., 2019). **Refugees and asylum seekers** are particularly vulnerable due to their exposure to traumatic events and ongoing stressors such as legal uncertainties and social isolation (Hodes et al., 2018; Craig et al., 2006). **Natural disaster survivors** often experience increased rates of depression, anxiety, and PTSD. The psychological impact of experiencing trauma, loss, and disruption of normal life can lead to a range of mental health disorders which are often exacerbated by the lack of accessible support services in the aftermath of a disaster (Austin & Godleski, 1999). Furthermore, the recovery process for these individuals is frequently hindered by the stigma surrounding mental health issues, which can deter them from seeking help, as well as the limited availability of culturally sensitive care tailored to their specific needs (Jaseema, 2024).

The integration of mental health services into disaster response plans is critical. This involves establishing well-trained mental health response teams that can be deployed quickly in the aftermath of a disaster (Christodoulou, 2024). Despite the importance of accessible mental health services, there are significant challenges in maintaining their visibility and relevance during crises. These include resource constraints, particularly in low-income regions, and the need for systemic changes to integrate mental health considerations into broader climate adaptation strategies (Oliveira et al.,

2024; Clayton & Crandon, 2024). Additionally, the psychological impacts of climate change are complex and multifaceted, requiring a comprehensive approach that includes both prevention and intervention measures (Clayton & Crandon, 2024; Ansari & Kar, 2024).

The barrier "**Climate Change and Climate-Related Disasters**" was reframed as the macro-level megatrend: ***Proactive and localised systemic capacities in the face of climate change and disasters***. These reframing positions climate change as a critical and ongoing context for mental health system planning, emphasizing the need for resilient, place-based mental healthcare responses that remain accessible and relevant during and after environmental crises. It highlights the system's responsibility to integrate mental health services into disaster preparedness and response efforts across all levels of care, addressing both anticipatory concerns like eco-anxiety (primary prevention) and the psychological aftermath of disasters (secondary and tertiary prevention).

4.1.7 Designing systemic mental healthcare information and pathways that are culturally attuned and socioeconomic inclusive

Socioeconomic inequalities and lower education levels are understood as structural trends within the scope of this analysis, reflecting broader macro-level dynamics; income distribution patterns, labour market structures, social protection systems, and education policies. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **approachability dimension**, particularly in relation to awareness, perceived relevance, and the capacity to engage with mental healthcare services.

For individuals with **lower education levels and subject to socioeconomic inequalities**, the approachability of mental health services relies heavily on how clearly, accessibly, and respectfully those services are communicated and delivered. Key indicators outlined in T1.2 include the use of plain language, culturally appropriate messaging, and materials adapted to varying literacy levels, such as multilingual formats, visual aids, or oral community presentations. Community-based outreach and clearly defined entry points help ensure visibility and navigability of services, especially when fragmented systems may otherwise deter engagement. Trust is fostered through transparency, ethical behaviour, and patient-centred care that respects lived experiences and addresses historical distrust. Collecting and sharing Patient Reported Experience Measures (PREMs) further supports this by capturing perceptions of service accessibility and cultural responsiveness. Finally, integrated health education and accessible screening initiatives tailored to low-education populations are essential for early recognition of mental health needs and reducing stigma around care-seeking.

The approachability dimension represents the initial gateway to healthcare access, requiring individuals to recognise health needs, identify available services, and possess the confidence to engage with healthcare systems. Education level fundamentally shapes this capacity through multiple pathways: health literacy development, system navigation skills, communication abilities, and stigma reduction (Raghav et al., 2024). For vulnerable populations in the EU, lower educational attainment creates cascading barriers that prevent effective engagement with mental health services, perpetuating cycles of inequality and unmet mental health needs. Research demonstrates that educational disadvantage operates through both direct mechanisms (limited health literacy, reduced awareness of services) and indirect pathways (increased stigma, reduced self-efficacy in healthcare interactions) (Henking, 2022). These barriers are particularly pronounced in mental healthcare,

where stigma and complexity of service delivery create additional obstacles for populations with limited educational resources. There is a need for comprehensive, interdisciplinary collaborations and policy adaptations that consider social determinants (socioeconomic status, education, employment, and social environments) to enhance mental health outcomes and reduce disparities across diverse populations (Wheatley, 2024).

Migrants with lower education levels demonstrate significantly reduced utilization of mental health services, often relying on informal support networks or traditional healing practices that may delay professional intervention. Cultural factors intersect with educational barriers, as those with limited formal education may hold stronger traditional beliefs that stigmatise mental health treatment. The complexity of EU healthcare systems, with varying referral processes and eligibility criteria, creates additional barriers for educationally disadvantaged migrants who lack the educational skills to navigate bureaucratic requirements (Gil-Salmerón et al., 2021). **People with disabilities** face compounded barriers when educational disadvantage intersects with disability-related obstacles. Individuals with intellectual disabilities often have lower average education levels due to historical exclusion from mainstream educational opportunities, limiting their mental health literacy and help-seeking behaviours. This population demonstrates reduced awareness of available accommodations and rights within healthcare systems, often relying on caregivers who may also have limited educational backgrounds. The intersection of disability and educational disadvantages particularly affects communication with healthcare providers, understanding of treatment options, and ability to advocate for appropriate care. Supply-side barriers include insufficient provider training on communicating with educationally disadvantaged individuals with disabilities and lack of accessible health information materials (Ismaili et al., 2024). Educational disadvantage within **LGBTQIA+** populations correlates with reduced awareness of affirming mental health services and limited knowledge of anti-discrimination protections. Lower education levels restrict access to supportive communities and resources that facilitate healthcare navigation, while also limiting understanding of the relationship between minority stress and mental health outcomes (Pfister et al., 2023). Structural educational exclusion among **Roma** communities creates profound barriers to mental healthcare approachability. Historical discrimination in educational systems has resulted in significantly lower average education levels, restricting health literacy and perpetuating reliance on traditional healing practices. This educational disadvantage intersects with ongoing discrimination in healthcare settings, creating multiple barriers to service access (Damyanov, 2024). Educational disadvantage among **older adults**, particularly women, creates barriers to understanding modern mental health concepts and available services. Generational differences in educational opportunities result in lower health literacy levels that affect recognition of mental health symptoms. This population often relies on outdated mental health information and may not understand contemporary treatment approaches (Berchet et al., 2022). Educational disadvantage among **disaster-affected populations** limits understanding of trauma-related mental health needs and available crisis support services. Lower education levels correlate with reduced awareness of post-disaster mental health resources and difficulty navigating fragmented service delivery systems during crisis periods. This population often lacks the health literacy necessary to understand the relationship between disaster exposure and mental health outcomes (Mezzina, 2022).

Clear and respectful communication of mental health services is essential for improving access among low-educated and socioeconomically disadvantaged groups. This includes providing information in a way that is understandable and culturally sensitive. The quality-of-service delivery, including the perception of care by service users, plays a critical role in encouraging utilisation.

Services that are perceived as high-quality and respectful are more likely to be used by individuals from disadvantaged backgrounds (Uwakwe et al., 2017).

The barrier "**Lower Education Levels and Socioeconomic Inequalities**" was reframed as the macro-level megatrend: **Designing systemic mental healthcare information and pathways that are culturally attuned and socioeconomic inclusive**. This transformation shifts the focus toward the system's responsibility to create inclusive, accessible mental healthcare pathways that account for disparities in education and social standing. It emphasises the need for clear, plain-language communication, diverse informational formats, and culturally sensitive outreach strategies to ensure that individuals - regardless of their educational background and economic status - can understand and navigate services across all levels of care (primary, secondary, tertiary). By reducing cognitive and social complexity, this approach enhances approachability and empowers vulnerable groups to engage with mental health support.

4.1.8 Structural trends

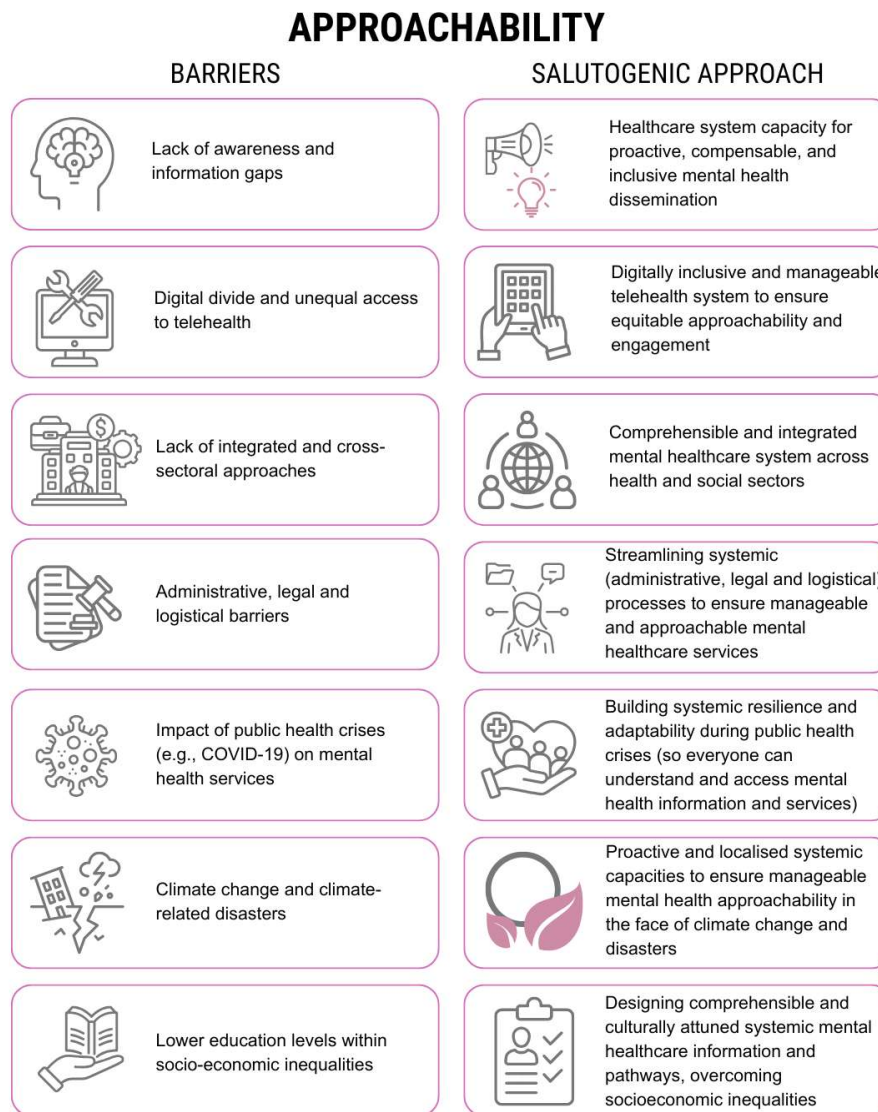


Figure 5: Approachability barriers to enablers

The identified barriers relevant to the Approachability dimension were analytically translated to reposition responsibility from individuals to the structural and institutional capacities of the mental health system. Rather than treating **information gaps** as a deficit in public awareness, the reframing emphasises **strengthening the system’s capacity for proactive, comprehensible, and culturally inclusive information dissemination** across primary, secondary, and tertiary prevention levels. Similarly, the **digital divide** was reconceptualised as the **need to cultivate a digitally inclusive and manageable telehealth ecosystem**, one that goes beyond service provision to ensure usability, accessibility, hybrid care options, and digital support for individuals with varying literacy and access levels. **Fragmentation and lack of cross-sectoral coordination** were reframed as the imperative to develop a seamlessly **integrated mental healthcare system**, embedding mental health within physical health, social services, education, and employment structures. **Administrative and logistical barriers** were transformed into a call for systemic streamlining, highlighting the importance of **user-friendly procedures and reduced bureaucratic complexity** to facilitate early and sustained engagement. **Crisis-related disruptions**, including pandemics and climate-related disasters, were repositioned as **drivers for building systemic resilience, adaptability, and localised preparedness**, ensuring continuity and relevance of services during and after disruptions. Finally, **socio-economic and educational inequalities** were reframed as a **structural obligation to design culturally attuned, plain-language, and socially inclusive care pathways**.

4.2 Levesque: Acceptability


Acceptability refers to how socially and culturally appropriate health services are perceived by individuals and communities. It is shaped by provider characteristics (e.g., gender, language, cultural background), service design (e.g., patient involvement, respectful communication), and the system’s sensitivity to cultural, religious, and identity-based norms, as well as its history of inclusion or exclusion. These factors interact with broader social norms, influencing whether care is viewed as appropriate, safe, and aligned with personal values. For some groups, services may seem alienating or inappropriate despite being formally available, especially when institutional design, communication, or provider attitudes fail to reflect community diversity.

Table 4: References related to Acceptability barriers

Acceptability	
Macro level trends affecting accessibility	References
Stigma and discrimination	(Ahad et al., 2023), (Alduraidi, 2022), (Archibong & Zaka, 2024), (Bacchus, 2022), (Baierl et al., 2024), (Bell & Zech, 2009), (Brown et al., 2016), (Chiarenza et al., 2019), (Ferris-Day et al., 2021), (Forray et al., 2024), (Gil-Salmerón et al., 2021), (Goetz et al., 2022), (Iudici et al., 2024), (Kirmayer & Jarvis, 2019), (Limiri, 2024), (Lowther-Payne et al., 2023), (Mladovsky, 2007), (Pattillo et al., 2023), (Priebe et al., 2016), (Sambrook Smith et al., 2019), (Soares et al., 2024), (Wasserman, 2024)

Cultural and social determinants	(Bacchus, 2022), (Barbo & Petrucka, 2024), (Forray et al., 2024) (Franks et al., 2007), (Guerrero et al., 2023), (Ladegard et al., 2022) (Sambrook Smith et al., 2019)
Lack of tailored and trauma-informed care	(Barbo, 2022), (Barbo & Petrucka, 2024), (Bell & Zech, 2009), (Bempi et al., 2024), (Dumke et al., 2024), (Ellinghaus et al., 2021), (Forray et al., 2024), (Guerrero et al., 2023), (Hoover et al., 2024), (Levenson et al., 2021), (Limiri, 2024), (Markey et al., 2022), (Markey et al., 2024), (McAllister et al., 2024), (Sue et al., 2012), (Sweileh, 2024), (Wylie et al., 2018)
Insufficient understanding of disability	(Baierl et al., 2024), (Bell & Zech, 2009), (Carter et al., 2022) (Dumke et al., 2024), (Schouler-Ocak, 2015), (Sin et al., 2010) (Sweileh, 2024), (Werner et al., 2013)
Violation of human rights	(Baierl et al., 2024), (Begum, 2024), (Evans et al., 2024), (Franks et al., 2007), (Sweileh, 2024)
Lack of individual autonomy	(Bell & Zech, 2009), (Guerrero et al., 2023), (Monteiro et al., 2013), (Nyikavaranda et al., 2023), (Raj et al., 2024), (Strasmayr et al., 2012), (Sweileh, 2024)

4.2.1 Cultivating a systemic culture of anti-stigma, respect, and non-discrimination



Grey literature derived trend:
“Pervasive Stigma and Discrimination”

Stigma and discrimination remain major barriers to mental healthcare for vulnerable populations in the EU. Societal attitudes create fear of judgment, marginalisation, and social rejection, which can outweigh the perceived benefits of seeking support, while individuals with mental disorders may face stigma even within care settings, discouraging treatment and limiting participation in decisions about their care (European Parliament, 2022; Barbato et al., 2014). Public health campaigns, professional training, and awareness initiatives are essential to shift attitudes and promote mental health as an accepted component of well-being (European Parliament, 2023). Discrimination, open and systemic, further affects access: racial and ethnic minorities, asylum seekers, and refugees often experience alienation or mistrust in healthcare, with policies and practices that fail to address their needs or hinder care, deepening mistrust and reducing service use (Mental Health Europe, 2024).

Stigma and discrimination are understood as structural trends within the scope of this analysis, reflecting broader macro-level dynamics; persistent societal attitudes, cultural norms, and insufficient prioritisation of anti-stigma policies. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **acceptability dimension**, particularly in relation to perceived stigma, trust, and willingness to seek care. A **culture of anti-stigma, respect, and non-discrimination** includes certain key indicators such as the cultural appropriateness of care, ensuring

alignment with users' values, religious beliefs, and privacy expectations and the availability of identity-concordant, culturally sensitive providers who reflect the diversity of the population. Respectful, empathetic communication, free from judgment or bias, alongside patient-centred practices such as shared decision-making and active involvement of families, greatly enhances perceived acceptability. Trust is further built when institutions visibly commit to inclusion through diverse staffing and leadership, offer tailored services for marginalised groups. Services must also actively counter stigma and provide psychologically safe, responsive environments that adapt to the needs of subpopulations, reinforcing the idea that all individuals deserve affirming, respectful care.

Stigma surrounding mental health significantly impedes psychiatric care, leading to delayed treatment and poorer health outcomes (Ahad et al., 2023; Goetz et al., 2022; Limiri, 2024; Sambrook Smith et al., 2019; Ferris-Day et al., 2021). It is a significant barrier to accessing mental health services, particularly in conservative and multicultural communities. It can prevent individuals from seeking help and reduce compliance with treatment (Archibong & Zaka, 2024). This is particularly crucial in multicultural and diverse societies where cultural competence and sensitivity can enhance the effectiveness and utilization of mental health services. Mental health services that respect and acknowledge the cultural identity and priorities of communities, such as refugees, are more likely to be accepted and utilised; innovative, culturally sensitive approaches are essential to enhance acceptance and use among these populations (Alduraidi, 2022). Cultural competence involves understanding and integrating cultural knowledge, values, and attitudes into mental health care, which can improve access, utilization, and health outcomes. This includes training practitioners in cultural competence, safety, and anti-racism (Kirmayer & Jarvis, 2019).

Pervasive stigma and discrimination significantly impact the acceptability dimension of mental healthcare services for various vulnerable groups in the EU. **Migrants** often face racial discrimination and biases in healthcare settings, which can lead to differential treatment and reduced quality of care. This discrimination is a significant barrier to accessing mental health services, as it affects the trust and willingness of migrants to seek care (Pattillo et al., 2023; Gil-Salmerón et al., 2021; Soares et al., 2024; Bacchus, 2022). **Refugees and asylum seekers** experience high levels of post-traumatic stress disorder (PTSD) and other mental health issues, yet stigma and discrimination in healthcare settings often prevent them from accessing necessary services (Priebe et al., 2016; Bell & Zech, 2009). There is a reliance on non-professional interpreters and multilingual staff, which can lead to miscommunication and mistrust that affect the acceptability of mental health services for migrants (Forray et al., 2024). **Unaccompanied minors and youth populations** often face stigma related to their age and migrant status, which can prevent them from accessing mental health services (Chiarenza et al., 2019). **LGBTQIA+** migrants face compounded discrimination due to their sexual orientation and migrant status, which can lead to reluctance in seeking mental health services due to fear of further stigmatization (Baierl et al., 2024). **Roma women** face significant discrimination in healthcare settings, which is compounded by poverty and lack of documentation. This discrimination affects their ability to access mental health services and contributes to health disparities (Mladovsky, 2007). In regards to **people with intellectual and developmental disabilities (IDD)**, stigma surrounding disabilities can lead to discriminatory practices in healthcare, affecting the acceptability of mental health services for individuals with disabilities (Gil-Salmerón et al., 2021). Older people often face ageism discrimination, which can hinder their access to mental health services. These biases can lead to a lack of tailored services that address their unique needs (Gil-Salmerón et al., 2021).

The barrier "Stigma & Discrimination" was reframed as: "Cultivating a Systemic Culture of Anti-Stigma, Respect, and Non-Discrimination", to emphasise the healthcare system's active responsibility in confronting and dismantling stigma, whether internalised, social, or structural, through sustained efforts across all levels of care and prevention. It calls for the creation of safe, respectful, and judgment-free environments where individuals feel genuinely accepted and encouraged to seek help, from broad anti-stigma public campaigns (primary prevention) to compassionate clinical encounters (secondary and tertiary care). This transformation enhances the meaningfulness and trustworthiness of mental health services, core components of the Sense of Coherence (SOC) framework, while also addressing manageability by removing the psychological barriers that stigma imposes.

4.2.2 Embedding cultural competence and responsiveness across mental healthcare services to ensure trust-based acceptability for diverse populations



Grey literature derived trend:
"Lack of Cultural Competence and Trust"

The acceptability of mental healthcare for vulnerable populations in the EU is weakened by a lack of cultural competence among healthcare professionals, which reduces trust (European Red Cross, 2023) and engagement. Insufficient understanding of diverse cultural backgrounds, beliefs, and experiences can lead to miscommunication, misdiagnosis, and interventions that do not fit the individual's context, while bias, overt or unintentional, further erodes trust among racial and ethnic minority groups (Mental Health Europe, 2024). This is especially relevant for migrants, refugees, and ethnic minorities, whose mental health perceptions, help-seeking behaviours, and trauma experiences may differ from mainstream approaches (International Organization for Migration, 2022). Improving cultural competence through mandatory training and building a diverse, representative mental health workforce can enhance service acceptability, communication, and trust between providers and service users.

Lack of culturally competent services is understood as a structural trend within the scope of this analysis, reflecting broader macro-level dynamics; migration patterns, population diversity, and insufficient integration of intercultural approaches in policy and training systems. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **acceptability dimension**, particularly in relation to inclusiveness and alignment with diverse user needs. Acceptability in mental healthcare hinges on the cultural competence and responsiveness of services, ensuring they are perceived as socially and culturally appropriate by diverse populations. Key indicators outlined in T1.2 include alignment of care with cultural beliefs, values, and traditions, as well as safeguarding privacy in stigmatised contexts. Provider diversity, identity-concordance, cultural sensitivity, and respectful, empathetic communication are crucial for fostering trust. Services must encourage active patient participation, align with individual preferences, and tailor care to the needs of specific groups while reflecting community diversity in staffing and leadership. Efforts to address historical distrust, avoid reinforcing stigma, and create psychologically safe environments further enhance acceptability. Ultimately, responsive and inclusive practices that adapt to diverse subgroups are essential for building trust-based, stigma-free mental healthcare systems.

The Levesque framework's dimension of acceptability on the supply side of healthcare emphasises the need for services to be culturally competent and responsive to the needs of diverse groups. Studies highlight the need for healthcare providers to understand and respect cultural differences to improve service acceptability and appropriateness (Baierl et al., 2024; Bacchus, 2022). In UK, **refugees, asylum seekers, and migrant workers** encounter barriers such as different understandings of mental health, stigma, and lack of trust in healthcare services. These barriers are exacerbated by previous negative experiences with healthcare systems, highlighting the need for culturally competent care (Franks et al., 2007; Sambrook Smith et al., 2019). **Refugees and asylum seekers**, particularly **youth**, face unique challenges in accessing mental healthcare. Cultural stigma, systemic discrimination, and lack of skilled practitioners are significant barriers. Schools are identified as potential venues for providing culturally competent mental health services to these populations (Ladegard et al., 2022). Barbo & Petrucka (2024) emphasise the need for culturally adapted mental health services for youth refugees and asylum seekers, identifying cultural competence as a key factor in improving access and engagement with mental healthcare services. **Roma** individuals, especially women, experience high levels of discrimination and social exclusion, which are compounded by language barriers and a lack of culturally competent care (Guerrero et al., 2023). **LGBTQIA+ individuals** face barriers such as cultural stigma and lack of culturally competent care. The need for healthcare providers to be trained in cultural competence to provide affirming and appropriate care is crucial (Ladegard et al., 2022).

The initial barrier, "**Cultural and Social Determinants**" was reframed as the macro-level megatrend: "**Embedding Cultural Competence and Responsiveness Across Mental Healthcare**", shifting the focus toward solution-building by emphasising the system's responsibility to integrate cultural and social understanding into every aspect of service design and delivery. It calls for language accessibility, culturally tailored interventions, and active trust-building efforts to ensure that mental healthcare aligns with the values, beliefs, and lived realities of diverse communities. By embedding cultural competence across all levels of care, ranging from outreach initiatives in primary prevention, to culturally adapted therapeutic approaches in secondary care, and inclusive practices in tertiary settings, the system enhances both the meaningfulness and acceptability of services.

4.2.3 Prioritising the systemic provision of highly tailored, trauma-informed, and person-centred care

Lack of trust in healthcare systems is understood as a structural trend within the scope of this analysis, reflecting broader macro-level dynamics; historical inequalities, institutional discrimination, governance transparency, and past experiences of exclusion or inadequate care. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **acceptability dimension**, particularly in relation to perceived reliability, safety, and confidence in mental healthcare services.

The lack of trauma-informed care is a critical issue, as it affects the quality and effectiveness of mental health services provided to vulnerable populations, such as refugees, asylum seekers, and trauma-exposed youth. This is characterised by systemic inadequacies in addressing the unique mental health needs of these groups, often resulting in underutilisation of services and inadequate treatment outcomes.

Maximising the acceptability of mental healthcare requires embedding tailored, trauma-informed, and person-centred approaches that prioritise trust, respect, and cultural responsiveness. Key indicators as outlined in T1.2 include providers demonstrating empathy, non-judgment, and affirmation of lived experiences, while minimising disrespectful interactions that erode trust. Services must actively involve patients and their support networks in shared decision-making, ensuring care aligns with individual needs and preferences. Additionally, services must avoid reinforcing stigma, create psychologically safe environments, and address historical distrust with marginalised communities.

Cultural competence training for healthcare providers is crucial, equipping professionals with the tools to understand and respect diverse cultural backgrounds and communicate more effectively (Sue et al., 2009). Mental health providers consistently demonstrate limited understanding of cultural interpretations of mental health and trauma. This inadequacy is compounded by structural issues such as language barriers, cultural insensitivity, and insufficient training of mental health professionals in trauma-informed care (Dumke et al., 2024). The lack of tailored and trauma-informed care is implied through the challenges faced by healthcare providers in addressing the specific needs of migrants, particularly in terms of language and communication, which can prevent effective care delivery (Forray et al., 2024). For **refugees and asylum seekers**, studies highlight they often experience post-traumatic stress disorder (PTSD), depression, and anxiety, yet encounter numerous obstacles in receiving appropriate mental health support (Barbo & Petrucka, 2024; Barbo, 2022; Bell & Zech, 2009). In addition, refugee women experiencing perinatal mental health issues encounter barriers due to the lack of culturally sensitive and trauma-informed care. The healthcare system often fails to align services with the specific needs of these women, resulting in inadequate support during critical periods (Markey et al., 2024; Markey et al., 2022). Providers often lack knowledge about cultural formulation tools despite their availability (Wylie et al., 2019). **Older people with a migrant background** may encounter age-related barriers in addition to cultural and language challenges, which are not adequately addressed by current mental health services (Bempi et al., 2024). In regards to **youth populations**, structural and relational barriers, such as the lack of understanding and empathy from service providers, further exacerbate the difficulties faced by trauma-exposed youth in accessing appropriate care (Ellinghaus et al., 2021). **Roma** populations report "a lack of understanding from healthcare providers" as a primary barrier to accessing mental health services (Guerrero et al., 2023). **LGBTQIA+** individuals often experience systemic discrimination and a lack of tailored services which can lead to underutilisation and unmet mental health needs (Limiri, 2024; Sweileh, 2024). They face challenges with provider cultural competence, as healthcare providers often lack training in affirming care practices (Levenson et al., 2021). For individuals with **intellectual and developmental disabilities**, providers frequently exhibit "**diagnostic overshadowing**," where mental health symptoms are incorrectly attributed to the disability rather than recognised as treatable conditions (McAllister et al., 2024; Hoover et al., 2024).

The barrier, "**Lack of Tailored and Trauma-Informed Care**," was reframed as the macro-level megatrend: "**Prioritising the Systemic Provision of Highly Tailored, Trauma-Informed, and Person-Centred Care**". These reframing shifts attention toward a solution-oriented approach that rejects one-size-fits-all models in favour of individualised care strategies that recognise and respond to each person's unique experiences and needs. It emphasizes the integration of trauma-informed principles and personalised care pathways across all levels, ranging from primary psychoeducation to secondary therapeutic interventions and complex tertiary care. By ensuring services are sensitive, respectful, and deeply attuned to past traumas and current realities, the system enhances the meaningfulness and trustworthiness of care, increasing individuals' willingness to engage. This

approach also strengthens manageability by reducing the emotional and psychological burden of navigating treatment.

4.2.4 Enhancing Systemic Competence in Understanding Disabilities

Discrimination against vulnerable groups is understood as a structural trend within the scope of this analysis, reflecting broader macro-level dynamics; systemic inequalities, gaps in rights-based policies, and weak enforcement of anti-discrimination frameworks. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **acceptability dimension**, particularly in relation to inclusiveness, perceived safety, and equitable treatment.

Enhancing the acceptability of mental healthcare for individuals with diverse abilities requires systemic commitment to inclusion, disability competence, and respectful care. Key indicators as outlined in T1.2 include diverse representation in staffing and leadership, along with services tailored to address specific disability needs. Providers must demonstrate cultural sensitivity, empathy, and accessible communication while avoiding assumptions. Services should adapt to the unique needs of different disability subgroups, actively challenge stigma, and create psychologically safe environments. Equally important is fostering active patient participation, ensuring care aligns with individuals' values, needs, and autonomy. Together, these indicators reflect a holistic approach to building trust, inclusivity, and meaningful engagement for people with diverse.

The lack of understanding and competence among service providers can lead to inadequate care and hinder access for various vulnerable groups. Werner et al. (2013) found that 90% of psychiatrists reported limited training in diagnosing and treating individuals with intellectual disabilities, with 34% to 72% feeling inadequate knowledge in specific areas. Disability service providers often struggle with accessing necessary information and resources, indicating a broader issue of familiarity with community resources among professionals (Carter et al., 2022).

There are significant barriers in accessing child and adolescent mental health services for **young people with learning disabilities**. The lack of skills and appropriate attitudes among service providers can result in inadequate care for this group, emphasising the need for specialised training and joint planning to improve service delivery (Sin et al., 2010). Studies identify the gap between legal rights and the reality of accessing mental healthcare for **refugees and asylum seekers**. The insufficient understanding of the unique needs of these populations by service providers contributes to inadequate treatment and low service utilization (Bell & Zech, 2009; Dumke et al., 2024). Schouler-Ocak (2015) point out the heterogeneous nature of immigrant populations and the stress factors they face, which are often not well understood by mental health service providers. **LGBTQIA+** individuals, particularly those who are also migrants, face barriers related to discrimination and a lack of understanding from healthcare providers. This results in negative care experiences and inadequate support, highlighting the need for more inclusive and culturally competent services (Baierl et al., 2024; Sweileh, 2024). Addressing these barriers requires a comprehensive approach that includes policy changes, provider training, and increased awareness of the unique needs of vulnerable populations.

The barrier, "**Insufficient Understanding of Disability by Service Providers**," was reframed as the macro-level megatrend: "**Enhancing Systemic Competence in Understanding**", shifting the focus to a solution-oriented approach that prioritises the system's responsibility to educate and train all levels of mental healthcare providers - from primary care to specialised services - on the unique

needs, perspectives, and rights of individuals with disabilities. This approach applies across all levels of prevention, ensuring equitable access and inclusion.

4.2.5 Upholding human rights and dignity as foundational pillars of all mental healthcare provision



Grey literature derived trend:
“Violation of Human Rights and Lack of Autonomy”

For individuals with psychosocial disabilities, the acceptability of mental healthcare in the EU is undermined by human rights violations and limited recognition of personal autonomy. Practices such as forced treatment and involuntary institutionalisation often occur without free and informed consent, creating fear and mistrust (European Disability Forum, 2023). The lack of consistent person-centred, rights-based approaches further erodes confidence, as disregarding preferences, lived experiences, and self-determination leads to disengagement and perceptions of disempowerment (European Disability Forum, 2023). Enhancing acceptability requires transforming service delivery toward non-coercive, collaborative models that respect rights, dignity, and autonomy, fostering trust and more effective, supportive care.

Violations of human rights and lack of autonomy are understood as structural trends within the scope of this analysis, reflecting broader macro-level dynamics; uneven implementation of rights-based policies and restrictive institutional frameworks. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **acceptability dimension**, particularly in relation to dignity, respect, and perceived safety. Indicators for addressing human rights violations in mental healthcare acceptability emphasise the importance of dignity, cultural respect, and psychological safety. Key indicators as outlined in T1.2 include the consistent demonstration of empathy, non-judgment, and respect by providers, as well as the absence of disrespectful or coercive interactions that undermine individual dignity. Services must foster a psychologically safe environment, actively prevent stigma or unethical treatment, and ensure informed consent and shared decision-making to protect against violations. Trust-building is critical, requiring transparency, accountability, and acknowledgment of historical injustices that may have eroded confidence in the system. Additionally, cultural alignment of services with the beliefs and values of the communities served is essential, as culturally incongruent care can perpetuate subtle forms of discrimination and neglect.

Coercive practices in mental health care, such as involuntary treatment and restraint, are prevalent and raise ethical and human rights concerns. These practices often occur without informed consent, undermining personal liberty and autonomy. Ethical guidelines in mental health care stress the importance of respecting patient autonomy, informed consent, and the least restrictive treatment options (Evans et al., 2024). Despite robust legal frameworks, the implementation of human rights protections in mental health care is inconsistent. Factors such as resource limitations, lack of awareness, and entrenched stigmatising attitudes hinder effective enforcement (Begum, 2024). **Migrants, refugees, and asylum seekers** often face systemic discrimination within mental healthcare systems. This discrimination can manifest as neglect or denial of care, where these groups are not provided with adequate mental health services due to biases and systemic inequities (Baierl et al., 2024; Franks et al., 2007). **LGBTQIA+ community** face unique challenges, including

discrimination and lack of LGBTQIA+, affirming care, which can lead to neglect and denial of appropriate mental health services (Sweileh, 2024). **Older populations**, especially those with a migrant background, face unique challenges in accessing mental healthcare due to age-related discrimination and a lack of tailored services (Sweileh, 2024).

The barrier, "**Violation of Human Rights**," was reframed as the macro-level megatrend: "**Upholding Human Rights and Dignity as Foundational Pillars of All Mental Healthcare Provision**", positioning human rights as the non-negotiable foundation of the mental healthcare system and emphasising the system's proactive responsibility to prevent neglect, coercion, or denial of care. It ensures that every interaction, from initial engagement in primary care to long-term tertiary support, fully respects individual autonomy, safety, and dignity. By embedding ethical standards and respect at every level, mental healthcare becomes inherently meaningful, trustworthy, and acceptable, fostering a system that individuals feel safe and willing to engage with. This principle is vital across all levels of prevention, reinforcing the system's legitimacy and approachability.

4.2.6 Empowering individual autonomy and shared decision-making within mental healthcare

Limited empowerment and shared decision-making are understood as structural trends within the scope of this analysis, reflecting broader macro-level dynamics; hierarchical care models and insufficient policy emphasis on patient participation. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **acceptability dimension**, particularly in relation to autonomy and alignment with user preferences.

Autonomy in mental healthcare acceptability requires prioritising shared decision-making, respectful communication, and accessible information to ensure individuals can actively participate in their care. Key indicators as outlined in T1.2 include the extent to which patients are empowered to contribute to care planning, make informed treatment choices, and have their preferences and values reflected in care decisions. Provider communication quality, such as clear explanations, active listening, and respect, is crucial, along with ensuring patients can ask questions and express concerns. Autonomy is also supported by promoting health literacy, addressing cognitive, emotional, or physical barriers to participation, and offering transparent, easily navigable service pathways. Collectively, these indicators measure whether services respect and enhance individuals' ability to make informed and independent decisions about their mental health care.

The question of whether a lack of individual autonomy is a barrier to accessing mental health care services in the EU is multifaceted, involving various systemic, cultural, and personal factors. The research indicates that barriers to accessing mental health care in the EU are complex and include legal, cultural, and systemic issues, which often intersect with the concept of autonomy. There is a significant gap between the legal rights to mental health care and the reality of accessing these services. For asylum seekers, the right to access mental health care is often theoretical, with practical access being limited due to systemic inefficiencies and lack of clear guidelines across EU member states (Bell & Zech, 2009). Irregular **migrants** often avoid seeking mental health care due to fear of being reported and deported, which is a significant barrier to accessing services (Straßmayr et al., 2012). Stigma associated with mental health issues and cultural beliefs can deter individuals from seeking help. This is particularly true for **female migrants** who may face additional gender-specific barriers and cultural expectations that limit their **autonomy in seeking care** (Nyikavaranda et al.,

2023). **LGBTQIA+** individuals and **ethnoreligious minorities** often experience discrimination and stigma within healthcare settings, which can deter them from seeking care and limit their autonomy in making healthcare decisions (Sweileh, 2024). The lack of understanding and instances of racism within healthcare services further limit the autonomy of **Roma** individuals in making informed decisions about their mental health care (Guerrero et al., 2023). Research indicates that Roma individuals often perceive mental health holistically, intertwining it with familial and community welfare, which suggests that interventions must be designed to resonate with these perspectives (Monteiro et al., 2013).

It's worth mentioning that there has been a shift from a medical to a legal-centric approach in mental health legislation, emphasising the protection of individual rights and autonomy. This evolution reflects a broader societal change towards recognizing the importance of personal autonomy in mental health care (Raj et al., 2024).

The barrier, "**Lack of Autonomy**," was reframed as the macro-level megatrend: "**Empowering Individual Autonomy and Shared Decision-Making Within Mental Healthcare**", emphasising the system's active commitment to ensuring that individuals are fully involved in decisions about their mental health journey. This includes providing transparent, comprehensible information, respecting personal choices, and fostering collaborative relationships between individuals and providers across all levels of care, such as co-creating treatment plans and ensuring informed consent for interventions. By prioritising autonomy, mental healthcare becomes more meaningful, personally relevant, and trustworthy, significantly increasing individuals' willingness to accept and adhere to treatment. This approach strengthens both secondary and tertiary prevention by encouraging active participation in recovery.

4.2.7 Structural trends

ACCEPTABILITY

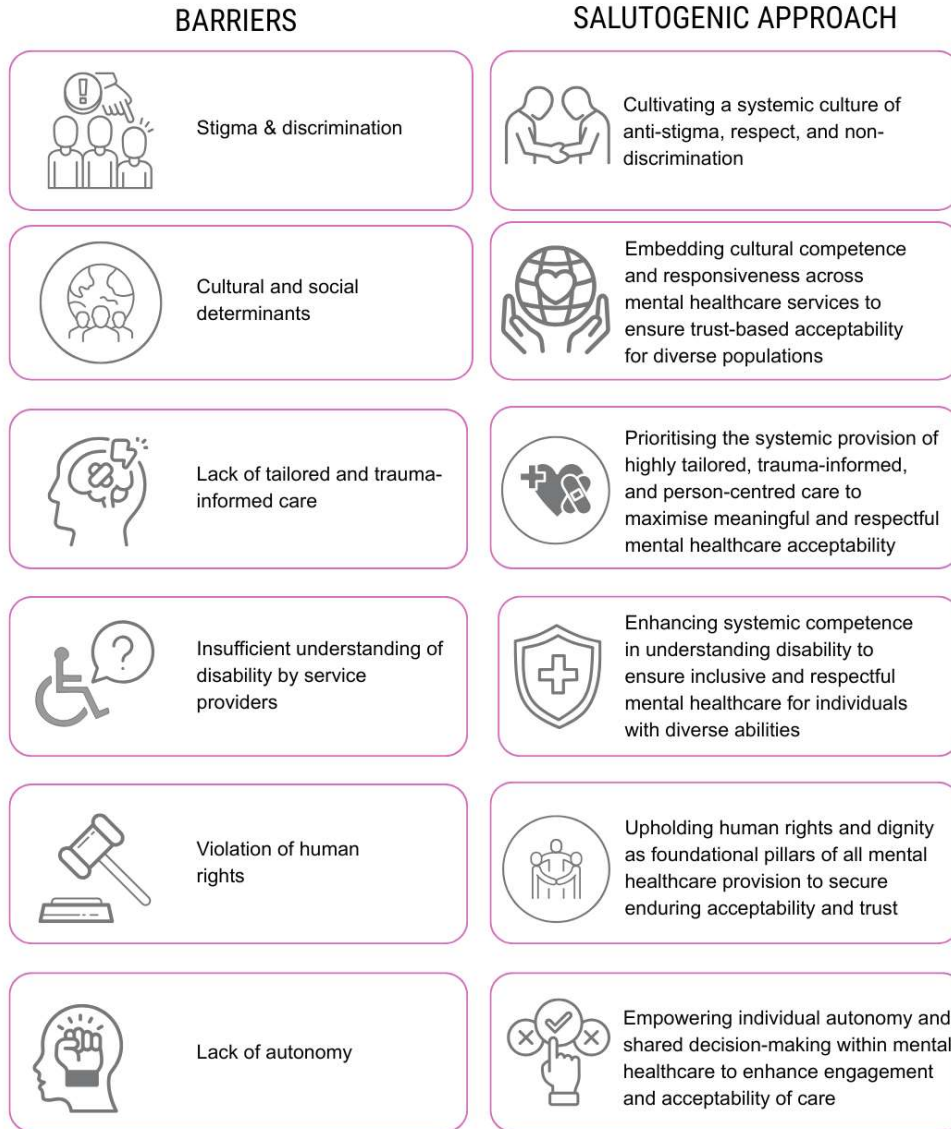


Figure 6: Acceptability barriers to enablers

The barriers associated with the Acceptability dimension were reinterpreted into macro-level, solution-oriented megatrends that place responsibility on the ethical orientation, cultural sensitivity, and relational practices of the mental healthcare system, rather than on individual perceptions or willingness to engage. Instead of framing stigma and discrimination as isolated social attitudes, they were conceptualised as manifestations of the need to foster a system wide culture grounded in anti-stigma, respect, and non-discrimination. Cultural and social determinants were translated into the imperative to systematically embed cultural competence and responsiveness within mental healthcare services, recognising trust as a prerequisite for acceptability across diverse populations. Deficits in tailored and trauma informed care were reframed as the need to strengthen person centred and trauma informed models of care, ensuring that services are emotionally safe, meaningful, and

responsive to lived experience. Limited understanding of disability among providers was reconceptualised as a requirement to enhance system level competence in disability inclusion, promoting respectful and appropriate care for individuals with diverse abilities. Human rights violations were reframed as structural failures in service acceptability, reinforcing the necessity of positioning human rights and dignity as core principles of mental healthcare provision. Finally, constraints on individual autonomy were translated into the need to reinforce shared decision making and user empowerment as central components of acceptable care.

4.3 Levesque: Availability & Accommodation

Availability and Accommodation refer to the physical and temporal accessibility of health services for all in need. This includes the presence, capacity, and distribution of facilities and staff, as well as how well services align with people’s living conditions, work schedules, and mobility needs. While services may formally exist, they can remain inaccessible due to uneven geographic distribution, staff shortages, rigid operating hours, or systems that exclude individuals with low literacy.

Availability and Accommodation Macro level trends affecting accessibility	References
Digital divide and unequal access to telehealth	(Anselm, 2023), (Barnils N Pedrós, 2024), (Guerrero et al., 2023), (Hynie et al., 2023), (Kan et al., 2023), (Knight, 2011), (Kohli et al., 2024), (Simon & Shachar, 2021)
Lack of effective telepsychiatry and digital interventions	(Augusterfer et al., 2015), (Barbo, 2022), (Barbo & Petrucka, 2024), (Guerrero et al., 2023), (Hunter et al., 2021), (Hynie et al., 2023), (Just & Stanford, 2024), (Mucic, 2021), (Welch et al., 2022)
Structural and systemic barriers (workforce, resource distribution)	(Baierl et al., 2024), (Bell & Zech, 2009), (Dumke et al., 2024b), (Forray et al., 2024), (Franks et al., 2007), (Goetz et al., 2022), (Hunter et al., 2021), (Lowther-Payne et al., 2023), (Peñuela-O'Brien et al., 2022), (Sambrook Smith et al., 2019), (Schouler-Ocak, 2015), (Turnpenny et al., 2018)
Lack of integrated and cross sectoral approaches	(Baierl et al., 2024), (Franks et al., 2007), (Ogbeta et al., 2022), (Silveri et al., 2022), (Sweileh, 2024), (van Duijn et al., 2018)
Geographic and rural disparities	(Baierl et al., 2024), (Cortina, 2023), (Franks et al., 2007), (Humphreys & Solarsh, 2008), (Maria et al., 2024), (Priebe et al., 2016)
Public health crises	(Coomans et al., 2024), (Cruz et al., 2024), (Hynie et al., 2023), (Winsper et al., 2024)
Demographic shifts	(Bäärnhjelm et al., 2013), (Connolly, 2012), (Ogugua et al., 2024), (Watters, 2010)
Climate Change	(Gattani, 2024), (Ghose & Ali, 2024), (Häggström, 2022), (Haworth et al., 2022), (Lindsay et al., 2022), (Mavrodaris, 2023),

(Narayanan et al., 2023), (Schmidt et al., 2023)

Table 5: References related to Availability and Accommodation barriers

4.3.1 Building a digitally equitable and robust telehealth infrastructure

Building a digitally equitable and robust telehealth infrastructure is understood as a structural trend within the scope of this analysis, reflecting broader macro-level dynamics; uneven digital infrastructure development, national e-health strategies, disparities in digital investment, and socioeconomic inequalities affecting access to technology. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **availability and accommodation dimension**, particularly in relation to continuity of access, service reach, and the system's capacity to provide flexible and digitally supported mental healthcare.

The **digital divide, characterised by disparities in access to technology, digital literacy, and supporting infrastructure**, significantly impacts the availability and accommodation of telehealth services. This divide is particularly pronounced among low-income, rural, and marginalised communities, where access to necessary digital tools and reliable internet is limited.

The presence of sufficient and comprehensive virtual mental health services, supported by qualified professionals trained to deliver telehealth effectively, is essential. Flexibility in modes of contact - offering both virtual and non-digital options - ensures inclusivity, while adaptation to language, literacy, and digital skills helps bridge the digital divide. The expansion of remote care via phone, video, and digital platforms must be paired with efforts to address affordability, privacy, and digital literacy challenges.

Regarding Infrastructure Development, national policies like the Infrastructure Act's Broadband Equity Access and Deployment Program aim to improve internet access, but significant gaps remain (Kan et al., 2023). The implications of the digital divide extend beyond immediate access to telehealth services, as they also affect the long-term mental health outcomes for vulnerable populations. This gap is particularly pronounced among **older adults** and those with lower socio-economic status, who may face compounded challenges due to age-related technological barriers and financial constraints (Barnils, 2023). As a result, addressing the digital divide is not merely a matter of increasing access to technology; it requires a comprehensive approach that includes enhancing digital literacy, improving infrastructure, and implementing targeted policies that prioritise the needs of marginalised communities. The integration of telehealth services within existing healthcare frameworks for older populations can be enhanced through the implementation of age-friendly technology initiatives. Such initiatives aim to create user-centric platforms that cater specifically to the needs of older adults, ensuring that they are not only accessible but also intuitive to navigate. For instance, studies have shown that when telehealth services are designed with the input of older users, satisfaction rates significantly increase, leading to better engagement and health outcomes (Knight, 2011). For **migrants and refugees**, the lack of infrastructure, such as reliable internet access, further limits the potential of telehealth to bridge the gap in mental healthcare access for these groups (Hynie et al., 2023). The **Roma population**, particularly women, experience significant barriers to accessing mental healthcare due to socio-economic factors and discrimination. The digital divide further exacerbates these challenges, limiting their access to telehealth services (Guerrero et al., 2023).

To address the digital divide, there is a need for policy interventions that focus on improving broadband infrastructure and providing financial support for technology access. Public-private

partnerships and value-based payment models are potential solutions to enhance telehealth accessibility (Simon & Shachar, 2021; Anselm, 2023). There is an urgent need to expand mental health resources in rural, low-income, and medically under-resourced communities due to their limited access to both broadband and mental healthcare services (Kohli et al., 2024).

The barrier, "**Digital Divide and Unequal Access to Telehealth**" (due to disparities in access to technology, digital literacy, and supporting infrastructure)," was reframed as the macro-level megatrend: "**Proactively Building a Digitally Equitable and Robust Telehealth Infrastructure**", highlighting the system's responsibility to go beyond simply offering telehealth by actively closing the digital gap. This involves addressing barriers related to infrastructure, technology access, and digital literacy to ensure that telehealth services across primary, secondary, and tertiary care are truly inclusive and functional for all individuals. By investing in supportive infrastructure, incorporating digital literacy initiatives into primary prevention efforts, and ensuring equitable access, telehealth can become a genuine Generalised Resistance Resource rather than a new barrier.

4.3.2 Optimising the deployment and usability of telepsychiatry and digital interventions

The deployment and usability of telepsychiatry and digital interventions are understood as structural trends within the scope of this analysis, reflecting broader macro-level dynamics; digital health policy development, regulatory frameworks for telehealth, uneven institutional uptake of innovation, and differences in digital literacy support. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **availability and accommodation dimension**, particularly in relation to usability, flexibility of service provision, and the practical accommodation of diverse user needs.

The lack of effective telepsychiatry and digital interventions in mental health care is a multifaceted issue that encompasses challenges related to the use, effectiveness, and accessibility of digital tools and remote mental health services.

Ensuring the **infrastructure availability and capacity of digital services** for mental healthcare involves offering a comprehensive range of online interventions supported by adequately trained and sufficient telehealth professionals. Key indicators as outlined in T1.2 include the usability and organization of digital services, such as flexible contact and appointment systems, online booking, and app-based consultations that cater to varying preferences and digital literacy levels. Services must also provide suitable hours and round-the-clock platform access where possible, ensuring timeliness by minimising wait times for virtual appointments. Adaptation to diverse needs, through culturally and linguistically appropriate content, user-friendly interfaces, and support for individuals with limited digital skills, is crucial for inclusivity. Additionally, robust virtual infrastructure, including reliable internet-based tools, online therapy sessions, and teleconsultations, as well as the provision of equipment and financial support for underserved groups, reflects the system's commitment to equitable and accessible digital mental healthcare.

While digital health interventions have shown promise in expanding access to mental health care, several barriers hinder their widespread and effective implementation. Hynie et al. (2023) highlight the potential of virtual mental healthcare services (VMHS) to improve access **for refugee and immigrant populations**; however, the accessibility of these services is often limited by factors such

as literacy, the need for financial and technical support, and the availability of technology. **Youth refugees and asylum seekers** are particularly vulnerable to mental health issues and face numerous barriers to accessing mental health support, including digital interventions. The lack of appropriate digital tools and support systems exacerbates these challenges (Barbo, 2022; Barbo & Petrucka, 2024). The **Roma** population face significant barriers to accessing mental healthcare, including digital services; these barriers are often related to social determinants of health, such as economic status and discrimination (Guerrero et al., 2023). **Older adults** often face a digital divide, which limits their access to digital mental health interventions. This divide is characterised by limited access to technology and the internet, as well as a lack of digital literacy among older populations. The effectiveness of digital interventions is often unevenly distributed, with a lack of high-quality evidence in certain areas, such as community-level outcomes and process indicators (Just & Stanford, 2024; Welch et al., 2022). Telemental health (TMH) has been identified as a crucial component in delivering mental health services in post-disaster settings, offering a means to provide sustained mental health care when physical access to services is limited (Augusterfer et al., 2015). However, for **survivors of natural disasters**, the accessibility of telepsychiatry is hindered by regulatory constraints, lack of expertise, and the need for clinicians to develop competencies in digital mental health tools (Mucic, 2021).

The barrier, "**Lack of Telepsychiatry and Digital Interventions**" (including the use, effectiveness, and accessibility of digital tools and remote mental health services), was reframed as the macro-level megatrend: "**Optimising the Deployment and Usability of Telepsychiatry and Digital Interventions**", recognising the transformative potential of digital tools while emphasizing the system's responsibility to ensure their effective, accessible, and user-friendly implementation. This involves integrating telepsychiatry and digital interventions into existing care pathways, ranging from primary screening and psychoeducation to specialised secondary and tertiary therapies, so that they enhance rather than hinder manageability and access.

4.3.3 Strategically Strengthening the Workforce and Resource Distribution



Grey literature derived trend:
"**Shortage of Mental Health Professionals**"

A key structural challenge impacting the availability of mental health services for people in vulnerable situations across the EU is the widespread shortage of qualified mental health professionals, including psychiatrists, psychologists, psychotherapists, and specialised psychiatric nurses, especially rural or remote regions (European Parliament, 2023). This scarcity creates a systemic bottleneck, resulting in long waiting periods for consultations and treatment that are especially harmful to individuals in acute distress or at risk of deterioration without prompt intervention (European Red Cross, 2023). Even where public coverage exists, session limits and below-recommended staffing levels, often under 20 psychologists per 100,000 people (Fundación Civio, 2021) contribute to delays, while workforce numbers declined from 50 to 45 per 100,000 between 2017 and 2020 (WHO Regional Office for Europe, 2023). Vulnerable individuals face worsening symptoms, greater suffering, and higher long-term costs due to delayed access. Addressing this requires strategic investment in education, training, recruitment, and retention to ensure sufficient staffing, which is essential for improving the availability, responsiveness, and equity of mental healthcare across the EU.

Strategically strengthening the workforce and resource distribution is understood as a structural trend within the scope of this analysis, reflecting broader macro-level dynamics; workforce planning policies, training and retention systems, regional disparities in staffing, and long-term underinvestment in mental health service capacity. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **availability and accommodation dimension**, particularly in relation to service capacity, geographical coverage, and the ability of systems to respond to demand in an equitable manner.

Addressing structural and systemic barriers such as workforce shortages and uneven service distribution is vital. Key indicators as outlined in T1.2 include the adequacy of qualified mental health professionals to meet demand, the physical presence and scope of services across all levels of the health system, and equitable geographic distribution to avoid disadvantaging rural populations. Accessibility of facilities and infrastructure, including transportation and mobility support, is also essential. Organisational factors, such as timely access with minimal wait times, suitable opening hours aligned with diverse lifestyles, and inclusive appointment and communication systems, further determine whether services are truly available and usable. These indicators collectively highlight how structural gaps and systemic inefficiencies can limit access despite the formal existence of services.

Systemic issues within healthcare frameworks can hinder access to services (Goetz et al., 2022; Lowther-Payne et al., 2023). A disparity in mental health service provision is particularly pronounced in low-and-middle-income countries (LMICs) in Europe, where resources are limited, and innovative interventions are being explored to optimise existing resources (Hunter et al., 2021). The shortage of mental health professionals and the uneven distribution of services are critical issues that affect **all vulnerable groups**. These structural barriers are compounded by systemic issues such as discrimination and a lack of resources, which further limit access to care (Baierl et al., 2024; Peñuela-O'Brien et al., 2022; Sambrook Smith et al., 2019). **Migrants and refugees** face numerous barriers to accessing mental healthcare, including a lack of understanding of mental health issues, stigma, and fear of authority. These barriers are exacerbated by resource limitations and a lack of interpreting services, which are crucial for effective communication and treatment (Franks et al., 2007; Schouler-Ocak, 2015; Dumke et al., 2024). There is a lack of availability of multilingual therapists and the reliance on untrained individuals as interpreters in various countries, which can compromise the quality of mental healthcare services (Forray et al., 2024).

In addition, there is a notable disparity in the distribution of mental health services across European regions. For instance, asylum seekers in Belgium face significant discrepancies between their legal rights to healthcare and the reality of accessing these services. This issue is compounded by the lack of clear guidelines and implementation of EU measures (Bell & Zech, 2009). Institutional and coercive practices in mental health services across Europe further exacerbate these barriers. Many individuals with mental health problems live in institutions, facing social exclusion and stigma, which hinders their access to community-based services (Turnpenny et al., 2018).

The barrier **"Structural and Systemic Barriers"**, referring to the shortage of mental health professionals, uneven distribution of services and resources across regions, was reframed as the macro-level megatrend: **"Strategically Strengthening the Workforce and Resource Distribution"**, shifting the emphasis from viewing shortages as static obstacles to recognizing the system's proactive

role in building a robust and equitably distributed workforce and infrastructure. This involves strategic measures such as targeted training, recruitment and retention initiatives, and the implementation of community-based care models to ensure that mental healthcare resources, across primary, secondary, and tertiary levels, are sufficient, accessible, and responsive to the needs of all populations, regardless of location. By ensuring that resources are available where and when they are needed, the system directly enhances the manageability and accessibility of care.

4.3.4 Integrated and coordinated mental healthcare service ecosystem



Grey literature derived trend:

“Limited Integration of Mental Health with Other Healthcare and Social Services”

The availability of comprehensive mental health services for vulnerable populations across the EU is further limited by the inadequate integration of mental healthcare with broader healthcare and social support systems. In many cases, mental health services are delivered in isolation detached from primary care, general health services, and social welfare programmes. This fragmented approach creates significant barriers for individuals with complex and overlapping needs, who often require coordinated and multidisciplinary forms of support (European Greens, 2022). For example, people living with chronic physical illnesses frequently experience mental health issues that go untreated due to poor communication between physical and mental health providers. The lack of systemic coordination can lead to fragmented care pathways, delayed treatment, and poorer health outcomes overall (European Parliament, 2023). Similarly, individuals facing social adversity, such as homelessness, unemployment, or social exclusion, require holistic interventions that address both psychological and socio-economic challenges. The current siloed structure of service delivery often fails to respond adequately to these interconnected needs, resulting in treatment gaps and unmet care requirements. Promoting better coordination between sectors is therefore essential. This includes creating formal referral mechanisms, co-locating mental health and social services, and fostering interdisciplinary collaboration among healthcare professionals, social workers, and community organisations. Integrated service models are better positioned to respond to the full scope of factors that influence mental well-being and are particularly important for ensuring equitable access for vulnerable groups.

An integrated and coordinated mental healthcare service ecosystem is understood as a structural trend within the scope of this analysis, reflecting broader macro-level dynamics; governance fragmentation, policy silos across sectors, weak coordination mechanisms, and insufficient integration between health and social care systems. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **availability and accommodation dimension**, particularly in relation to continuity of care, coordination across services, and the system’s capacity to accommodate complex needs.

A lack of integrated and cross-sectoral approaches limits the ability of services to meet diverse needs effectively. Key indicators as outlined in T1.2 include the degree of functional integration between mental, physical, and social care services, as well as the continuity of care across different providers and levels of the system. Collaboration with non-health sectors, such as social services, education, and employment is vital, with indicators assessing joint initiatives, mental health training

for front-line actors, and the presence of integrated entry points that facilitate early recognition and access to care. Equally important is the active involvement of service users and communities in co-producing policies and services, ensuring that care delivery is inclusive, context-sensitive, and grounded in lived experience.

The lack of integrated and cross-sectoral approaches in the EU significantly impacts the accessibility and effectiveness of care pathways for **all vulnerable groups**. This fragmentation is evident in the limited coordination between mental health, general healthcare, and social services, which often leads to disjointed care experiences for individuals with complex needs. Successful integration of services across sectors often depends on strong leadership and organisational support. These elements are essential for sustaining integrated service delivery and ensuring that care systems are responsive to the needs of vulnerable groups.

The lack of integration between mental health services and other healthcare sectors results in fragmented care pathways, which can be particularly detrimental to vulnerable populations such as **refugees, asylum seekers, and migrants**. These groups often face complex health needs that require coordinated care across multiple sectors, yet the current system's fragmentation hinders effective service delivery (Baierl et al., 2024; Franks et al., 2007). Vulnerable populations, including the **LGBTQIA+ community, individuals with disabilities, and ethnoreligious minorities**, often encounter barriers from systemic discrimination and the absence of culturally competent services. These challenges are compounded by the lack of integrated, holistic approaches that address their unique and intersecting needs (Silveri et al., 2022; Sweileh, 2024). For example, members of the LGBTQIA+ community frequently face discrimination and stigmatization within healthcare settings, which can discourage them from seeking necessary care. Engaging communities in the design and delivery of mental health services can help ensure that services are culturally appropriate and accessible. Community-based interventions can also facilitate better coordination between different service providers (Ogbeta et al., 2022).

The scarcity of integrated services that are specifically attuned to their needs further amplifies these barriers (Silveri et al., 2022). The barrier, **"Lack of Integrated and Cross-Sectoral Approaches"** (e.g., limited coordination between mental health, general healthcare, and social services, leading to fragmented and inaccessible care pathways), was reframed as the macro-level megatrend: **"Fostering a Seamlessly Integrated and Coordinated Service Ecosystem"**, positioning the challenge as an opportunity for the system to actively develop cohesive and interconnected care pathways. This involves ensuring that mental healthcare at all levels primary, secondary, and tertiary is made genuinely available through smooth transitions and shared understanding between mental health, general healthcare, and social services. By reducing fragmentation, the system enhances manageability and creates an accommodating environment for individuals with complex, multifaceted needs, thereby supporting comprehensive prevention efforts.

4.3.5 Decentralised and culturally responsive mental healthcare service models



Grey literature derived trend:
"Uneven Distribution of Services and Resources"

The availability of mental health services across the EU is characterised by significant inequalities between and within Member States, shaped by regional and socioeconomic conditions that lead to uneven coverage (European Parliamentary Research Service, 2023), quality, and scope of care (European Parliament, 2022). Urban areas concentrate specialised facilities and professionals, while rural and remote regions face shortages in infrastructure and personnel, and people with higher incomes can access private care, whereas disadvantaged groups rely on overstretched public systems. These disparities reinforce social and territorial inequalities and place vulnerable populations at a disadvantage in accessing timely and adequate support. Targeted policy responses are needed, including increased investment in underserved areas, expansion of community-based care, and more equitable funding mechanisms (European Parliament, 2022). In several Member States, public systems do not consistently provide treatment for common conditions such as anxiety and depression, despite high prevalence in countries like Portugal, the Netherlands, and Ireland, leaving many undiagnosed or untreated, with gaps particularly pronounced in Eastern Europe (Fundación Civio, 2021).

Decentralised and culturally responsive mental healthcare service models are understood as structural trends within the scope of this analysis, reflecting broader macro-level dynamics; territorial inequalities, migration and demographic diversity, decentralisation policies, and uneven integration of cultural responsiveness within health system planning. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **availability and accommodation dimension**, particularly in relation to local service reach, territorial accessibility, and the accommodation of culturally diverse populations. These patterns reflect **territorial accessibility challenges**, particularly affecting populations in **rural, remote, and left-behind areas**, where structural constraints such as limited infrastructure, workforce shortages, and service centralisation significantly hinder equitable access to mental healthcare.

Geographic and rural disparities in mental healthcare availability and accommodation highlight the challenges of ensuring equitable access across urban and underserved regions. Key indicators as outlined in T1.2 include the equitable geographic distribution of services and the physical presence of facilities with sufficient scope across all levels of care. Resource allocation is measured by facility and hospital bed density, as well as the availability of qualified health professionals, which is often lacking in rural areas. Long travel times, limited infrastructure, and higher indirect costs further reduce the timeliness and effectiveness of access. Additionally, digital access plays a critical role, with disparities in telemedicine availability, affordability of devices and internet, and the capacity to use digital platforms creating barriers. Addressing these disparities requires targeted investments in infrastructure, staffing, and digital inclusion to ensure that location does not determine the quality or accessibility of mental healthcare.

Geographic and rural disparities in mental healthcare services for vulnerable groups in the EU are a significant concern, particularly in low- and middle-income countries (LMICs) and underserved regions. These disparities manifest in various forms, including the rural-urban divide, limited access to services, and specific challenges faced by marginalised groups. Rural populations generally experience poorer mental health outcomes compared to urban dwellers, partly due to limited access to healthcare services and broader socio-economic determinants (Humphreys & Solarsh, 2008).

Geographic disparities are further complicated by the influence of social groups, which can vary significantly within rural and urban areas, affecting mental health outcomes (Cortina, 2023).

Migrants and refugees often reside in areas with limited mental health resources. Geographic isolation, coupled with cultural and language barriers, significantly restricts their access to necessary mental health services. In Munich, Germany, for instance, migrants face barriers related to the geographical distribution of services and bureaucratic processes (Baierl et al., 2024). Similarly, in East Anglia, UK, practical barriers such as transport and appointment hours further limit access for these groups (Franks et al., 2007). **Older migrants** often live in rural or underserved areas where mental health services are scarce. Geographic isolation, combined with language and cultural barriers, further complicates their access to mental healthcare (Priebe et al., 2016). **LGBTQIA+** individuals in rural areas face unique challenges, including limited mental health services, workforce deficiencies, and travel burdens. These issues are exacerbated by societal stigma and discrimination, which hinder access and engagement with mental health services; the isolation experienced by rural LGBTQIA+ populations can result in heightened levels of anxiety and depression, often exacerbated by the absence of supportive community networks and mental health resources (Maria et al., 2024). The geographic and rural disparities in mental healthcare access highlight the need for targeted interventions to address these systemic barriers. While the focus is often on increasing service availability, it is equally important to ensure that these services are culturally competent and accessible to all vulnerable groups.

The barrier, "**Geographic and Rural Disparities**", including the rural-urban divide and limited access to mental healthcare services, particularly in low- and middle-income countries or underserved regions" was reframed as the macro-level megatrend: "**Developing Decentralised and Culturally Responsive Service Models**", underscoring the system's proactive responsibility to address geographic inequities. This involves implementing innovative service delivery approaches - such as mobile units, community-based programs, and robust integration of mental health into primary care - to ensure that mental healthcare at all levels (primary, secondary, tertiary) is physically accessible and tailored to the unique cultural and contextual needs of rural and underserved populations. By bringing services closer to communities and adapting them to local realities, the system enhances manageability and ensures meaningful availability across all levels of prevention. Impact of Public Health Crises (e.g., COVID-19)

4.3.6 Building systemic resilience and adaptability to ensure sustained and accommodating mental healthcare availability during public health crises and increased demand

Systemic resilience and adaptability during public health crises and periods of increased demand are understood as structural trends within the scope of this analysis, reflecting broader macro-level dynamics; crisis preparedness policies, emergency governance mechanisms, surge-capacity planning, and the resilience of healthcare financing and workforce systems. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **availability and accommodation dimension**, particularly in relation to continuity of provision, flexibility of service delivery, and the ability of systems to remain accessible under pressure.

Public health crises greatly affect mental healthcare by challenging the capacity, organisation, and accessibility of services. Key indicators as outlined in T1.2 include the rapid expansion and effective

use of remote and virtual care platforms, as well as the availability of digital infrastructure. Service organisation is measured by changes in wait times, continuity of staffing, and the system's flexibility in offering alternative contact and appointment options when traditional pathways are disrupted.

Public health crises significantly impact access to mental healthcare services for vulnerable populations in the EU, including service disruptions, increased demand, and a shift towards remote or alternative delivery methods. The COVID-19 pandemic has necessitated adaptations in service delivery, but these changes have not uniformly benefited all groups, often leaving the most vulnerable at a disadvantage (Coomans et al., 2024). The shift to remote services highlighted the need for financial and technical support to ensure equitable access, as many vulnerable populations lacked the necessary resources to benefit from these services (Hynie et al., 2023). In regard to **youth refugees**, research indicates that the lack of tailored educational support during this period has led to increased dropout rates, which can hinder long-term mental health recovery and social integration efforts (Winsper et al., 2024). Therefore, it is imperative to implement targeted educational programs that not only address academic needs but also incorporate mental health support, ensuring these vulnerable youths receive comprehensive care that fosters resilience and connection in a post-pandemic landscape. **People with disabilities** experienced a predominantly negative effect on healthcare access due to COVID-19 measures, which were not fully inclusive of their needs. Only a small fraction of policies specifically targeted PWDs, focusing on intellectual or mental disabilities (Cruz et al., 2024). The shift to telehealth, while beneficial in some respects, has also highlighted the digital divide, leaving those without reliable internet access or technological literacy at a disadvantage.

The barrier, "**Impact of Public Health Crises**" (e.g., COVID-19, including service disruptions, increased demand, and shifts toward remote or alternative delivery methods), was reframed as the macro-level megatrend: "**Building Systemic Resilience and Adaptability**", emphasizing the system's proactive responsibility to maintain and adapt mental healthcare services through times of crisis. This involves ensuring that care at all levels, primary, secondary, and tertiary, remains accessible and accommodating despite disruptions, managing surges in demand, and effectively transitioning to alternative delivery methods such as telehealth. By prioritising continuity and flexibility, the system enhances manageability and ensures individuals can reliably access support when it is most needed, which is crucial for mitigating the widespread mental health impacts across all levels of prevention.

4.3.7 Designing flexible and culturally responsive service models to ensure availability in response to dynamic demographic shifts

Flexible and culturally responsive service models in response to demographic shifts are understood as structural trends within the scope of this analysis, reflecting broader macro-level dynamics; ageing populations, migration, changing household structures, and evolving territorial population patterns. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **availability and accommodation dimension**, particularly in relation to service adaptability, territorial responsiveness, and the capacity to accommodate changing population needs.

For **demographic shifts such as increased migration and an aging population**, the availability and accommodation of mental healthcare services depend on their ability to adapt to evolving and diverse needs. Key indicators outlined in T1.2 include the adaptability of services across different

subgroups, ensuring cultural appropriateness, and addressing language, literacy, and communication barriers to build trust and engagement. Equitable geographic distribution and accessible physical infrastructure are essential, alongside sufficient staffing levels with providers trained or matched to the cultural and linguistic needs of specific populations.

Demographic shifts in the European Union, such as increased migration and an ageing population, have significantly impacted access to mental healthcare services, particularly for people in vulnerable situations. These shifts necessitate mental health services that are adaptable, culturally responsive, and accessible across diverse locations. The demographic transition in Europe requires mental health services to adopt public health approaches to cater to an **aging population**. This includes integrating services to address the needs of older adults and migrants (Connolly, 2012). Demographic shifts, including increased migration and an ageing population, necessitate a focus on the organization and delivery of services for migrants and refugees; their integration into health systems must be accompanied by efforts to address social determinants of health, such as housing, employment, and education, which significantly impact mental health outcomes (Watters, 2010).

Bäärnhielm et al. (2013) highlight that the demographic shifts, including increased migration and cultural diversity in Germany, Norway, and Sweden, necessitate adaptable and culturally responsive mental health services. These shifts create barriers to access for **youth populations**, emphasizing the need for services that accommodate diverse backgrounds and the development of national guidelines and quality standards, ensuring mental health care is equitable and accessible.

The barrier "**Demographic Shifts**", such as increased migration and an ageing population, creating a need for mental health services to be adaptable in format, culturally responsive, and accessible across diverse locations, was reframed as the macro-level megatrend: "**Designing Flexible and Culturally Responsive Service Models to Ensure Accommodating Mental Healthcare Availability in Response to Dynamic Demographic Shifts**", highlighting the system's proactive role in adapting to evolving population needs. This involves tailoring service formats, enhancing cultural responsiveness, and improving accessibility across primary, secondary, and tertiary care to effectively serve diverse groups such as migrants and the older populations. By aligning mental healthcare with these demographic changes, the system ensures care remains manageable, meaningful, and accommodating, critical for successful prevention and intervention efforts.

4.3.8 Integrating mental healthcare preparedness into climate-related disaster response

The integration of mental healthcare preparedness into climate-related disaster response is understood as a structural trend within the scope of this analysis, reflecting broader macro-level dynamics; climate change, disaster preparedness policy, environmental risk exposure, and unequal territorial resilience across regions. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **availability and accommodation dimension**, particularly in relation to emergency preparedness, service continuity, and the accommodation of needs arising in disaster-affected settings.

In the context of **climate change and disasters**, the availability and accommodation of mental healthcare services depend on their resilience, adaptability, and ability to meet surging needs despite disruptions. Key indicators outlined in T1.2 include the continuity and capacity of physical

infrastructure, tracking how many mental health facilities remain operational or are quickly restored, as well as the accessibility of facilities and equitable geographic distribution, particularly for displaced populations. Workforce availability is crucial, with indicators measuring the number and rapid deployment of trained professionals in affected areas. Flexible service delivery, including mobile units, temporary hubs, and virtual care, is essential when traditional access points fail, alongside tracking timeliness of care and minimising wait times. Finally, systemic preparedness is reflected through integration of mental health into emergency response frameworks, coordination with other sectors, and sustained public investment in both immediate disaster response and long-term mental health recovery.

Migrants and refugees often face complex legal and administrative hurdles that limit their access to healthcare services. These include restrictive policies that do not recognise climate migrants as refugees, thereby excluding them from certain protections and services (Gattani, 2024; Narayanan et al., 2023). Many healthcare facilities and emergency shelters are not adequately equipped to accommodate **individuals with physical disabilities**, leading to significant accessibility issues during disasters. This lack of infrastructure adaptation can prevent timely access to necessary medical care and support services during emergencies (Häggström, 2022; Lindsay et al., 2022). Current Disaster Risk Reduction (DRR) Policies are insufficiently inclusive of **LGBTQIA+** needs, often reflecting a binary understanding of gender and sexuality that fails to accommodate the diversity within these communities (Haworth et al., 2022). Inadequate infrastructure and resource allocation in areas predominantly inhabited by the **Roma** can hinder the delivery of essential health services, exacerbating health inequities (Schmidt et al., 2023). **Older adults** are particularly vulnerable to climate change due to physical frailty and pre-existing health conditions. They may face barriers in accessing mental health services due to mobility issues and the need for age-appropriate care models (Mavrodaris, 2023). Existing legal frameworks often lack provisions for accommodating the unique needs of **climate refugees** and other displaced individuals, which can exacerbate their mental health vulnerabilities. There is a need for more inclusive policies that address these gaps and ensure equitable access to mental health services (Ghose & Ali, 2024).

The barrier "**Climate Change and Climate-Related Disasters**", including damage to healthcare infrastructure, population displacement, and disruptions in the delivery of mental health services, was reframed as the macro-level megatrend: "**Integrating Mental Healthcare Preparedness into Disaster Response to Ensure Continuous and Accommodating Service Availability**", emphasising the system's critical role in addressing climate-related challenges through robust planning and resilience-building. This involves adapting infrastructure and implementing flexible, mobile delivery models across primary, secondary, and tertiary care to maintain uninterrupted and accessible mental health services despite environmental disruptions and displacement. By proactively preparing for these crises, the system enhances manageability and supports all levels of prevention and long-term recovery.

4.3.9 Structural trends

AVAILABILITY & ACCOMMODATION



Figure 7: Availability & Accommodation barriers to enablers

The barriers identified within the Availability and Accommodation dimension were reformulated to emphasise the organisational capacity, territorial reach, and adaptive strength of mental healthcare

systems. Instead of viewing the digital divide as a constraint linked to individual access or skills, it was reframed as the need to build digitally equitable and robust telehealth infrastructure that supports hybrid models of care and ensures continuity across diverse contexts. Limitations in telepsychiatry and digital interventions were translated into the imperative to optimise the deployment, usability, and integration of digital mental health solutions, enhancing their effectiveness and reach. Structural shortages and uneven distribution of professionals and resources were reconceptualised as a call to strategically strengthen workforce capacity and resource allocation, ensuring equitable availability across regions and levels of care. Fragmented and poorly coordinated services were reframed as the need to establish integrated and coordinated mental healthcare ecosystems, embedding mental health within primary care and strengthening cross-sectoral collaboration. Geographic and rural disparities were translated into the development of decentralised and culturally responsive service models capable of reaching underserved and remote populations. Finally, disruptions linked to public health crises were repositioned as drivers for building systemic resilience and adaptability, highlighting the importance of flexible delivery models and preparedness to sustain service availability during periods of increased demand.

4.4 Levesque: Affordability


Affordability refers to the ability of individuals and households to access appropriate health services without financial hardship. It reflects the balance between direct and indirect costs of care (e.g., fees, medicines, transport, income loss) and a person’s capacity to pay, shaped by financing models, coverage, and out-of-pocket payments. When services are only partially covered or rely on private provision, costs can lead to delayed care and unmet needs.

Table 6: References related to Affordability barriers

Affordability Macro level trends affecting accessibility	References
Inadequate funding and resource allocation	(Forray et al., 2024), (Hunter et al., 2021), (Knapp et al., 2006), (McDaid et al., 2006), (Mubarak et al., 2023), (Robertson-Preidler et al., 2019), (Szkody et al., 2024)
Lack of comprehensive insurance coverage	(Asif & Kienzler, 2022), (Delany-Moretlwe et al., 2015), (Dumke et al., 2024), (Kühlbrandt et al., 2014), (OECD/European Union, 2022), (Silveri et al., 2022), (Thomson et al., 2023)
Income, education inequalities	(Archibong & Zaka, 2024), (Baierl et al., 2024), (Castro-Ramirez et al., 2021), (Corcadden et al., 2018), (Franks et al., 2007), (Guerrero et al., 2023), (Henking, 2024), (Henking et al., 2023) (Knapp et al., 2006), (Limiri, 2024), (Maria et al., 2024), (Neugebauer, 2024)
Lack of employment and financial stability	(Curl & Kearns, 2014), (Doody, 2013), (Lê Cook et al., 2019) (O’Flynn, 2001), (Zafar et al., 2024), (Zeeman et al., 2019)

Economic disparities and inequality	(Alexiadou, 2023), (Amaddeo & Jones, 2007), (Arundell et al., 2020), (Baierl et al., 2024), (Franks et al., 2007), (Guerrero et al., 2023), (Huang, 2024), (Izutsu & Tsutsumi, 2024), (Macintyre et al., 2018), (Shokri, 2023)
Economic crises	(Barbo, 2022), (Barbo & Petrucka, 2024), (McAllister et al., 2018) (Neugebauer, 2024), (Reynish et al., 2022), (Silva et al., 2020) (Themelis, 2016), (Zeeman et al., 2019)

4.4.1 Prioritising strategic funding and resource allocation to ensure the systemic provision of comprehensibly affordable and broadly available mental healthcare



Grey literature derived trend:
“Underfunding of Mental Health Services”

Mental health consistently receives a smaller share of national healthcare budgets compared to physical health services, resulting in systemic resource constraints, insufficient staffing, and limited availability of publicly funded treatment options (European Parliament, 2023). Workforce instability further exacerbates this affordability crisis. Low pay, difficult working conditions, and limited career development opportunities contribute to high turnover rates and staff shortages. These issues severely limit service capacity and contribute to burnout among remaining professionals (Foundation for European Progressive Studies, 2023). A key shortfall in current systems is the limited emphasis on prevention. Mental health professionals often find themselves overwhelmed by acute cases, with little time or capacity to engage in early intervention or preventive outreach. As one adolescent psychiatrist noted, emergency care dominates daily practice, leaving little space for preventative work—either due to training gaps, time constraints, or institutional culture (Foundation for European Progressive Studies, 2023). This reactive model leaves little room for outreach to individuals at risk before conditions escalate, reinforcing a cycle of chronic under-treatment (Foundation for European Progressive Studies, 2023). This persistent funding shortfall directly affects affordability, particularly for those who rely on public systems, with relevant implications on the Availability & Accommodation aspect as well; limited resources translate into workforce shortages, long waiting lists, and reduced availability of essential services. People in vulnerable situations, who are less likely to access private care, are disproportionately impacted, often facing delays or gaps in care that may worsen their conditions. When public options are unavailable or insufficient, those who can afford it may resort to expensive private alternatives, while others go without care altogether. Even where mental health services are available, they remain out of reach for many individuals. Among the 21 EU Member States with relevant data, only 11 offer psychological support free of charge through their public healthcare systems, and just three provide care without limits on duration. Typically, funding for these services is split between healthcare and social care systems, two distinct governmental domains, which often fail to coordinate effectively. This fragmentation further complicates access for those in need. Similar challenges are present in non-EU countries across the broader European region (European Greens, 2022).

Strategic funding and resource allocation for affordable and broadly available mental healthcare are understood as structural trends within the scope of this analysis, reflecting broader macro-level dynamics; public spending priorities, national financing models, budgetary constraints, and the long-

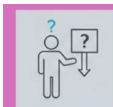
standing under-prioritisation of mental health in health system investment. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **affordability dimension**, particularly in relation to financial accessibility, service coverage, and the system’s capacity to reduce cost-related barriers.

Inadequate funding of mental health services significantly undermines their affordability by shifting costs onto individuals and creating financial barriers to care. Key indicators outlined in T1.2 include high out-of-pocket payments for consultations, medications, or diagnostics, as well as limited coverage of essential mental health services in public or insurance-based schemes. Indirect costs, such as transportation, income loss, or childcare, often reflect supply-side shortcomings like distant facilities or inflexible hours. Public investment levels, measured by the proportion of government health spending allocated to mental health, reveal the system’s ability to reduce user fees and subsidise care.

Many European countries face economic challenges that limit the allocation of resources to mental health services. This results in a lack of funding for necessary services, which disproportionately affects migrants and refugees who already face numerous barriers to accessing care. In addition, there is often a mismatch between the allocation of resources and the actual mental health needs of the population. This is particularly true for **migrants and refugees**, who may not be prioritised in resource distribution despite their high mental health needs (McDaid et al., 2006). Funding and resource allocation issues are noted while biases and financial constraints can hinder fair distribution of services to all communities, limiting access to affordable mental health services for disadvantaged populations (Forray et al., 2024; Mubarak et al., 2023). The combination of inadequate funding, discrimination, and systemic barriers leads to higher costs for users and limited-service availability; **LGBTQIA+** individuals often face long waitlists, lack of insurance coverage, and incompetent care from non-affirming providers, all of which contribute to the inaccessibility of mental health services (Szkody et al., 2024). The distribution of mental health resources is often inequitable, with a concentration of services in urban areas and a lack of community-based care options (Knapp et al., 2006; Hunter et al., 2021); this is particularly problematic for vulnerable populations such as the **Roma** communities, who may live in marginalised or rural areas with limited access to mental health services. The scarcity of resources forces healthcare systems to make difficult trade-offs, often deprioritising mental health services, including psychotherapy (Robertson-Preidler et al., 2019), which is crucial for treating mental disorders in **older and youth** populations.

The barrier "**Inadequate funding and resource allocation for mental health services**", leading to higher costs for users and limited-service availability, was reframed as the macro-level megatrend: "**Prioritising Strategic Funding and Resource Allocation**", to emphasize the system’s proactive responsibility to secure adequate and strategic financing. This involves allocating resources across all levels of care—primary prevention, secondary early intervention, and tertiary specialised treatment, to establish a robust foundation that reduces out-of-pocket costs for users.

4.4.2 Comprehensive and inclusive mental healthcare insurance schemes



Grey literature derived trend:
"Lack of Comprehensive Insurance Coverage"

Inadequate and uneven health insurance coverage across the EU remains a key barrier to affordable mental health care, particularly for vulnerable populations. Many individuals lack insurance that includes mental health services, leaving them financially exposed. This disproportionately affects undocumented migrants, Roma communities nearly one in four of whom lack national health insurance (Mental Health Europe, 2024) and people in precarious employment who face exclusion or administrative barriers (International Organization for Migration, 2022). Limited awareness of entitlements among both patients and providers further delays or prevents access to specialist care (Fundación Civio, 2021), (WHO, 2016). These challenges are intensified by insurance and system-level constraints. In some countries, such as the Netherlands, insurers prioritise mild conditions over complex mental health needs, resulting in delayed or insufficient care (WHO, 2024). Many systems hold reimbursable therapy sessions and suffer from underfunding and staff shortages. In Romania, a minimum-wage earner must work nearly four days to afford one private psychology session, while in Slovakia, Estonia, and Croatia the cost exceeds two days' wages. Even where coverage exists in principle, uninsured groups remain excluded: Romania's social health insurance covers only 86% of the population, leaving Roma communities, informal workers, and homeless individuals entitled only to emergency care (European Observatory on Health Systems and Policies, 2016).

Comprehensive and inclusive mental healthcare insurance schemes are understood as structural trends within the scope of this analysis, reflecting broader macro-level dynamics; entitlement frameworks, insurance design, national reimbursement policies, and disparities in coverage across population groups. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **affordability dimension**, particularly in relation to financial protection, equity of coverage, and sustained access to mental healthcare services.

A **lack of comprehensive insurance coverage** greatly impacts the affordability of mental healthcare services by shifting costs to individuals and creating financial hardship. Indicators outlined in T1.2 include the breadth and depth of insurance coverage, assessing whether essential mental health services such as therapies, medications, and diagnostics are fully included or leave users with significant out-of-pocket expenses. Public financing and investment levels are crucial. Financial protection mechanisms, such as subsidies or exemptions for vulnerable populations, indicate how well the system mitigates inequities caused by insufficient coverage. Additional indicators track the risk of catastrophic or impoverishing expenditure when service costs exceed household capacity, as well as inequities in the cost burden disproportionately affecting low-income or marginalised groups.

The absence of comprehensive insurance coverage means that many **migrants and refugees** must pay out-of-pocket for mental health services, which can be prohibitively expensive. This financial burden is a significant deterrent to seeking care (Dumke et al., 2024). Charging regulations in some countries can lead to significant debt for migrants, which is reported to immigration authorities, potentially resulting in detention or deportation. This creates a chilling effect, discouraging individuals from accessing necessary healthcare services (Asif & Kienzler, 2022). Inadequate financial protection in health systems leads to financial hardship, particularly affecting those with long-term treatment needs, such as **individuals with physical and intellectual disabilities**. The lack of comprehensive insurance coverage often results in **LGBTQIA+** individuals being unable to afford necessary mental health services, leading to unmet mental health needs (Silveri et al., 2022). **Roma**

populations in Central and Eastern Europe (CEE) are significantly less likely to have health insurance compared to non-Roma, with coverage gaps persisting even after adjusting for socio-economic factors such as employment and income. In countries like Montenegro, Bosnia and Herzegovina, Croatia, Bulgaria, and Romania, the disparity in insurance coverage remains significant, highlighting systemic issues in the accessibility of health insurance for Roma communities (Kühlbrandt et al., 2014). Many **older adults** lack comprehensive insurance coverage, leading to increased reliance on out-of-pocket payments for essential services like outpatient medicines and mental health care (Thomson et al., 2023). Systemic issues, such as the lack of integrated services that address the specific developmental needs of youth, contribute to the underutilization of mental health services. This is particularly true for **youth** populations who face additional barriers such as stigma and discrimination (Delany-Moretlwe et al., 2015).

The barrier "**Lack of Comprehensive Insurance Coverage,**" was reframed as the macro-level megatrend: "**Establishing Comprehensive and Inclusive Mental Healthcare Insurance Schemes**", to emphasise the system's responsibility to develop insurance frameworks that fully cover mental health needs and eliminate gaps or prohibitive co-pays. By providing clear and broad coverage across primary, secondary, and tertiary care, the system ensures that the cost of mental healthcare is both manageable and predictable, alleviating financial anxiety.

4.4.3 Designing income-adjusted and educationally-considerate pathways to ensure mental healthcare affordability for all socioeconomic levels

Income-adjusted and educationally-considerate pathways for mental healthcare affordability are understood as structural trends within the scope of this analysis, reflecting broader macro-level dynamics; income inequality, educational disparities, differential health literacy, and unequal social policy protections across socioeconomic groups. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **affordability dimension**, particularly in relation to equitable payment capacity, cost sensitivity, and the reduction of socioeconomic barriers to care.

Individuals of higher income are more likely to consult mental health professionals and perceive this treatment as very helpful (Henking et al., 2023), while mental health service utilisation is significantly higher in high-income countries (HICs) compared to low- and middle-income countries (LMICs) (Henking, 2024). Among the most common barriers for people with mental health conditions is skipping care treatment due to its cost (Corcadden et al., 2018). The affordability of mental healthcare for individuals with **lower income and education levels** is shaped by how well the health system minimises financial and informational barriers. Key supply-side indicators include the level of public financing and investment in mental health services, which determines the extent of user fees, subsidies, and the availability of free or low-cost programs. Coverage breadth and depth reflect whether essential services, such as therapy, medications, and diagnostics, are fully included in public or insurance schemes. Indirect costs, such as transportation, childcare, or income loss are critical, with indicators assessing whether service locations, operating hours, and design reduce these burdens for vulnerable groups. Financial protection mechanisms, such as fee waivers or subsidies, help prevent catastrophic expenditure, which disproportionately affects low-income households.

Migrants and refugees often experience financial instability, which limits their ability to pay for mental health services. This is exacerbated by the lack of insurance coverage or inadequate

coverage that does not fully cover mental health services (Baierl et al., 2024; Archibong & Zaka, 2024). Socioeconomic deprivation in host countries, such as high rates of unemployment and poverty, further restricts access to mental health services for these populations (Franks et al., 2007). Individuals with lower income levels often struggle with the direct costs of mental health services, such as high deductibles and co-pays, which can be prohibitive (Neugebauer, 2024). This financial burden is particularly acute for **individuals with disabilities**, who may have additional healthcare needs and expenses. **LGBTQIA+** individuals from lower socioeconomic backgrounds face significant financial barriers, such as high costs of mental health services, which are often not covered by insurance or public health systems. This is particularly problematic in rural areas where services are scarce, and travel costs add to the financial burden (Maria et al., 2024). The **Roma** community often experiences poverty, which directly impacts their ability to afford mental health services. Financial constraints limit their access to necessary treatments and medications, contributing to poorer mental health outcomes (Guerrero et al., 2023). Structural barriers, such as limited access to transportation and healthcare facilities, disproportionately affect **older adults** in rural or underserved areas, compounding the challenges posed by income and education barriers (Neugebauer, 2024). Socioeconomic factors, including income and education, are closely linked to stigma and discrimination, which can further hinder access to mental health services. **Youth** from lower socioeconomic backgrounds may face stigma both within their communities and from service providers, discouraging them from seeking help (Castro-Ramirez et al., 2021). Many mental health systems, particularly in low- and middle-income countries, are underdeveloped, which can also apply to certain regions within the EU. This insufficiency in resources makes it challenging to provide adequate mental health care to **disaster survivors** (Knapp et al., 2006).

The barrier “**Income and Education**” (e.g. lower income levels directly limit the affordability and accessibility of mental health services), was reframed as the macro-level megatrend: “**Designing Income-Adjusted and Educationally-Considerate Financial Pathways**”, highlighting the system’s responsibility to address the intertwined challenges of income and education in accessing care. This involves creating flexible payment options, subsidies, or free services—particularly in primary prevention but extending to all levels of care—that accommodate lower-income populations. Additionally, financial information and pathways are communicated in clear, comprehensible ways regardless of educational background, thereby reducing the financial burden and enhancing the manageability of engaging with mental healthcare.

4.4.4 Systemic support for employment stability and financial security to ensure affordability of mental healthcare for all



**Grey literature derived trend:
“High Out-of-Pocket Costs and User Fees”**

In many EU Member States, essential mental health services, particularly those provided by psychologists and therapists, are not fully covered by public health insurance, forcing individuals to pay substantial out-of-pocket fees (European Parliament, 2023). Even where public funding exists, user fees and coverage caps create significant financial barriers, disproportionately affecting vulnerable groups such as low-income individuals, the unemployed, migrants, and refugees. These costs often lead to delayed or foregone care despite urgent needs (European Parliament, 2023). In countries where mental health services are not systematically covered, individuals must rely on private care, which remains unaffordable for many facing economic hardship. Although private consultation costs may be relatively lower in countries like France, they still exclude those with unstable incomes, raising serious equity concerns and undermining universal health coverage (Fundación Civio, 2021). Consequently, unmet mental health needs are far more prevalent among lower-income groups; in Greece, for example, income-related inequality reached a ratio of 23.8, illustrating the strong link between economic hardship and untreated mental health conditions (Bioengineer.org, 2025). Displaced populations, including refugees from Ukraine, face similar challenges, as limited financial resources and structural barriers restrict access to mental healthcare, even when services are physically available (International Organization for Migration, 2023). Public funding for psychological care varies widely across EU Member States: in Bulgaria and Latvia, only psychiatric services are covered; France excludes psychologists from its public system despite launching a pilot programme in 2018; and Luxembourg is currently considering their integration. Initially, high out-of-pocket costs and user fees were identified as a standalone megatrend due to their immediate impact on individuals. However, further analysis showed that these costs are largely a downstream effect of two systemic issues, underfunding of mental health services and lack of comprehensive insurance coverage, leading to their integration under these broader megatrends to better reflect the structural roots of the affordability gap.

Systemic support for employment stability and financial security is understood as a structural trend within the scope of this analysis, reflecting broader macro-level dynamics; labour market insecurity, precarious employment, welfare state arrangements, and broader economic policies affecting household financial resilience. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **affordability dimension**, particularly in relation to individuals’ sustained capacity to pay for care and avoid cost-related discontinuities in mental healthcare access.

The affordability of mental healthcare for individuals with **unstable employment or financial insecurity** is shaped by how well the health system is funded, structured, and supported by protective policies. Key supply-side indicators outlined in T1.2 include the level of public investment in mental health services, which reduces user fees and reliance on employment-linked insurance, as well as the breadth and depth of public or private insurance coverage for essential services like therapy, medications, and diagnostics. Financial protection mechanisms, such as fee waivers, subsidies, or income-based exemptions, are critical for reducing out-of-pocket expenses which disproportionately

affects those with precarious jobs. System integration with social and employment support services is another indicator, reflecting efforts to improve financial stability and employment outcomes for mental health service users.

Financial instability is a significant predictor of mental health recovery, with stable financial conditions leading to better mental health outcomes. Economic security reduces stress and encourages adherence to treatment, highlighting the need for income support and financial literacy programs (Zafar et al., 2024). Many **migrants and refugees** experience financial insecurity, which directly impacts their ability to afford mental health services. The cost of services, coupled with a lack of financial resources, makes it difficult for these populations to access care (Hynie et al., 2023). Unemployment is a major barrier to accessing mental health services. Individuals with disabilities often face higher unemployment rates, which limits their financial resources and access to employer-sponsored health benefits (O'Flynn, 2001). **LGBTQIA+** individuals often encounter workplace discrimination, which can lead to job instability and financial insecurity. This discrimination is compounded by societal stigma, which can further marginalise these individuals and limit their employment opportunities (Zeeman et al., 2019). **Roma communities** experience high unemployment rates, which are often a result of discrimination and exclusion from the labour market. This lack of employment leads to financial instability, making it difficult for Roma individuals to afford mental health services (Cook et al., 2019; O'Flynn, 2001). Economic policies and austerity measures have exacerbated financial difficulties for **older adults**, leading to increased affordability issues for essential services, including mental health care. This has resulted in a decline in mental health across deprived communities (Curl & Kearns, 2014). High unemployment rates, particularly among youth, contribute to financial instability, which in turn affects mental health. In Greece, for example, youth unemployment reached 54%, leading to increased psychological distress and reduced access to mental health services due to affordability issues (Doody, 2013).

The barrier "Employment and Financial Stability", (unstable employment or financial insecurity can create barriers to accessing mental health services due to affordability concerns and lack of employer support), was reframed as the macro-level megatrend: "**Implementing Systemic Supports for Employment Stability and Financial Security**", expanding the focus to address the broader systemic factors influencing financial well-being. It emphasises cross-sector collaboration among health systems, social services, and employment sectors to ensure that financial insecurity does not impede access to care. This includes advocating for policies that promote stable employment, providing direct financial assistance for mental health expenses, and ensuring employer-sponsored mental health benefits are accessible and manageable.

4.4.5 Reducing economic disparities through equitable resource distribution

Reducing economic disparities through equitable resource distribution is understood as a structural trend within the scope of this analysis, reflecting broader macro-level dynamics; regional economic inequality, redistributive policy choices, uneven public investment, and structural disparities in access to social and health resources. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **affordability dimension**, particularly in relation to equity in access, fair allocation of resources, and the reduction of structurally embedded financial barriers.

Addressing affordability in the context of **economic disparities and inequality** requires supply-side measures that reduce financial barriers and ensure equitable access to mental healthcare. Equity in cost burden is crucial, assessing whether financing mechanisms make services equally affordable for all income and employment groups. Insurance coverage breadth and depth, along with targeted financial protection mechanisms like fee waivers, transportation vouchers, or income-based subsidies, play a vital role in shielding vulnerable populations from high costs (Kayi et al., 2025).

Socioeconomic status (SES) is a significant determinant of mental health service utilisation. Individuals with lower SES are more likely to experience higher psychiatric morbidity but often have less access to mental health services (Amaddeo & Jones, 2007).

Migrants and refugees often face financial barriers due to low-income levels, which limit their ability to afford mental health services. Many are employed in low-wage jobs or are unemployed, exacerbating their financial instability (Franks et al., 2007). Systemic barriers, including discrimination and inequality, further limit access to mental health services for migrants and refugees. These barriers are often embedded within the healthcare system, affecting the availability and affordability of services (Baierl et al., 2024). Individuals from lower socioeconomic backgrounds often face financial barriers that limit their access to mental health services. This includes the inability to afford out-of-pocket expenses for mental health care, which is a significant issue for people with disabilities who may already face higher healthcare costs overall (Shokri, 2023). The high cost of mental health services, coupled with inadequate public funding and insurance coverage, disproportionately affects **LGBTQIA+** individuals, who may already face economic marginalisation due to discrimination in employment and housing (Macintyre et al., 2018; Izutsu & Tsutsumi, 2024). Systemic inequalities within the mental healthcare system contribute to the barriers faced by **older populations**. These include a lack of targeted interventions and policies that address the specific needs of disadvantaged groups, as well as insufficient funding for mental health services in underserved areas (Arundell et al., 2020). Economic inequality is linked to higher rates of mental health disorders, such as stress, anxiety, and depression, which are exacerbated in the aftermath of natural disasters (Huang, 2024).

The barrier "**Economic Disparities and Inequality**", including the widening gap between different socioeconomic groups, which limits access to affordable mental health services for disadvantaged populations), was reframed as the macro-level megatrend: "**Reducing Economic Disparities Through Equitable Resource Distribution**". This highlights the system's crucial role in advocating for and implementing policies that address broader economic inequalities.

4.4.6 Systemic financial resilience to safeguard the enduring affordability and availability of mental healthcare during economic changes and crises

Systemic financial resilience during economic changes and crises is understood as a structural trend within the scope of this analysis, reflecting broader macro-level dynamics; macroeconomic instability, fiscal adjustment policies, inflationary pressures, and the vulnerability of healthcare financing systems during crises. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **affordability dimension**, particularly in relation to the sustainability of service funding, protection from cost escalation, and continued affordability during periods of economic disruption.

Supply-side indicators for mental healthcare affordability during **economic changes and crises** focus on how effectively the system adapts to protect vulnerable groups from financial hardship. Key indicators include the flexibility of public financing and investment, reflecting the ability to maintain or increase funding for mental health services, reduce user fees, and prevent cost-shifting during economic downturns. Contingency planning measures, such as emergency funding mechanisms or targeted subsidies, ensure continuity of affordable care. Insurance systems are evaluated for their resilience in maintaining coverage breadth and depth, particularly when individuals lose employment-linked benefits, while scalable financial protection mechanisms (e.g., fee waivers, transportation vouchers) safeguard low-income or newly vulnerable populations. Monitoring and mitigating catastrophic health expenditure risks is critical, with data-driven policies aimed at preventing households from falling into debt due to mental health costs. Additionally, the proactive development of low-cost or free service models, such as publicly funded online programs or community-based initiatives, alongside efficient resource allocation, ensures services remain both accessible and affordable during crises.

In certain cases, austerity measures were linked to poorer mental health outcomes and increased inequalities, cautioning against shrinking welfare states (McAllister et al., 2018). **Migrants and refugees** often face financial barriers, such as high deductibles and co-pays, which are burdensome for low-income individuals. These financial constraints are exacerbated by economic downturns, which can lead to reduced income and increased unemployment among these populations (Neugebauer, 2024). Individuals with **physical and intellectual disabilities** face additional structural barriers, such as limited transportation options and inadequate healthcare facilities, which are compounded by economic crises (Neugebauer, 2024). The intersection of economic hardship and minority stress due to discrimination compounds the mental health challenges faced by LGBTQIA+ individuals, making it difficult for them to seek and receive appropriate care (Reynish et al., 2022; Zeeman et al., 2019). Economic crises, such as the Eurozone crisis, have disproportionately affected vulnerable populations, including the **Roma**, by increasing poverty and widening income inequality. This has led to a higher prevalence of mental health issues among these groups, as financial stress and unemployment exacerbate mental health problems (Themelis, 2016). High deductibles and co-pays are particularly burdensome for low-income individuals, including many **older adults** who rely on pensions that may be reduced during economic downturns (Neugebauer, 2024). **Youth**, especially those from marginalised groups such as refugees and asylum seekers, face additional barriers to accessing mental health services. These groups are often disproportionately affected by economic crises, which exacerbate existing inequalities and limit their access to care (Barbo, 2022; Barbo & Petrucka, 2024). **Natural disasters** increase the demand for mental health services, but economic crises limit the supply, creating a significant treatment gap (Silva et al., 2020).

The barrier, "**Economic Changes and Crises, Widening Inequalities**", such as economic downturns or financial crises, which exacerbate existing inequalities and further limit access to mental health services for vulnerable groups), was reframed as the macro-level megatrend: "**Building Systemic Financial Resilience**". This emphasises the system's responsibility to proactively protect mental healthcare access amid economic downturns by implementing measures such as emergency funding, flexible payment deferrals, and maintaining strong public investment in mental health services across all levels of care.

4.4.7 Structural trends

AFFORDABILITY

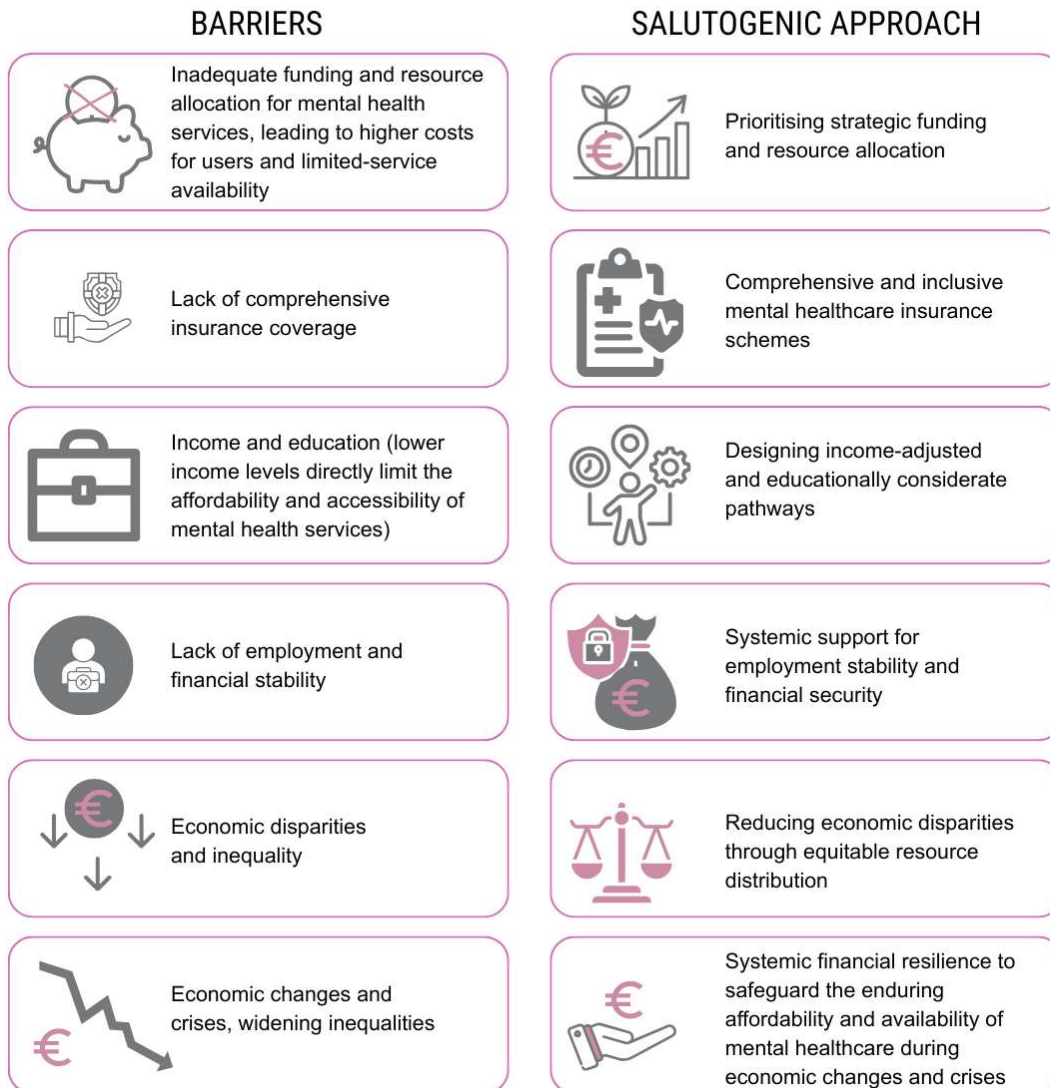


Figure 8: Affordability barriers to enablers

The barriers associated with the Affordability dimension were reframed to highlight the role of financing structures, social protection mechanisms, and economic resilience in shaping access to mental healthcare. Rather than treating cost related barriers as individual financial limitations, they were repositioned as systemic challenges linked to strategic funding priorities and resource allocation within mental healthcare systems. Insufficient or fragmented insurance coverage was translated into the need to establish comprehensive and inclusive mental healthcare insurance schemes that ensure coverage for preventive, community based, and specialised services. Income and education related constraints were reframed as the imperative to design income adjusted and educationally considerate pathways, ensuring affordability across diverse socioeconomic contexts. Employment instability and financial insecurity were reconceptualised as indicators of the need for systemic support for employment stability and financial security, recognising their direct influence on the ability to access and sustain mental healthcare. Broader economic disparities were translated

into the necessity to reduce inequalities through equitable resource distribution, prioritising disadvantaged and underserved populations. Finally, economic crises and downturns were reframed as drivers for strengthening systemic financial resilience, emphasising the importance of adaptive financing mechanisms capable of protecting access to mental healthcare during periods of economic instability.

4.5 Levesque: Appropriateness

Appropriateness refers to how well health services meet individuals' specific needs, considering timeliness, quality, and the adequacy of care. Truly appropriate care is coordinated, continuous, effective, and acceptable, going beyond mere availability or affordability. Poor-quality or fragmented services do not constitute meaningful access, as alignment with needs is essential for positive outcomes and user satisfaction.

Appropriateness	
Macro level trends affecting accessibility	References
Cultural, social determinants	(Abramson et al., 2002), (Ahad et al., 2023), (Aiello et al., 2018), (Baierl et al., 2024), (Collazos & Qureshi, 2005), (Dumke et al., 2024b), (Guerrero et al., 2023), (Krystallidou et al., 2023), (Limiri, 2024), (Lowther-Payne et al., 2023), (Müller, 2020), (Pantović & Djordjević, 2024), (Reynish et al., 2022), (Soares et al., 2024), (Sweileh, 2024), (Tarricone et al., 2019), (Teo, 2023), (Wasserman, 2024)
Structural and Systemic Barriers	(Clemente et al., 2022), (Delany-Moretlwe et al., 2015), (Dobrieva & Ananchenkova, 2023), (Drakos, 2024), (Elshaikh et al., 2023) (Galdava, 2024), (Hernandez-Tejada et al., 2024), (Lund & Burgess, 2021), (Maria et al., 2024), (Markey et al., 2024), (Puchner et al., 2018), (Rabheru, 2022), (Ressler, 2022), (Shaligram et al., 2024), (Spengler et al., 2023), (Watters, 2010), (Wise, 2009)
Lack of tailored and trauma informed care	(Bacchus, 2022), (Cations et al., 2020), (Dewey, 2022), (Guerrero et al., 2023), (Havens & Marr, 2017), (Huo et al., 2023), (Lê Cook et al., 2019), (Levington, 2023), (O'Malley et al., 2022), (O'Malley et al., 2024), (Qureshi et al., 2016), (Stroumsa et al., 2024), (Zhang et al., 2024)
Insufficient understanding of disability by service providers	(Carter et al., 2022), (Gréaux et al., 2023), (Lê Cook et al., 2019) (Lowther-Payne et al., 2023), (Marshall & Cahill, 2021), (Yarwood et al., 2022)
Demographic shifts, migration, ageing population	(Fernandes et al., 2015), (Khan, 2023), (Priebe et al., 2016), (Rabheru, 2022), (Solway et al., 2010)

Public health crises

(Alarcão et al., 2022), (Danilewitz et al., 2020), (Hynie et al., 2023) (Jarrett et al., 2021), (Malmquist et al., 2023), (Oakley et al., 2020) (OECD/European Union, 2021), (Siegel et al., 2021), (The mental distress of our youth, 2022)

Table 7: References related to Appropriateness barriers

4.5.1 Cultivating deep cultural competence and responsiveness across all mental healthcare services to appropriateness for diverse populations



**Grey literature derived trend:
“Lack of Culturally and Linguistically Appropriate Services”**

The appropriateness of mental healthcare for vulnerable populations in the EU is often undermined by limited cultural and linguistic sensitivity. Mental health systems frequently fail to account for the cultural values, beliefs, and lived experiences of migrants, refugees, and ethnic minorities, resulting in ineffective care and reduced trust in services (European Red Cross, 2023). Language barriers further restrict access, as many individuals lack access to trained interpreters or professionals fluent in their native language. This hampers communication, accurate diagnosis, therapeutic rapport, and the tailoring of interventions. As a result, minority groups underutilise mental health services due to language difficulties, lack of culturally responsive care, and fears of discrimination, including differential treatment based on appearance or limited language proficiency (Mental Health Europe, 2024). Even when legal access exists, linguistic and cultural barriers limit individuals’ ability to benefit from care, leading to misunderstandings, poor adherence to treatment, and worse outcomes. The COVID-19 pandemic exposed critical gaps in multilingual health communication, highlighting that effective care requires not only translation but also cultural understanding (Migration Policy Institute, 2024). Additionally, insufficient training in culturally competent care among mental health professionals contributes to misdiagnosis and inappropriate treatment, while experiences of bias and racism within healthcare settings further exacerbate psychological distress and mistrust (Mental Health Europe, 2024).

Deep cultural competence and responsiveness across mental healthcare services are understood as structural trends within the scope of this analysis, reflecting broader macro-level dynamics; migration and population diversity, insufficient integration of intercultural approaches in health policy, and uneven investment in culturally competent workforce development. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **appropriateness dimension**, particularly in relation to relevance, responsiveness, and the capacity of care to align with the needs of diverse populations.

In the context of **cultural and social determinants**, it is essential that services are designed and delivered to meet the diverse needs of individuals while respecting their cultural, linguistic, and social contexts. Key indicators include culturally appropriate service design that aligns with the beliefs, values, and traditions of different population, along with cultural competence training, diversity among staff. Respectful and empathetic communication, free from judgment or discrimination, is essential to patient engagement. Systemic indicators outlined in T1.2 include the functional integration of mental health services with social, educational, and employment sectors, as well as

co-production with communities to ensure policies and services reflect lived experiences and real needs. Finally, the presence of robust legal and policy frameworks that protect human rights, prohibit discrimination, and promote inclusion further ensures that services are context-sensitive and appropriate for all cultural and social groups.

Cultural and social determinants as significant barriers to accessing mental healthcare services, highlighting how cultural beliefs and attitudes influence the perception of mental illness (Ahad et al., 2023; Limiri, 2024; Wasserman, 2024; Lowther-Payne et al., 2023; Dumke et al., 2024). However, many healthcare systems lack the necessary training and awareness to provide culturally sensitive care. This can lead to mistrust and reluctance to seek help among minority groups (Collazos & Qureshi, 2005).

Cultural competence involves understanding and respecting the cultural backgrounds and values of patients, which is often lacking in the current mental healthcare systems in the EU. Cultural differences can affect symptom presentation and the diagnostic process, as healthcare providers may not be familiar with culturally specific expressions of mental health issues (Tarricone et al., 2019). Stigma related to mental illness can differ significantly between genders, influenced by cultural norms and expectations (Ahad et al., 2023). Language barriers are a significant impediment to accessing mental healthcare for **migrants and refugees**. The lack of language support options often results in miscommunication and misunderstanding between healthcare providers and patients, leading to inadequate care (Krystallidou et al., 2023; Müller, 2020; Soares et al., 2024). **LGBTQIA+ migrants and refugees** may encounter additional layers of discrimination and stigma, which can deter them from seeking mental healthcare (Baierl et al., 2024). Language barriers are a significant obstacle for **individuals with intellectual disabilities**, as they often face challenges in communication that can prevent them from accessing appropriate healthcare services. This can lead to poorer health outcomes compared to the general population (Teo, 2023). **LGBTQIA+** individuals often face compounded discrimination due to intersecting identities, such as race, gender, and sexual orientation, which can exacerbate mental health issues and hinder access to appropriate care (Reynish et al., 2022). Gender-specific challenges, such as those faced by transgender individuals, are often not adequately addressed in mental health services, leading to further marginalization (Sweileh, 2024). Language barriers are a significant impediment to accessing mental healthcare for the **Roma**, as many Roma individuals do not speak the dominant language of the country they reside in, limiting their ability to communicate effectively with healthcare providers (Guerrero et al., 2023). Cultural differences, including traditional beliefs and practices, often clash with the medical models used in mental healthcare, leading to misunderstandings and mistrust between Roma patients and healthcare providers (Pantović & Djordjević, 2024) (Aiello et al., 2018). There is a lack of cultural competence among healthcare providers, which affects their ability to understand and address the unique needs of diverse **older populations** (Abramson et al., 2002). The absence culturally and linguistically appropriate interpreters and culturally tailored mental health interventions can prevent **young people** from accessing the care they need (Soares et al., 2024).

The barrier, **"Cultural and Social Determinants"**, including language and cultural barriers, gender and intersectionality, lack of cultural competence and trust, and the absence of culturally and linguistically appropriate services, was reframed as the macro-level megatrend: **"Proactively Cultivating Deep Cultural Competence and Responsiveness Across All Mental Healthcare Services"**. This highlights the system's responsibility to integrate cultural, linguistic, and intersectional awareness into every level of care, ranging from primary prevention initiatives to

secondary and tertiary treatments, ensuring that services resonate with individuals' values, beliefs, and lived experiences.

4.5.2 Reorienting Systemic Structures Towards Person-Centred and Rights-Based Approaches

Structural and systemic barriers are understood as structural trends within the scope of this analysis, reflecting broader macro-level dynamics; fragmented governance, institutional rigidity, inadequate policy coordination, and long-standing inequities embedded within healthcare system organisation. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **appropriateness dimension**, particularly in relation to the coherence, responsiveness, and overall suitability of mental healthcare provision.

In regards to addressing **structural and systemic barriers**, the focus is on how well services are tailored, rights-based, and person-centred. Key indicators outlined in T1.2 include the system's responsiveness to individual needs through accurate assessments, culturally sensitive care, and treatment plans that reflect the preferences and values of diverse subgroups. Adequacy of clinical effort, with sufficient time and resources devoted to complex needs, underscores the system's commitment to quality care. Systemic integration and coordination, across physical, mental, and social services, as well as with education and employment sectors, ensure holistic and continuous care, while co-production with communities ensures inclusivity and responsiveness.

The healthcare systems in many EU countries are not adequately equipped to address the specific needs of **migrants and refugees**. This includes a lack of culturally appropriate services and insufficient training for healthcare providers in cultural competence (Markey et al., 2024; Watters, 2010). There is a notable absence of person-centred care approaches that consider the individual needs and rights of migrants and refugees. This can lead to a one-size-fits-all approach that fails to address the unique challenges faced by these groups (Puchner et al., 2018; Dobrieva & Ananchenkova, 2023). Rights-based approaches, which emphasize the right to health and equitable access to services, are often not fully implemented, leaving migrants and refugees without adequate support and protection in the healthcare system (Dobrieva & Ananchenkova, 2023). There is a notable lack of training among healthcare professionals regarding the specific needs and rights of **individuals with disabilities**. This gap in knowledge can result in suboptimal care and a lack of understanding of how to effectively communicate and engage with these patients (Clemente et al., 2022). **LGBTQIA+** individuals often encounter healthcare environments that are not tailored to their specific needs, leading to poor quality services and unmet mental health needs. This is exacerbated by a heterocentric healthcare environment that fails to recognise the unique health disparities faced by this community (Galdava, 2024; Lund & Burgess, 2021). The absence of LGBTQIA+-attuned professionals and a lack of comprehensive, inclusive healthcare services further compound these issues, particularly in rural areas where services are limited (Maria et al., 2024). Structural barriers such as cost, time, and lack of knowledge on how to access services are major impediments to mental health care for LGBTQIA+ individuals. These barriers are often the strongest predictors of help-seeking intentions among sexual minorities (Spengler et al., 2023). **Older adults** often face ageism, which intersects with other forms of discrimination such as ableism, leading to violations of their human rights and poor quality of life (Rabheru, 2022). This discrimination is evident in the limited access to age-appropriate mental health services, such as out-of-hours and crisis services, and

psychological treatments (Wise, 2009). In addition, there is a significant gap in the provision of mental health services that are specifically designed for older adults. Many older individuals prefer informal help over professional services due to stigma and negative beliefs about mental health care (Elshaikh et al., 2023). This preference is exacerbated by the lack of services that cater to their unique needs, such as those related to trauma or elder mistreatment (Hernandez-Tejada et al., 2024). Mental healthcare services often lack a person-centred approach, which is essential for addressing the specific needs of vulnerable **youth populations**. This includes the need for holistic evaluations and comprehensive care plans that consider the individual's context and experiences (Shaligram et al., 2024; Delany-Moretlwe et al., 2015). Ineffective policy decisions and a lack of inclusive policymaking contribute to the neglect of youth mental health needs. This is particularly concerning given the high incidence of mental health issues among young people (Drakos, 2024). **Natural disasters** often weaken social support networks, which are crucial for mental health recovery. The loss of these networks can exacerbate mental health issues and hinder recovery efforts (Ressler, 2022).

The barrier, "**Structural and Systemic Barriers**", such as insufficient tailoring of services to the specific needs of vulnerable groups, including a lack of person-centred and rights-based approaches, was reframed as the macro-level megatrend: "**Reorienting Systemic Structures Towards Person-Centred and Rights-Based Approaches to Guarantee the Meaningful and Individualised Appropriateness of Mental Healthcare.**" This reorientation emphasises the system's responsibility to embed autonomy, respect, and individual rights into all levels of care, primary, secondary, and tertiary, ensuring that services move beyond standardised models toward truly personalised interventions.

4.5.3 Integrating trauma-informed principles and highly individualised care to ensure sensitive and meaningful appropriateness of mental healthcare



Grey literature derived trend:
"Lack of Person-Centred and Rights-Based Approaches"

A person-centred and rights-based approach places individuals at the heart of mental healthcare, ensuring that care respects their needs, preferences, dignity, and autonomy while promoting non-discrimination and inclusion. To improve the appropriateness and ethical quality of care, mental health systems must fully operationalise these approaches through informed choice, accessible information, shared decision-making, and recovery-oriented services. The COVID-19 pandemic highlighted gaps in this regard: people living with non-communicable diseases (NCDs), such as diabetes, experienced significant mental health deterioration due to service disruptions and isolation. Over half of respondents with diabetes reported worsening mental health, and more than 40% reported increased anxiety during the pandemic (International Diabetes Federation Europe, 2023). Similarly, people with disabilities or chronic conditions have faced heightened mental health challenges, yet their needs are often overlooked despite strong links between physical and mental health. Addressing this requires integrated, multidisciplinary care that combines long-term physical treatment with accessible mental health support (Scholz, 2021). Across the EU, insufficient training in culturally sensitive care among healthcare professionals contributes to misdiagnosis and inadequate treatment, particularly for minority populations. Limited understanding of structural racism and social inequality within health systems deepens disparities and can lead to discriminatory practices (Mental Health Europe, 2024). Racism

exacerbates mental health challenges through social exclusion, discrimination, and violence, disproportionately affecting racialised groups, including Black and Muslim individuals. These inequalities are reflected in mental healthcare, where biased treatment and diagnostic delays persist; women of colour, for example, face higher mental health risks but often receive poorer-quality care (Mental Health Europe, 2024). Refugees also encounter major barriers, as access to psychological support during the asylum process is often severely limited and marked by underdiagnosis or misdiagnosis (European Greens, 2025).

The integration of trauma-informed principles and highly individualised care is understood as a structural trend within the scope of this analysis, reflecting broader macro-level dynamics; crisis exposure, displacement, violence, and insufficient institutionalisation of trauma-informed approaches within policy and service design frameworks. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **appropriateness dimension**, particularly in relation to sensitivity, individual relevance, and the capacity of services to respond meaningfully to lived experiences of trauma.

In regards to addressing the **lack of tailored and trauma-informed care**, the focus is on ensuring that mental healthcare services are responsive, sensitive, and individualised. Key indicators outlined in T1.2 include the capacity of services to accurately assess and meet the unique needs of trauma survivors through evidence-based, context-sensitive treatment plans and sufficient clinical effort to manage complex cases. Respectful, empathetic, and culturally sensitive care delivery is critical to building trust, avoiding re-traumatization, and ensuring the acceptability of services. The presence of trauma-informed training for professionals along with mental health are essential (Kayi et al., 2025).

A multi-level approach tailored to the unique needs of diverse populations was deemed necessary for effective intervention (Zhang et al., 2024). Effective implementation of trauma-informed care (TIC) requires strong leadership and adequate resources. Many organizations lack the financial and staffing resources necessary to support TIC initiatives, which can lead to inconsistent application and support for trauma survivors. Despite the recognised benefits of trauma-informed care, its implementation is often hindered by organisational barriers such as insufficient leadership engagement, lack of resources, and resistance to change within healthcare systems (Huo et al., 2023). Healthcare providers often do not receive adequate training in trauma-informed care, which is essential for understanding and addressing the complex needs of trauma survivors. This lack of training can lead to re-traumatization and a reluctance among **refugees** to seek care (Qureshi et al., 2016; Huo et al., 2023). Individuals with **intellectual disabilities** are disproportionately affected by trauma, yet services often fail to recognise and address this. The lack of empirical research and tailored interventions for this population further exacerbates the issue (Dewey, 2022; Levington, 2023). **LGBTQIA+** individuals frequently encounter stigma and discrimination within healthcare settings, which can exacerbate trauma and deter them from seeking care. This is particularly true for transgender and nonbinary individuals who face unique forms of minority stress and stigma, leading to disparities in health outcomes (Stroumsa et al., 2024). Experiences of racism and discrimination within healthcare settings discourage **Roma** individuals from seeking care. Negative interactions with healthcare providers, who may lack understanding or sensitivity towards Roma culture and trauma history, contribute to a distrust of the healthcare system (Guerrero et al., 2023; Lê Cook et al., 2019).

A significant proportion of **older adults** have experienced at least one traumatic event, with estimates suggesting up to 70% have such experiences, and 20-40% may develop PTSD (Cations et al., 2020). Trauma symptoms can resurface in later life, exacerbated by aging-related challenges such as medical illnesses and loss of loved ones. Despite the recognised need though, there is a lack of formal TIC models in long-term care settings, which are crucial for mitigating the effects of trauma in older adults (O'Malley et al., 2024; O'Malley et al., 2022). Inadequate screening processes for trauma exposure in youth can lead to misdiagnosis or underdiagnosis of trauma-related conditions, resulting in inappropriate treatment plans (Havens & Marr, 2017).

From "Lack of Tailored and Trauma-Informed Care" where services fail to address the unique needs of individuals, particularly those with a history of trauma, through sensitive and individualised approaches, to: **"Systemically Integrating Trauma-Informed Principles and Highly Individualised Care"**. This emphasises the system's responsibility to recognise the pervasive impact of trauma and embed trauma-informed principles throughout all levels of care (e.g., trauma-informed primary care screening, secondary therapy, tertiary residential care). By ensuring that services are delivered with sensitivity, respect, and a deep understanding of individual experiences, care becomes profoundly *meaningful* and safe, increasing its *appropriateness* and effectiveness for those with trauma histories.

4.5.4 Strengthening systemic competence and training on disability to ensure highly accommodating appropriateness of mental healthcare



Grey literature derived trend:
"Insufficient Tailoring to Specific Needs of Vulnerable Groups"

A further barrier to the appropriateness of mental healthcare services within the European Union is the insufficient adaptation of care models to the distinct needs of different vulnerable populations. Mental health needs, as well as the obstacles to accessing care can differ significantly between groups such as children, adolescents, older adults, persons with disabilities, and LGBTQ+ individuals. Despite these differences, mental health systems often rely on standardised, "one-size-fits-all" approaches that fail to account for the specific contexts, experiences, and risk factors affecting each group (European Parliament, 2022). For example, children and adolescents may require developmentally appropriate interventions that account for their cognitive and emotional stages, while older adults might struggle with isolation, physical health comorbidities, or bereavement. People with disabilities often encounter additional structural and communicative barriers, and LGBTQ+ individuals may face stigma, discrimination, and mental health burdens linked to social exclusion. Applying generic solutions across these diverse populations' risks overlooking key psychological, social, and cultural dimensions of care, thereby undermining both relevance and effectiveness (WHO, 2025). To enhance the appropriateness of mental health support, it is critical to design and implement targeted, group-specific interventions that respond to the realities and priorities of each population. This requires a deep understanding of the unique stressors, vulnerabilities, and resilience factors that influence mental well-being within each group. It also necessitates inclusive collaboration with affected individuals and the civil society organisations that represent them. The European Parliament has called for a comprehensive policy shift toward a "mental-health-in-all-policies" approach, which recognises that mental health is shaped by a wide range of socioeconomic, environmental, and biological factors. This framework advocates for cross-sectoral strategies to prevent and manage

mental health conditions throughout the life course. Crucially, it highlights the need to prioritise access for groups facing compounded vulnerabilities including youth, LGBTQIA+ individuals, migrants, ethnic minorities, the elderly, and those living with chronic conditions or disabilities (European Parliament, 2023).

Systemic competence and training on disability are understood as structural trends within the scope of this analysis, reflecting broader macro-level dynamics; disability policy implementation gaps, insufficient professional training structures, and limited integration of accessibility and inclusion principles within mental healthcare systems. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **appropriateness dimension**, particularly in relation to accommodation, inclusiveness, and the adequacy of care for persons with disabilities.

In regards to addressing **insufficient understanding of disability** the focus is on ensuring that mental healthcare services are inclusive, tailored, and responsive to the unique needs of individuals with disabilities. The availability of adequately trained staff and mental health training for front-line actors (e.g., teachers, emergency responders, and primary care staff) ensures early recognition and appropriate responses. Service design must be need-responsive, adaptable to diverse subgroups, and supported by accessible facilities that eliminate physical barriers.

The insufficient understanding of disability by service providers in Europe significantly impacts the adequacy of mental health care for individuals with disabilities. The lack of awareness and training among service providers leads to inadequate support and care, creating barriers for individuals with disabilities seeking mental health services. This problem is compounded by systemic issues within the healthcare system, including a lack of resources and training opportunities for healthcare professionals. The healthcare system in Europe faces systemic barriers that hinder the provision of appropriate mental health care for individuals with disabilities. These include organizational failures, lack of resources, and physical barriers within healthcare facilities (Gréaux et al., 2023). Service providers often struggle to access necessary information and resources to support individuals with disabilities effectively. This lack of access to information is a critical barrier that affects the quality of care provided (Carter et al., 2022).

For **migrants and refugees**, cultural explanatory models of mental distress are frequently misunderstood or ignored, creating barriers between service users and providers. Providers often exclude patients with complex mental health presentations from services, demonstrating inadequate competency in managing the multifaceted needs of refugee populations (Marshall & Cahill, 2021). Significant competency gaps exist in providing affirming mental healthcare to **LGBTQIA+** populations. Key barriers include lack of provider competency in caring for LGBTQIA+ patients and discrimination based on multiple marginalised identities (Yarwood et al., 2022). Service providers in both asylum and health systems require training for affirmative, culturally sensitive, and intersectional approaches (Ladegard et al., 2022). **Roma** communities report predominantly negative experiences with mental health services, including lack of understanding from healthcare providers and instances of racism and discrimination (Lê Cook et al., 2019). Age-related competency gaps manifest differently across the lifespan. For **older adults**, providers often lack understanding of age-specific mental health presentations, comorbidity management, and ageism's impact on care access (Lowther-Payne et al., 2023).

The barrier "**Insufficient Understanding of Disability by Service Providers**" which results in inadequate support and a lack of proper care for individuals with disabilities due to limited awareness and training among service providers, was reframed as the macro-level megatrend: "**Strengthening Systemic Competence and Training on Disability to Ensure Appropriateness of Mental Healthcare for Individuals with Diverse Abilities.**" This highlights the system's proactive responsibility to educate and train all mental health providers, across primary, secondary, and tertiary levels, on the specific needs, rights, and lived experiences of individuals with disabilities. By embedding respectful accommodation and fostering a deep understanding of disability, mental healthcare becomes not only more meaningful and trustworthy but also more manageable and inclusive. This ensures that people with disabilities can access tailored, appropriate care that supports their well-being and prevents additional barriers or stress, reinforcing effective prevention and recovery pathways.

4.5.5 Proactively adapting service design and delivery to ensure meaningful and contextually appropriate mental healthcare in response to evolving demographic shifts

The proactive adaptation of service design and delivery in response to demographic shifts is understood as a structural trend within the scope of this analysis, reflecting broader macro-level dynamics; ageing populations, migration, changing social structures, and territorial demographic transformations. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **appropriateness dimension**, particularly in relation to contextual relevance, flexibility, and the ability of services to remain aligned with evolving population needs.

In regards to addressing **demographic shifts** the focus is on tailoring mental healthcare services to meet the unique needs of diverse groups, such as migrants and aging populations. Services must demonstrate adaptability across subgroups, ensuring care is clinically sound, culturally competent, and sensitive to age-related conditions. Respectful and empathetic provider interactions, culturally sensitive communication, and comprehensible, multilingual information are critical for fostering trust and engagement.

The ageing population in Europe is projected to increase significantly, with a 70% rise in those aged over 65 and a 170% increase in those over 80 by 2050. This demographic shift places immense pressure on healthcare systems, particularly in managing chronic diseases and mental health disorders, which are prevalent in older adults (Fernandes et al., 2015). Ageism, often intersecting with other forms of discrimination, exacerbates the mental health challenges faced by older adults. This bias can lead to violations of human rights and poor quality of life for older individuals (Rabheru, 2022). The ageing population in Europe presents unique challenges for mental healthcare, particularly for **older adults** from diverse backgrounds. These individuals may face additional barriers related to language, cultural beliefs, and socioeconomic status (Solway et al., 2010). Poor socioeconomic conditions, including unstable housing and financial insecurity, exacerbate mental health issues and limit access to care. These conditions are prevalent among migrants and refugees, who may also face discrimination and social exclusion (Priebe et al., 2016). The intersection of migration with ageing populations requires healthcare systems to be adaptable and culturally sensitive, ensuring that services are accessible and appropriate for diverse populations (Khan, 2023).

The barrier, "**Demographic Shifts**", such as migration and an ageing population, which create a need for mental health services to be tailored to the specific needs of diverse demographic groups, was reframed as the macro-level megatrend: "**Proactively Adapting Service Design and Delivery**". This reframing underscores the system's responsibility to remain agile and responsive by tailoring mental health services to the specific and changing needs of diverse populations, including older adults and migrant communities. By embedding culturally appropriate interventions, age-sensitive care models, and contextually relevant outreach strategies across primary, secondary, and tertiary levels, the system ensures that mental healthcare remains both meaningful and effective.

4.5.6 Building systemic agility and innovation to ensure the adapted interventions and flexible service delivery models of mental healthcare interventions during public health crises

Systemic agility and innovation in mental healthcare during public health crises are understood as structural trends within the scope of this analysis, reflecting broader macro-level dynamics; emergency governance, crisis preparedness, innovation capacity, and the resilience of health systems under disruption. Examined through the Levesque framework as an operational lens, their effects are analysed in structural terms of service-level accessibility conditions. In this context, they primarily influence the **appropriateness dimension**, particularly in relation to adaptability, relevance of interventions, and the flexibility of service delivery models during crisis conditions.

In regards to addressing public **health crises** the focus is on the system's ability to adapt, remain responsive, and maintain quality care under challenging conditions. Key indicators outlined in T1.2 include the rapid adaptation of services to emerging needs, reduced wait times for urgent cases, and the implementation of flexible contact and appointment mechanisms such as virtual consultations and walk-in options. Expanding remote and digital service delivery, while ensuring alignment with individuals' crisis-related constraints (e.g., caregiving or work challenges), is essential to maintain continuity of care. Effective integration between mental health, general healthcare, and other sectors (e.g., social services, education, and employment) ensures holistic and context-sensitive support (Kayi et al., 2025).

The pandemic has highlighted and intensified existing inequalities in mental health service provision for **migrants and refugees**. The shift to virtual mental health services, while beneficial for some, has created new barriers for those without access to technology or the internet (Hynie et al., 2022; Alarcão et al., 2022). Additionally, the pandemic has increased the mental health burden on migrants and refugees, who are already at higher risk for mental health disorders due to pre-migration trauma and post-migration stressors (Alarcão et al., 2022). Individuals with **intellectual disabilities** faced significant barriers in accessing COVID-19 related health services, including testing and treatment. This exclusion was often due to communication challenges and ICU triage protocols that indirectly discriminated against these groups, leading to a lack of appropriate care and support during the pandemic. In addition, the pandemic led to interruptions in standard health and social care services, leaving a large percentage of individuals with disabilities without necessary support. This disruption in services further highlighted the inadequacies in the mental healthcare system's ability to provide continuous and appropriate care during crises (Oakley et al., 2020). COVID-19 restrictions have limited access to mental health services, with many **LGBTQIA+** individuals unable to access in-person support or community resources. This has been particularly challenging for those in non-affirmative households, where isolation can exacerbate mental health issues (Malmquist et al.,

2023). The shift to telehealth services, while beneficial for some, has not fully addressed the needs of LGBTQIA+ individuals, particularly those requiring gender-affirming care or those without access to private, safe spaces for virtual consultations (Jarrett et al., 2021). The pandemic led to a significant interruption in traditional face-to-face mental health services, which were not adequately replaced by virtual alternatives for **older adults**. This disruption was due to the rapid transition to virtual care, which many older adults found challenging to navigate due to technological barriers and a lack of digital literacy (Siegel et al., 2021; Danilewitz et al., 2020). The pandemic has led to a significant rise in mental health issues among **young people**, with symptoms of depression and anxiety more than doubling in several European countries (OECD, 2021).

The barrier, **"Impact of Public Health Crises"** (e.g., COVID-19) on Mental Health Services which highlights the need for adapted interventions and flexible service delivery models to address the evolving challenges posed by such crises" was reframed as the macro-level megatrend: ***"Building Systemic Agility and Innovation to Ensure Adapted Interventions and Flexible Service Delivery Models"***. This reframing emphasises the system's capacity for rapid, evidence-based adaptation to evolving challenges, ensuring that mental health services remain effective and meaningful even during periods of disruption. It calls for the proactive development of crisis-responsive strategies, such as swift transitions to telehealth, targeted outreach, and specialised programs like grief and trauma support across primary, secondary, and tertiary care. By maintaining relevance and flexibility, the system ensures the appropriateness and continuity of mental healthcare during times of heightened stress.

4.5.7 Structural trends

APPROPRIATENESS

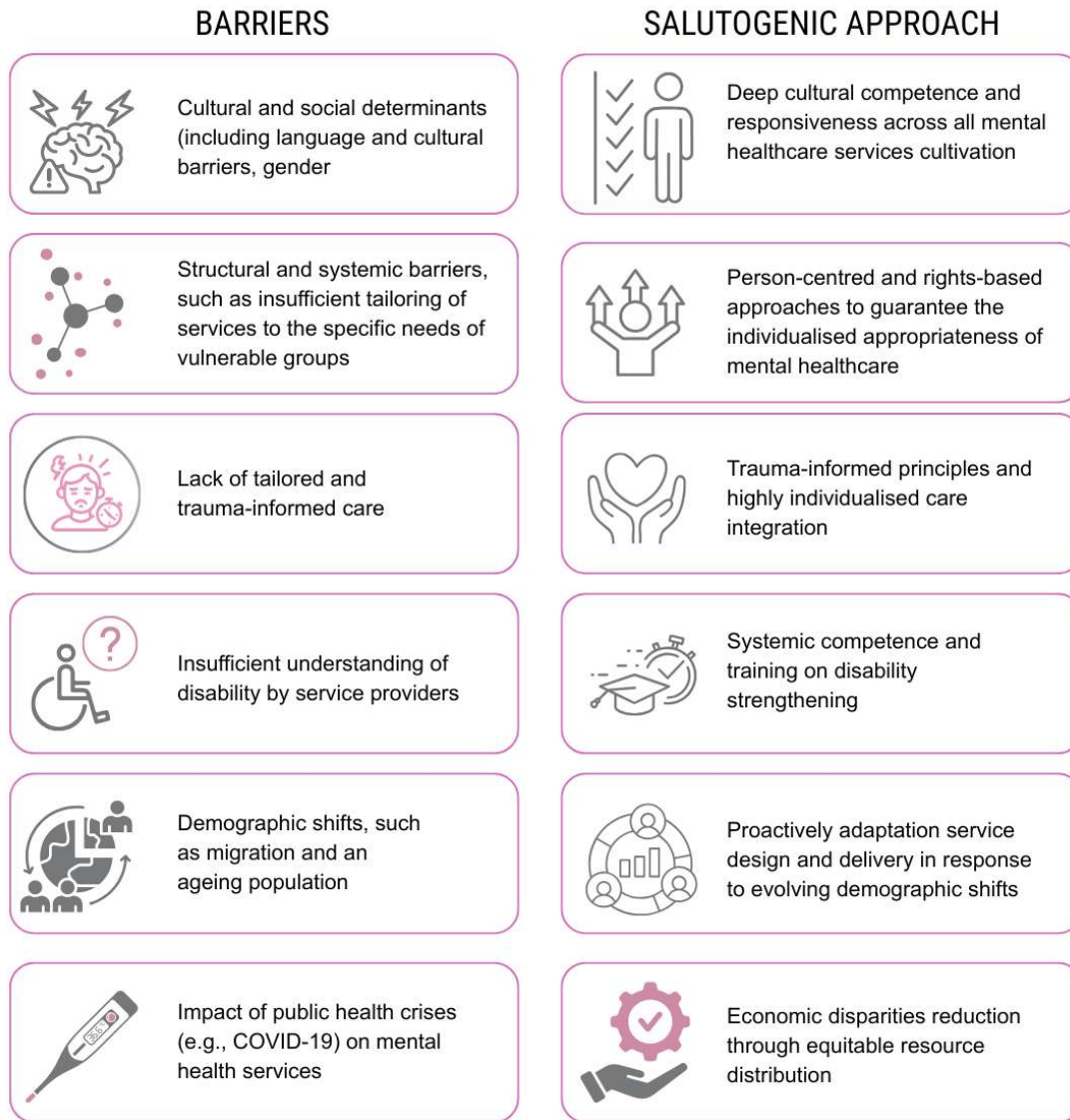


Figure 9: Appropriateness barriers to enablers

The barriers identified within the Appropriateness dimension were reinterpreted to deliver care that is responsive, person centred, and aligned with diverse and evolving needs. Rather than framing cultural and social determinants as external constraints, they were reconceptualised as a call to cultivate deep cultural competence and responsiveness across mental healthcare services, ensuring care is appropriate, trusted, and relevant for diverse populations. Structural and systemic barriers, including rigid service designs and rights-based gaps, were reframed as the need to prioritise person centred and rights-based approaches that recognise individual needs, histories, and contexts. Deficits in tailored and trauma informed care were translated into the integration of trauma informed principles within highly individualised care models, acknowledging the importance of emotional safety and meaningful engagement, particularly for individuals with histories of trauma. Limited understanding of disability among providers was reframed as the need to strengthen systemic

competence through ongoing training and disability inclusive practice, ensuring appropriate care for individuals with diverse abilities. Demographic shifts were reconceptualised as drivers for proactively adapting service delivery models to ensure responsiveness to changing population needs across life stages and social contexts. Finally, disruptions linked to public health crises were repositioned as imperatives to build systemic agility and innovation, enabling flexible, adaptive, and resilient models of care that maintain appropriateness during periods of rapid change and increased demand.

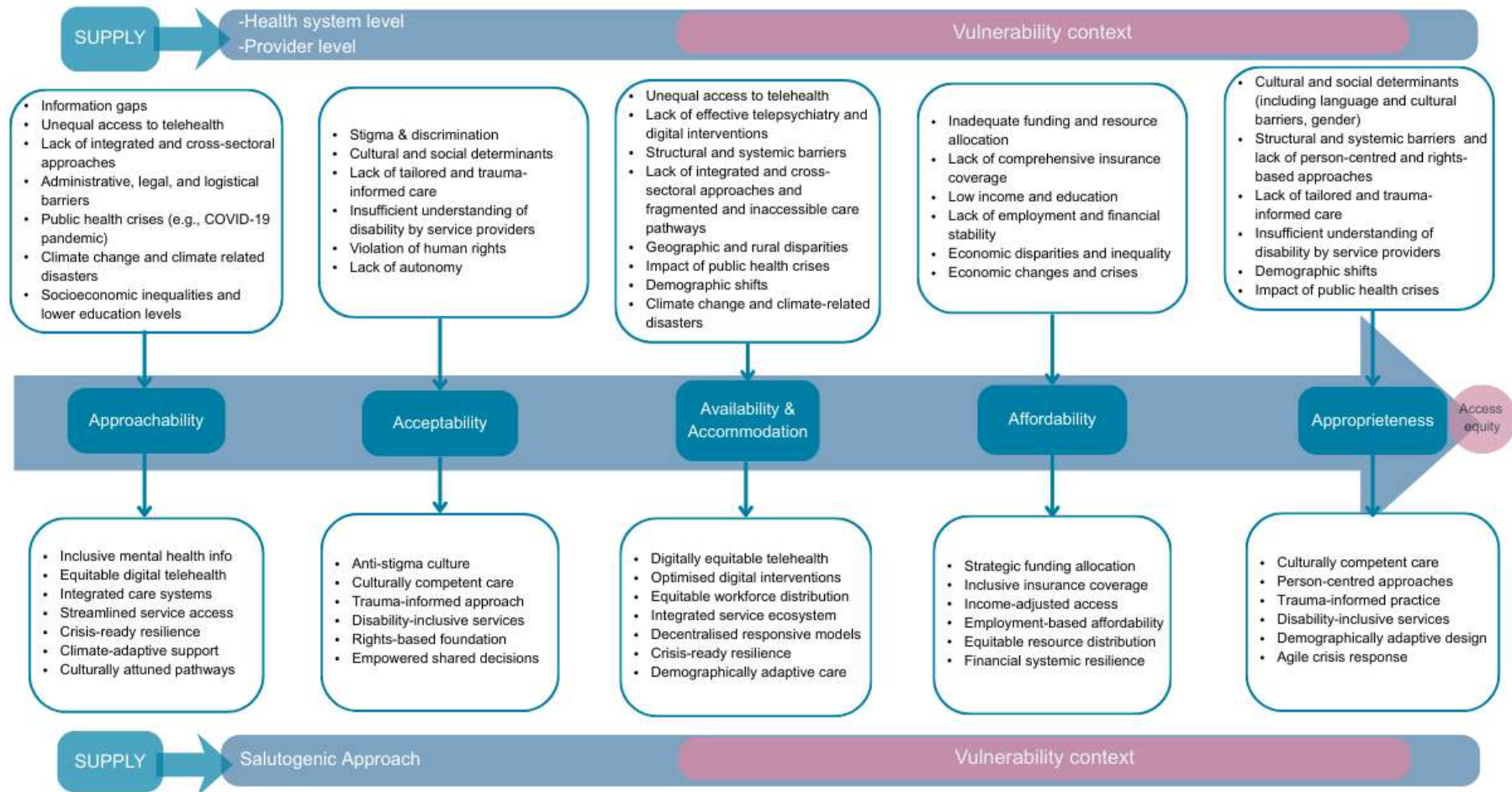


Figure 10: Barriers transformed into enablers through the Salutogenic approach

4.6 Interdimensional Structural trends

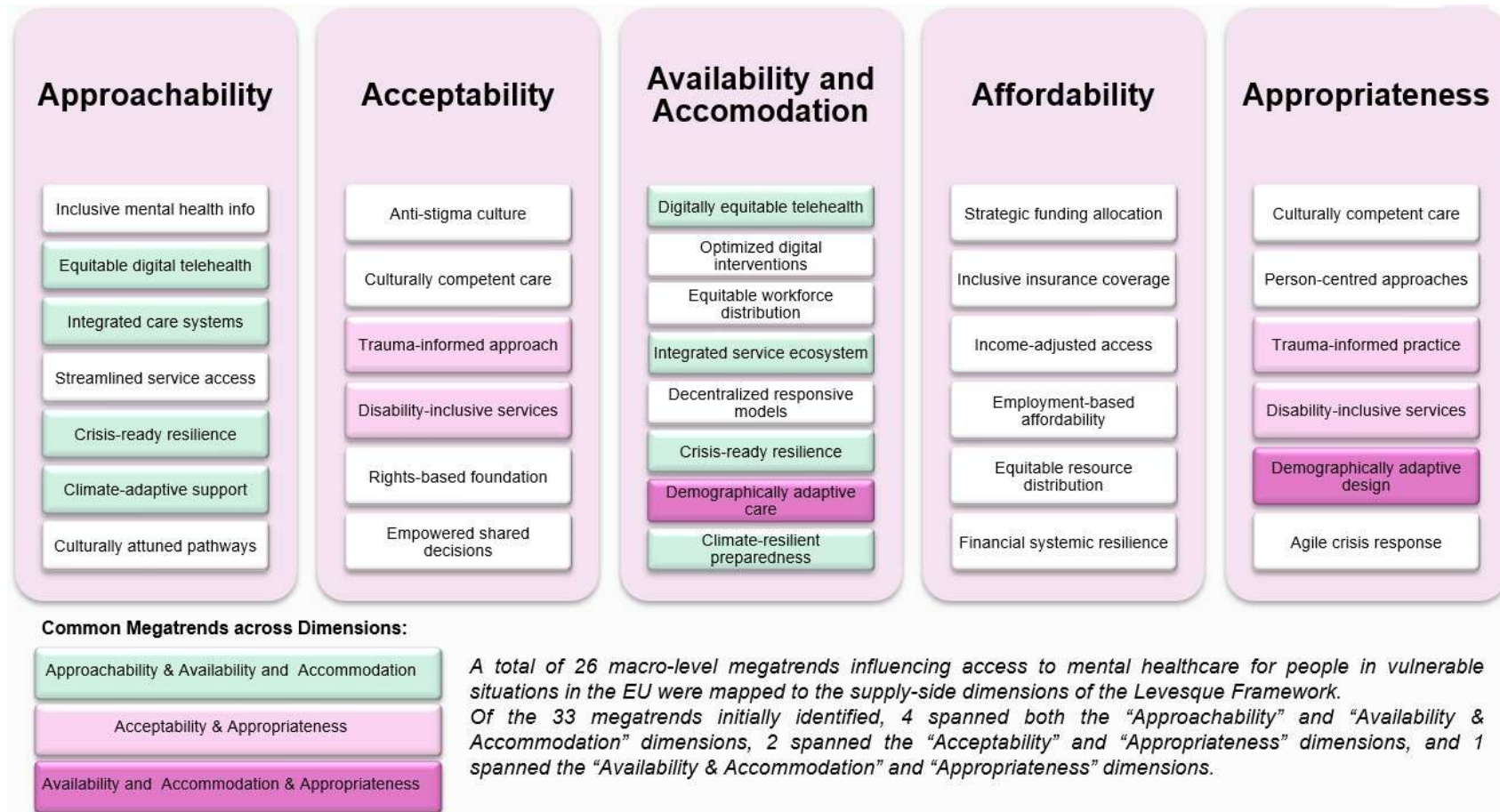


Figure 11: Trends identified in each dimension

The analysis identified a subset of interdimensional megatrends that extend beyond a single access dimension of the Levesque framework, reflecting their systemic and cross-cutting nature. These megatrends were categorised as interdimensional as their impact simultaneously influences multiple determinants of access. For example, “Equitable digital telehealth” and “Integrated care systems” affect both **Approachability** (visibility, navigation, initial engagement) and **Availability & Accommodation** (service capacity and delivery models). Similarly, “Trauma-informed approach” and “Disability-inclusive services” bridge **Acceptability** and **Appropriateness**, as they shape both the cultural legitimacy of care and its clinical responsiveness. Megatrends such as “Demographically adaptive care” span **Availability & Accommodation** and **Appropriateness**, reflecting the need to align workforce distribution and service models with population needs while ensuring person-centred and context-sensitive interventions.

Their classification as interdimensional underscores the interconnected structure of access barriers and solutions. These megatrends operate at the structural level, influencing governance, service design, and system organisation rather than addressing isolated service components. As such, they cannot be meaningfully confined to a single dimension without underrepresenting their broader systemic implications. Categorising them as interdimensional allows the analysis to capture their integrative function within the access framework and highlights that sustainable improvements in mental healthcare equity require coordinated reforms across multiple access domains simultaneously.

This integrative perspective directly informed the subsequent design of the Delphi Survey. In forming the final questionnaire, megatrends were not treated as isolated thematic items but were structured to reflect their cross-dimensional relevance, allowing experts to evaluate their anticipated impact across interconnected domains of access. By preserving their interdimensional character within the survey instrument, the Delphi process was able to capture systemic priorities and identify which cross-cutting reforms are perceived as most critical for shaping equitable mental healthcare over the next 15 years.

5. Delphi Survey

5.1 Delphi Methodology

The Delphi method is a structured, iterative process used to reach group consensus by surveying a panel of experts across multiple questionnaire rounds, with anonymised feedback shared after each round to allow participants to revise their views in light of collective responses (Sablitzky, 2022). Originating in the 1950s at the RAND Corporation¹⁷, the method was designed to elicit informed judgement from geographically dispersed experts on complex or uncertain issues (Crisp et al., 1997; Humphrey-Murto et al., 2020). The approach is grounded in the principle that pooled expert intelligence can enhance individual judgement and generate more robust collective insights (Shariff, 2015).

A typical Delphi process involves the careful selection of experts with relevant expertise, followed by the design and administration of an initial questionnaire. Responses are analysed to identify areas of agreement and divergence, and feedback is provided to participants in subsequent rounds. This process is repeated until predefined consensus criteria- often based on percentage agreement thresholds - are met. By maintaining anonymity and structured feedback, the Delphi method minimises the influence of dominant individuals while supporting reflection and refinement of opinions (Shariff, 2015; Crisp et al., 1997).

The Delphi method is widely used in mental healthcare research to support consensus-building on complex policy, clinical, and system-level issues (Hasson et al., 2000). Its iterative design enables interdisciplinary dialogue and the integration of diverse perspectives from clinicians, researchers, and policymakers, strengthening the validity and credibility of findings. The quality of outcomes depends on appropriate expert selection and clear question design, while repeated feedback cycles encourage reconsideration of initial views, contributing to more nuanced and reliable conclusions (Jorm, 2015).

5.1.1 Key Characteristics

The Delphi method holds significant value and utility within the broader research landscape, particularly when addressing complex issues where knowledge is either incomplete or subject to uncertainty. It is often deemed appropriate when other research methods that might provide higher levels of evidence are not feasible due to ethical, logistical, or practical reasons. The Delphi technique is particularly effective for generating expert-based judgments on topics where empirical data may be limited or non-existent.

Anonymity is a key feature, ensuring that the identities of the participating experts are concealed from one another throughout the study. This anonymity is crucial as it mitigates the potential for dominant individuals to unduly influence the opinions of others, thereby fostering unbiased responses and reducing the 'halo effect' where higher priority might be given to the views of more powerful or higher-ranking members (Shariff, 2015; Crisp et al., 1997). By allowing experts to express their opinions freely without fear of repercussion or judgment, anonymity encourages a more honest and open exchange of ideas. Another central characteristic is **iteration**, which involves conducting the survey in multiple rounds, typically ranging from two to four. These multiple rounds provide an

¹⁷ <https://www.rand.org/topics/delphi-method.html>

opportunity for experts to revisit and refine their initial opinions based on the feedback received from the group. This iterative process allows for a more thoughtful and considered evaluation of the issues at hand, facilitating the gradual convergence of opinions towards a consensus (Flanagan et al., 2016). Finally, **statistical aggregation** is employed in the Delphi method, particularly in later rounds where quantitative data is collected through rating scales. The combination of iteration and anonymity within the Delphi method fosters an environment where experts can thoughtfully reconsider their opinions based on the collective knowledge of the group, free from the social pressures that might arise in face-to-face discussions. This can lead to a more robust and well-reasoned consensus on complex issues. However, the effectiveness of the Delphi method is intrinsically linked to the careful selection of experts and the meticulous design of clear and focused questionnaires.

5.1.2 Importance of the Delphi Method in Mental Healthcare Research and relevant paradigms

The Delphi survey method is a robust tool for achieving expert consensus in mental healthcare research, offering a systematic approach to addressing complex issues with limited empirical evidence. It is particularly useful in fields where decisions have to be made in highly charged domains or where actions may have severe outcomes, such as politics, education, and mental healthcare (Humphrey-Murto et al., 2020). It is effective in gathering information on topics with scarce evidence or agreement, making it a valuable tool in health services research (Gallardo & Olmos, 2008).

Mental healthcare research is increasingly adopting a holistic perspective, acknowledging that mental health is shaped by a complex interaction of individual, social, environmental, and technological factors. This is evident in the expanding research on social determinants of mental health, the development and evaluation of technology-based interventions, and the studies examining the impact of global events. In mental healthcare, the Delphi method has been used to prioritise activity-related determinants affecting adolescent mental health, aiding in the development of occupational therapy-based interventions (Parsonage-Harrison et al., 2024). It helps in defining foundational concepts and determining collective values, such as identifying research priorities (Jorm, 2015). Delphi surveys have successfully identified and prioritised determinants of mental health, such as personal self-confidence and activity balance in adolescents, informing intervention development (Parsonage-Harrison et al., 2024). They have also contributed to the consensus on training and service provision models for mental health professionals, supporting task-sharing initiatives in healthcare systems (Moodley et al., 2024). By integrating cultural considerations into the Delphi process, researchers can enhance the relevance and applicability of mental health interventions, ensuring they resonate with the unique experiences and needs of various communities, thereby fostering more effective and inclusive care (Trevelyan and Robinson, 2015). Moreover, the Delphi method's capacity to adapt to the evolving landscape of mental healthcare research can significantly enhance its application in addressing pressing issues such as the integration of technology in treatment approaches. The method is also applied for **forecasting and predicting trends** in mental healthcare, helping to anticipate future developments and challenges in the field.

5.2 EQUICARES' Delphi Approach

Electronic surveys are commonly used to administer Delphi studies, allowing for efficient data collection and analysis (Moodley et al., 2024). The use of online platforms facilitates the participation of geographically dispersed experts, enhancing the diversity and breadth of expert input (Humphrey-Murto et al., 2020). Researchers conducting Delphi surveys in mental healthcare research commonly utilise a variety of platforms, software, and tools to facilitate the process. These range from specialised Delphi platforms designed with the specific features of the methodology in mind to more general survey software that can be adapted for this purpose.

Welphi was used for the needs of this study; Welphi is a web-based application that incorporates automation features to support various stages of the Delphi process, including questionnaire design, data collection across multiple rounds, and statistical analysis. Welphi was used among other platforms and tools (e.g. eDelphi¹⁸, Mesydel¹⁹, Calibrium (SurveyLet)²⁰, ExpertLens²¹, COMET DelphiManager²²) as it fulfils the main required criteria for facilitating the survey process, namely: a) **Ease of use** for both the researchers in setting up and managing the survey and for the participants in responding to the questionnaires; b) features **specific to the Delphi method**, such as ensuring **anonymity, managing iterative rounds, and facilitating controlled feedback**; c) provides the ability to **manage multiple rounds** efficiently and provide feedback to participants in a clear and timely manner.

Regarding panel size, the study aimed to recruit at least 50 participants to balance methodological robustness with feasibility. Delphi studies do not rely on statistical representativeness but on informed expert judgment; therefore, panel size is determined by the complexity of the topic, the need to capture diverse perspectives, and anticipated attrition across rounds. For multidisciplinary and pan-European Delphi exercises addressing complex health system issues, panels ranging from 30 to 100 experts are commonly recommended to ensure adequate diversity while maintaining manageability and meaningful feedback synthesis (Nasa et al., 2021). Targeting 50 experts allowed for broad representation across disciplines, countries, and stakeholder groups, while ensuring sufficient retention and analytical stability across multiple Delphi rounds.

It should be noted that the Delphi exercise was designed to assess the perceived magnitude of impact and future relevance of identified structural trends, barriers, mitigation measures, and innovative solutions on equitable access to mental healthcare over a 15-year horizon (up to 2040). While the literature review provides contextual explanations regarding the mechanisms through which these barriers operate, the Delphi results should be interpreted primarily as a structured expert judgement on their relative importance and expected evolution. This study followed the methodology as described in GA, which required the engagement of a large expert panel (at least 50 experts) to ensure geographic and disciplinary diversity across the EU. Within this methodological design, experts were asked to evaluate the expected impact of systemic developments on mental healthcare accessibility over the next 15 years, providing a structured assessment of future relevance.

¹⁸ <https://www.edelphi.org/>

¹⁹ <https://mesydel.com/en>

²⁰ <https://calibrium.com/>

²¹ <https://www.rand.org/pubs/tools/expertlens.html>

²² <https://www.comet-initiative.org/delphimanager/>

5.3 Participant recruitment and involvement

The participant selection and recruitment process for the Delphi survey under Task 1.3 was designed to ensure broad, balanced, and expert-driven input from across the European Union, with a specific emphasis on diversity in thematic knowledge, geographical representation, and experience with vulnerable groups.

During the first semester, EQUICARES partners were instructed to propose expert candidates based on clearly defined selection criteria. Experts were expected to:

- Have professional experience relevant to mental healthcare systems, vulnerable populations, or rights-based approaches;
- Be familiar with EU-level or national mental health policies and care practices;
- Represent a variety of stakeholder groups (academia, policy, practice, advocacy); and
- Be willing to participate in a two-round Delphi process.

The process was initiated in M3 of the project, and all partners were actively involved in nominating experts through a structured internal exercise. Partners were provided with clear guidelines and a standardised Excel template for submitting nominations. Each partner was requested to propose expert profiles from their networks, across three thematic categories:

1. Mental Healthcare Providers (e.g. Psychiatrists, Psychologists, Nurses, Social Workers, Child Protection Workers)
2. Policy Makers and Administrators (e.g. Government Officials involved in mental health policy development and resource allocation, Public Health Administrators, Government Health Agencies, Health Insurance Executives)
3. Academia / Research (e.g. Mental Health Researchers, Researchers on Economic / technological trends in Mental healthcare, Health Services Researchers, Clinical Research Experts, Diversity and Inclusion Specialists)
4. Technology and Innovation Experts (e.g.: Patient-Centric Technology Developers, Health IT Specialists, Health Data Analysts, Digital Health Consultants, AI/ML Experts in Healthcare)
5. NGOs, CSOs, Advocates and Community Leaders (e.g. Mental Health Advocates representing the interests of people with mental health conditions, Community Leaders understanding the needs and priorities of specific groups in vulnerable situations, Patient & Human Rights Advocates)

Business and Industry professionals related to mental healthcare and/or people in vulnerable situations (e.g.: Educators Focused on Minorities, Cultural Sensitivity Trainers, Legal Advocates, Journalists, Business related to groups in vulnerable situation). The goal was to gather a pool of experts, allowing flexibility for attrition or dropouts across the two Delphi rounds. An emphasis was placed on ensuring representation across various sectors (policy, academic, clinical, civil society), countries, and domains of vulnerability (e.g. migration, disability, minority rights, etc.).

Selection criteria included:

- Expertise in mental health accessibility or policy (via academic background, field experience, or published work)
- Experience working with or for vulnerable populations
- Geographical diversity within the EU

- Commitment to participate in both rounds

A total of 231 experts were nominated by partners, forming the suggested expert pool from which final participants were recruited. This group represented a wide array of nationalities and disciplinary backgrounds, ensuring the broadest possible representation of perspectives.

The expert nominations were drawn from a diverse range of countries, reflecting both the geographical composition of the consortium and the reach of partners' established country-of-origin professional networks. The highest proportion of suggested experts were based in Greece, followed by Spain, Germany and France. This distribution is largely explained by the fact that several consortium partners are headquartered in these countries and relied on well-developed national networks in academia, public authorities, industry, and civil society when proposing experts.

To mitigate potential geographical concentration effects and ensure balanced participation, targeted measures were implemented to actively involve networks from underrepresented countries. These included requesting partners to extend nominations beyond their immediate national contacts, engaging European-level thematic networks and umbrella organisations, and explicitly encouraging the inclusion of experts from countries with lower initial representation. These actions contributed to broadening the geographical scope of nominations and supported more inclusive participation across a wider set of countries.

By M7, 126 experts had confirmed their participation. Prior to their participation in the Delphi survey, all invited experts were required to review and sign an informed consent form, in line with Horizon Europe ethical requirements and GDPR provisions (Annex 8.1). The consent process was designed to ensure that participants were fully informed about the purpose of the survey, the scope of their involvement, the voluntary nature of participation, and the way their data would be collected, processed, stored, and used.

The informed consent documentation included an information sheet describing the EQUICARES project, the objectives and structure of the two-round Delphi survey, the expected time commitment, and the absence of financial compensation. It clearly outlined the types of data collected (contact, demographic, professional, and expert opinion data), the measures taken to ensure confidentiality and anonymity, and the fact that consent forms were stored separately from survey responses. Experts were informed of their rights to access, correct, restrict, or delete their data, as well as to withdraw from the survey at any point without consequences. Only experts who provided consent were granted access to the Delphi survey. This procedure ensured ethical compliance, protected participants' rights, and guaranteed that all contributions were provided knowingly, freely, and under transparent conditions.

The final expert panel was composed of a cross-disciplinary and multinational group. This expert diversity significantly strengthened the foresight dimension of the study and ensured that the Delphi results were grounded in real-world experience and cross-sectoral knowledge. Sixty-six (66) experts participated in both the 1st and 2nd Delphi rounds.

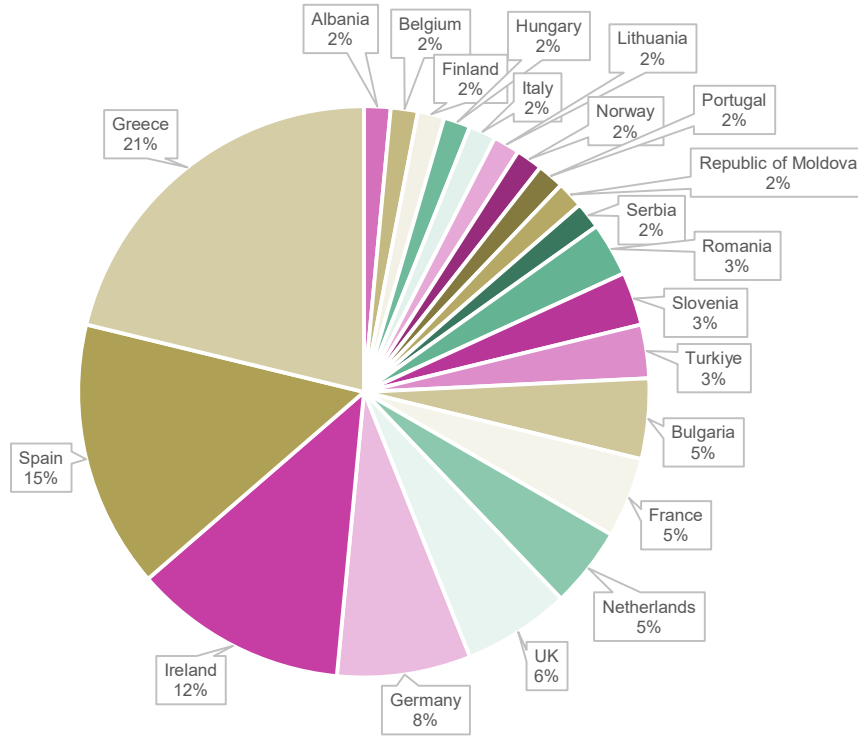


Figure 12: Expert residence country (participation in both Delphi Rounds: n=66)

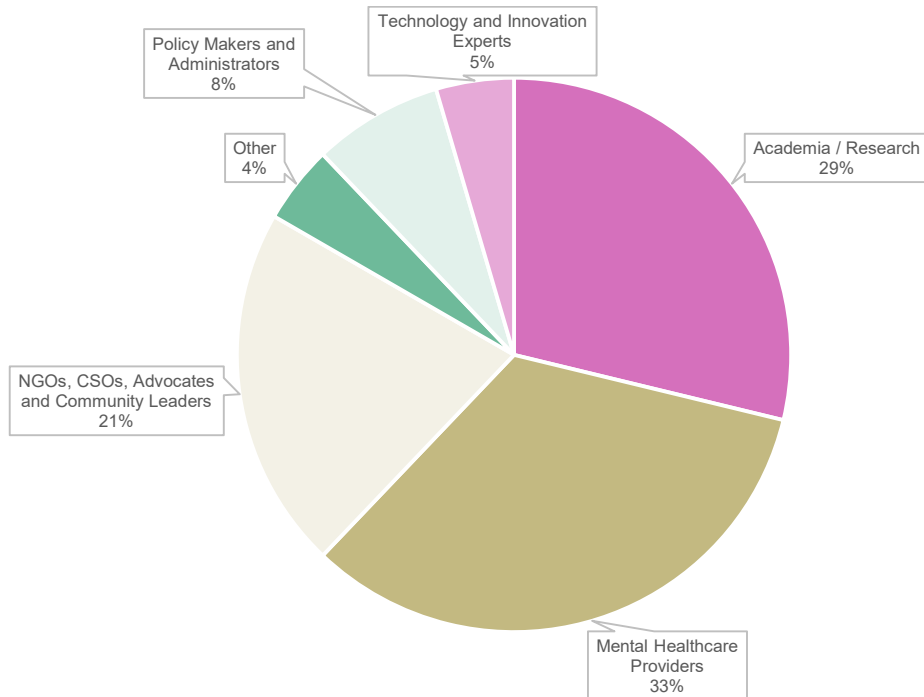


Figure 13: Categories of expertise (participation in both Delphi Rounds: n=66)

5.4 Questionnaire

The development of the Delphi questionnaire (Annex 8.2) constituted a key step in translating the findings from the literature reviews into a forward-looking, evidence-based forecasting tool. Building directly upon the barriers identified through the systematic review of grey and scientific literature, the questionnaire was designed to examine how these challenges might evolve in the future and what strategic responses may be required. The conceptualisation of the questionnaire was grounded in four main thematic pillars: (i) the service accessibility needs of different vulnerable groups from a territorial perspective, such as those living in remote, rural, or left-behind areas; (ii) the structural and systemic barriers limiting equitable access to mental healthcare for vulnerable groups, analysed through an intersectional lens to capture how overlapping factors (such as disability, gender, ethnicity, age, migration status, and socioeconomic conditions) compound access constraints, and the projected multi-dimensional impacts of current and emerging megatrends on these barriers over the next 15 years (to 2040); and (ii) the identification of mitigation and prevention measures, especially through innovative, inclusive, and sustainable solutions.

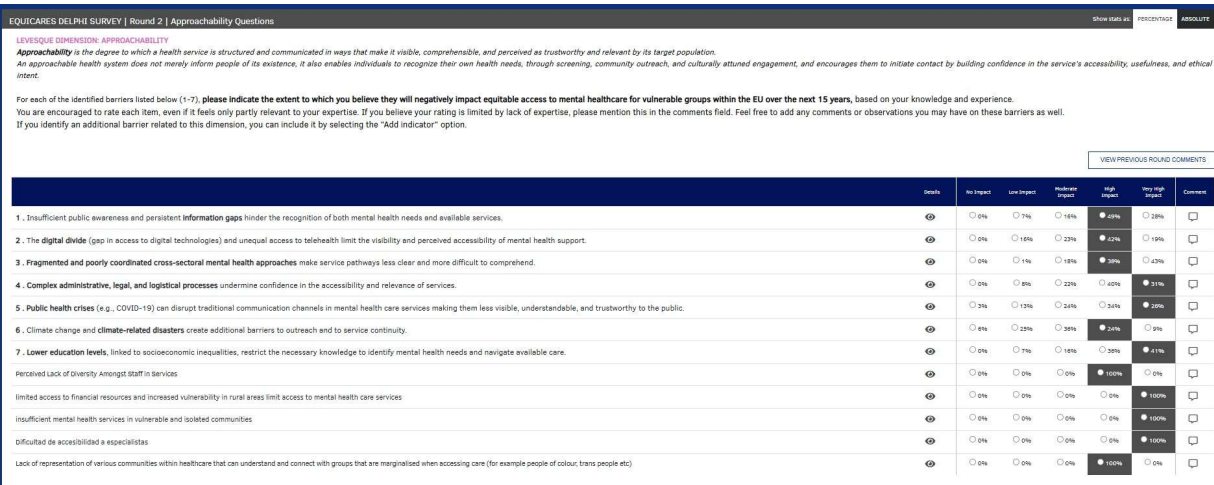


Figure 14: Welphi screenshot of Delphi Round 2 results: perceived impact of barriers on mental healthcare approachability

To reflect these themes, the questionnaire (Annex 8.2) was structured into **three main sections**. The **first section focused on the Impact of Identified Barriers on Equitable Mental Healthcare**, asking experts to assess the extent to which the barriers previously mapped through the 5 Levesque framework dimensions negatively affect access to care for vulnerable groups. The **second section, Mitigation and Prevention Strategies**, invited participants to select and prioritise among a list of evidence-informed options that could be implemented to address these barriers and foster more equitable access. These strategies were developed in alignment with the same five Levesque dimensions and were **further informed by the outcomes of the draft Levesque Framework elaborated by KOC University under Task 1.2**, which introduced **refined indicators tailored to the context of mental healthcare access for vulnerable populations**. These indicators were included in the 2nd section of this document, serving as structured options for mitigation strategies.

The **third and final section, Anticipated Impacts and Innovative Strategies**, explored experts' expectations regarding future developments in the field, with a particular focus on technology- and policy-related trends at the EU level. This section aimed to elicit forward-looking insights into systemic

innovations, solutions, and cross-national policy mechanisms that could shape the landscape of equitable mental healthcare by 2040.

Each dimension was clearly introduced to participants within the Welphi platform, accompanied by a brief conceptual definition and contextual explanation to ensure a shared understanding of its scope and meaning. The identified structural trends were then grouped and presented under their corresponding dimensions, and experts were asked to assess the perceived magnitude of impact of each of them on equitable access to mental healthcare over a 15-year horizon. This structure ensured that the evaluation was dimension-specific and conceptually anchored, allowing for a consistent interpretation of how systemic trends affect different aspects of access.

The questionnaire was disseminated using the Welphi software, an online platform specifically designed to support Delphi survey implementation. This tool ensured anonymity and confidentiality, supported iterative rounds of data collection, and enabled participants to revise their responses considering group feedback, in line with the methodological standards of the Delphi technique.

Before launching the survey, the draft questionnaire was internally reviewed by WP1 partners, who provided feedback to refine the wording, thematic structure, and conceptual clarity of the items. In addition, the questionnaire was **internally piloted on the Welphi platform with a selected number of experts** from Q-PLAN's professional network to assess usability, clarity of instructions and questions, and potential ambiguities in the survey flow. This internal validation process ensured that the final instrument aligned with the objectives of Task 1.3, the updated Levesque framework, and the overall methodology of the EQUICARES project.

5.5 Results

5.5.2 Consensus Assessment

This section presents the results of the Delphi survey, which aimed to capture expert consensus on the impact of macro-level megatrends, defined as long-term, transformative socioeconomic, technological, and structural forces on the EU's capacity to ensure equitable access to mental healthcare for vulnerable groups. The Delphi process demonstrated a clear convergence of expert opinion between Round 1 and Round 2, confirming the robustness of the identified structural determinants of equitable mental healthcare access.

Experts were asked to assess the perceived impact of each megatrend using a five-point Likert scale (1 = No Impact, 2 = Low Impact, 3 = Moderate Impact, 4 = High Impact, 5 = Very High Impact). For analytical purposes, consensus was measured as the proportion of respondents assigning ratings of 4 or 5. Based on this approach, levels of agreement were classified as follows: Very High Consensus ($\geq 85\%$), High Consensus ($\geq 75\%$), Moderate Consensus ($\geq 60\%$), and No Consensus ($< 60\%$).

The strongest convergence occurred in structurally oriented items, particularly workforce shortages (+10.2%), human rights violations (+10.2%), financial instability drivers (+6-12%), and integrated service ecosystem measures. Several items shifted from Moderate to High or Very High consensus between rounds, particularly within mitigation strategies addressing financial resilience, workforce deployment, and rights-based governance. Conversely, some climate-related items and fully digital telehealth models either stagnated or declined slightly in agreement, reflecting uncertainty regarding their long-term systemic impact. This pattern suggests that **experts perceive structural reform and**

system redesign as urgent and actionable within the next 15 years, whereas longer-term transformation drivers involve **greater contextual variability** across EU Member States.

5.5.3 Impact of Identified Barriers on Equitable Mental Healthcare

The first section of the Delphi questionnaire examined how a range of structural, social, economic, and systemic barriers, as identified in the literature review, affect equitable access to mental healthcare for people in vulnerable situations across the EU. Using the 5 Levesque dimensions it asked experts to assess the magnitude of negative impacts associated with key megatrends such as digitalisation gaps, socioeconomic inequalities, demographic shifts, public health crises, and climate-related disruptions. The purpose of this section was to build a shared, evidence-informed understanding of where and how inequities emerge within mental healthcare systems, and which barriers are most critical in limiting access for vulnerable groups. It should be noted that the analysis presented in this section focuses on the perceived magnitude of impact of identified trends on equitable access to mental healthcare, as assessed through expert judgement in the Delphi process. While the section initially refers to understanding “how” inequities emerge, the Delphi methodology applied here is designed to capture the extent to which these trends are expected to influence access. The interpretation of how these inequities are produced is therefore primarily informed by the literature review and thematic synthesis, while the Delphi results provide a structured assessment of their relative importance and anticipated impact over time.

5.5.3.1 Very High Consensus (Round 2: ≥85%)

Very high consensus barriers cluster around *structural system capacity, financing, and fragmentation*, with fewer items per Levesque dimension meeting the ≥85% threshold on the 2nd round of the survey; an important finding, as it shows that only a small set of barriers are seen as *uniformly critical across EU contexts*.

In **Approachability**, the only barrier reaching very high consensus is the fragmentation of cross-sectoral approaches (90.2%). This indicates that experts see navigability and clarity of care pathways as fundamentally undermined by weak coordination across mental health, social care and other services, creating systemic opacity that disproportionately harms vulnerable groups.

In **Acceptability**, stigma and discrimination (89.4%) is the sole very-high item, suggesting experts view social and institutional stigma not as a secondary barrier but as a core driver that actively suppresses demand and weakens trust even when services exist.








In **Availability & Accommodation**, two barriers reach very high consensus: workforce/resource shortages (90.9%) and fragmented care pathways (87.9%). Together, these findings frame inequity as a dual failure of *capacity* (too few staff, uneven distribution) and *organization* (poor continuity and referral pathways), which compounds delays and drop-out risk for people needing sustained care.

In **Affordability**, the very high barriers are insufficient public funding and resource allocation (92.4%) and economic inequalities (89.4%). This combination suggests a **structural affordability trap**: underfunded systems shift costs to individuals, while inequality reduces people’s ability to absorb these costs, widening access gaps.

Finally, in **Appropriateness**, systemic gaps and lack of coordination preventing services from meeting vulnerable groups’ needs (89.4%) reaches very high consensus, reinforcing that equity failures are not only about getting into care, but about whether care is fit-for-purpose once accessed.

Across these dimensions, very high consensus converges on a single interpretation: **inequity is driven most strongly by system architecture; financing, workforce capacity, integration, and the social legitimacy of care.** These findings suggest that without structural reform, improvements in awareness or digitalization alone will not substantially reduce inequities.

Table 8: Top Highest-Rated Barriers per Levesque dimension in Very High Consensus Level (≥85% agreement, Round 2)

Levesque Dimension	Barrier Statement	Round 1 Agreement (≥4)	Round 2 Agreement (≥4)	
 Affordability	Insufficient public funding and resource allocation increases out-of-pocket costs and limit equitable access.	89.7%	92.4%	≥ 90%
 Availability & Accommodation	Systematic workforce and resource shortages reduce service capacity and equitable availability.	80.7%	90.9%	
 Approachability	Fragmented and poorly coordinated cross-sectoral approaches create confusion and reduce clarity of care pathways.	80.7%	90.2%	88% – < 90%
 Appropriateness	Systemic gaps and lack of coordination prevent services from meeting the needs of vulnerable groups.	84.8%	89.4%	85%– < 88%
 Affordability	Economic inequalities reduce individuals' ability to afford services and related costs.	86.4%	89.4%	< 85%
 Acceptability	Stigma and discrimination deter individuals from seeking or continuing mental healthcare.	84.1%	89.4%	
 Availability & Accommodation	Fragmented care pathways undermine continuity and coordination of services.	84.8%	87.9%	

5.5.3.2 High Consensus (Round 2: 75–84%)

High consensus barriers reveal the “next tier” of system pressures that are widely recognised but slightly more context-dependent across EU settings.

In **Approachability**, insufficient public awareness and information gaps (82.0%) and lower education linked to socioeconomic inequality limiting system navigation (82.0%) indicate that inequity is exacerbated by differences in health literacy and informational accessibility. Administrative, legal, and logistical complexity (75.4%) further suggests that bureaucratic opacity constitutes a meaningful barrier, particularly for vulnerable populations with limited institutional familiarity.









In **Acceptability**, cultural and social determinants creating mismatches between services and community norms (78.8%) and human rights violations undermining trust and safety (77.3%) reflect the importance of cultural alignment and ethical safeguards. These findings show that beyond stigma, deeper trust and rights-based concerns shape individuals' willingness to engage with mental health services.

In **Availability & Accommodation**, geographic and rural disparities (81.8%) and demographic shifts such as migration and ageing requiring adaptable services (78.8%) highlight spatial and demographic mismatches between service supply and population needs. These barriers indicate that equitable distribution is not static and must evolve alongside demographic transitions.

In **Affordability**, economic crises and downturns (84.8%), unstable employment and financial insecurity (83.3%), fragmented public insurance coverage (81.8%), and low income or education limiting financial capacity (81.8%) show strong recognition of macroeconomic instability as a driver of inequity. This suggests that affordability barriers are shaped not only by health budgets but also by broader socioeconomic volatility.

In **Appropriateness**, cultural and language barriers combined with lack of cultural competence (77.3%) demonstrate that services must align with linguistic and cultural realities to ensure meaningful accessibility.

Table 9: Top Highest-Rated Barriers per Levesque dimension in High Consensus Level (75–84% agreement, Round 2)

Levesque Dimension	Barrier Statement	Round 1 Agreement (≥4)	Round 2 Agreement (≥4)	
 Affordability	Economic crises and downturns reduce service stability and access.	79.5%	84.8%	82% – < 85%
	Unstable employment and financial insecurity limit ability to afford care.	77.2%	83.3%	
 Approachability	Insufficient public awareness and information gaps reduce visibility of services.	76.9%	82.0%	79% –< 82%
 Availability & Accommodation	Geographic disparities (e.g., rural–urban) limit equitable service distribution.	81.8%	81.8%	
 Acceptability	Cultural and social determinants create mismatches between services and community norms.	78.8%	78.8%	75% –< 79%
 Availability & Accommodation	Demographic shifts (migration, ageing) require adaptable and culturally responsive services.	78.8%	78.8%	
 Appropriateness	Cultural and language barriers and lack of cultural competence reduce trust and equitable care.	76.9%	77.3%	
 Acceptability	Human rights violations undermine trust and willingness to seek care.	67.1%	77.3%	< 75%
 Approachability	Administrative, legal and logistical complexity creates barriers to navigating services.	70.5%	75.4%	

5.5.3.3 Low Consensus (Round 2: <65%)

Barriers receiving below 65% agreement in Round 2 reflect areas where expert perspectives are more divided and where impacts are likely perceived as conditional, context-dependent, or emerging rather than uniformly systemic. These lower-consensus items are concentrated primarily in the domains of digitalisation, climate-related disruptions, crisis responsiveness, and certain dimensions of disability inclusion.

In **Approachability**, climate change and climate-related disasters creating outreach and continuity barriers (26.2%) show particularly low agreement. This suggests that experts do not yet view environmental crises as consistently impairing the visibility or navigability of mental health services across the EU. This does not imply irrelevance; rather, it likely reflects uneven geographic exposure and variability in preparedness levels across EU.

Within **Availability & Accommodation**, several barriers fall below 65%: public health crises disrupting service continuity and straining delivery systems (63.6%), the digital divide limiting equitable telehealth access (56.1%), insufficient telepsychiatry and digital interventions (56.1%), and climate-related disasters damaging infrastructure and disrupting care (31.8%). These findings indicate that, while crises and digital gaps are acknowledged as challenges, experts do not uniformly perceive them as dominant structural constraints compared to workforce shortages and fragmentation. The relatively modest agreement on telepsychiatry insufficiency suggests that digital capacity may be improving in some contexts, reducing its perceived urgency as a generalised EU-level barrier.


In **Appropriateness**, multiple barriers fall under 65%: public health crises exposing service gaps and the need for flexible care models (62.1%), and limited disability awareness and training among providers (54.5%). The lower consensus around disability-related training may indicate variability in national standards and implementation levels. Similarly, crisis-exposed flexibility deficits may be seen as temporary or context-specific rather than persistent structural weaknesses.





Importantly, no barriers within **Affordability** fall below 65%, underscoring that financial determinants are consistently regarded as high impact across contexts.

Likewise, in **Acceptability**, all barriers remain above the 65% threshold, indicating relatively stable recognition of stigma, cultural misalignment, and rights-related concerns.

Low consensus barriers are characterised by contextual variability and emerging transformation dynamics, particularly digitalisation and climate-related disruption, rather than core structural deficits. The pattern suggests that experts differentiate between foundational systemic constraints (financing, workforce, fragmentation) and secondary or evolving pressures whose impact depends more heavily on local infrastructure, governance maturity, and exposure to crisis conditions.

Table 10: Lowest Low-Rated Barriers per Levesque dimension in Low Consensus Level (Round 2 <65%)

Levesque Dimension	Barrier Statement	Round 1 Agreement (≥4)	Round 2 Agreement (≥4)	
 Approachability	Climate change and climate-related disasters create barriers to outreach and communication.	32.90%	26.20%	< 30%

	Availability & Accommodation	Climate change and disasters damage infrastructure and disrupt continuity of services.	39.80%	31.80%	
	Appropriateness	Limited disability awareness and training among providers reduce service responsiveness.	56.80%	54.50%	30% - < 40%
	Availability & Accommodation	Insufficient telepsychiatry and digital interventions limit service reach.	54.50%	56.10%	40% -< 55%
	Appropriateness	Public health crises expose service gaps and require flexible care models.	55.30%	62.10%	55% -< 65%

5.5.3.4 Highest Difference rate

Examining the highest difference rates reveals where Delphi feedback most strongly shifted expert alignment. In **Approachability**, cross-sectoral fragmentation increased sharply (+9.5%), while administrative/legal/logistical complexity also rose (+5.0%), suggesting that experts increasingly converged on the idea that “pathway clarity” is a systemic function of governance and coordination rather than of individual knowledge alone. Digital divide (+5.8%) and crisis-related communication disruption (+5.3%) increased moderately, indicating growing recognition of their relevance, yet not enough to cross into high consensus, consistent with their context-dependent character. Climate-related barriers decreased (-6.7%), implying that Round 2 reflection led experts to differentiate climate impacts from more immediate system bottlenecks.

In **Acceptability**, the largest shift is human rights violations (+10.2%), moving the item into high consensus. This is analytically significant: it indicates that experts increasingly foreground ethical safety, non-discrimination, and institutional trust as prerequisites for engagement, particularly relevant for groups with prior exposure to discrimination or precarious legal status. Stigma increased (+5.3%), reinforcing its pervasive influence, while cultural mismatch was stable (+0.4%), suggesting experts already agreed on its importance in Round 1.





In **Availability & Accommodation**, workforce/resource shortages showed a major increase (+10.2%), further consolidating it as the dominant availability barrier. The largest negative change in this dimension was climate change and disaster-related disruption (-8.0%), again reflecting lowered perceived uniformity of climate impacts compared to capacity and coordination problems.

In **Affordability**, shifts were strongest for unstable employment/financial insecurity (+6.1), insurance fragmentation (+5.7), and economic downturns (+5.3), indicating increased convergence around macroeconomic volatility as a direct amplifier of access inequity. Even already-high items (public funding +2.7; inequality +3.0) strengthened further, reinforcing the stability of expert agreement on affordability.

In **Appropriateness**, the largest increase concerned crisis-driven service model flexibility (+6.4%), followed by trauma-informed care (+5.3%). This suggests growing recognition that appropriateness is not static; it must adapt during shocks and across evolving population needs. Meanwhile, disability training declined (-2.3%), suggesting uncertainty or divergent interpretations about its macro-level weight relative to other appropriateness drivers.

Overall, the difference-rate analysis shows that Round 2 strengthened consensus most where barriers relate to governance, rights, capacity, and economic precarity, while climate and some digital elements became more differentiated rather than more agreed upon.

Table 11: Highest Round-to-Round Shifts (positive and negative)

Levesque Dimension	Barrier Statement	Round 1 Agreement (≥4)	Round 2 Agreement (≥4)	Δ	
 Acceptability	Human rights violations undermine trust and willingness to seek care.	67.10%	77.30%	10.20%	> +10%
 Availability & Accommodation	Systematic workforce and resource shortages reduce service capacity and equitable availability.	80.70%	90.90%	10.20%	> +5% - +10%
 Approachability	Fragmented and poorly coordinated cross-sectoral approaches create confusion and reduce clarity of care pathways.	80.70%	90.20%	9.50%	+5%
	Climate change and climate-related disasters create barriers to outreach and communication.	32.90%	26.20%	-6.7%	-5% < -5% - -10%
 Availability & Accommodation	Climate change and disasters damage infrastructure and disrupt continuity of services.	39.80%	31.80%	-8.0%	< -10%

5.5.4 Mitigation and Prevention Strategies

The second section focuses on identifying and prioritising strategies that could effectively mitigate or prevent the negative impacts identified in the first section. For each dimension of access, experts were invited to select the most promising policy, system-level, community-based, and service-level interventions that can enhance equity in mental healthcare. Emphasis was placed on proactive, inclusive, and rights-based approaches, such as culturally responsive service design, workforce development, digital inclusion, financial protection mechanisms, and cross-sectoral coordination. By mapping concrete strategies to specific barriers, this section aimed to generate actionable insights that can inform future policy development, system reforms, and targeted investments at both national and EU levels.

5.5.4.1 Very High Consensus (Round 2: ≥ 85%)

Strategies reaching very high consensus in Round 2 are mainly structural, redistributive, and capacity-oriented.

In **Approachability**, the establishment of one-stop service access points (89.4%) stands out as a major priority. This reflects strong expert agreement that simplifying entry points into the system is essential for reducing navigational complexity and improving visibility, particularly for marginalised populations.

Within **Acceptability**, providing reasonable accommodations such as assistive technologies, home visits, and extended consultation times (90.9%) achieved the highest agreement across all strategies.










This indicates that disability inclusion is not seen as an optional enhancement but as a core structural requirement for equitable access.

In **Availability & Accommodation**, deploying mobile and hybrid care teams (87.9%) and strengthening workforce distribution to underserved areas (above 85%) confirm that redistributive capacity expansion is perceived as fundamental. These strategies directly address workforce shortages and geographic inequities identified in the barriers section.

In **Affordability**, increasing public funding, implementing targeted funding allocations (86.4%), reducing out-of-pocket costs including zero co-payment mechanisms (86.4%), and strengthening inclusive insurance schemes (above 85%) show very high consensus. These findings demonstrate that financial protection measures are regarded as central levers for equity. Strategies such as return-to-work programs for vulnerable populations (90.9%) and crisis-resilient funding frameworks (above 85%) further illustrate that experts prioritize integrated economic and mental health interventions.

Interdimensionally, crisis-adaptive funding models and return-to-work programs (90.9%) reflect recognition that economic and mental health recovery are structurally linked. Very high consensus strategies therefore converge on redistributive, inclusive, and capacity-building reforms that operate across multiple Levesque dimensions simultaneously.

Table 12: Top Highest-Rated Barriers per Levesque dimension in Very High Consensus Level ($\geq 85\%$ agreement, Round 2)

Levesque Dimension	Item	Mitigation Strategy	Round 1	Round 2		
	Acceptability	Understanding and including disability in mental healthcare	Provide reasonable accommodation, such as assistive technology, home visits for older adults, or extended consultation times.	85,2%	90,9%	$\geq 90\%$
	Availability & Accommodation	Employment and financial stability support	Develop return-to-work programs co-designed with community organisations to help older adults and survivors of trauma regain financial stability.	79,5%	90,9%	$88\% - <90\%$
	Approachability	Streamlining systemic (administrative, legal, logistical) processes	Establish “one-stop” service access points (physical centres in rural areas or digital hubs for remote users) to reduce navigation barriers and increase visibility.	86,4%	89,4%	
	Appropriateness	Localised systemic capacities and preparedness in climate disaster response	Include mental health professionals in national disaster task forces, ensuring services are immediately integrated post-disaster.	81,8%	89,4%	$85\% - <88\%$
	Affordability	Embedding cultural competence and disability-inclusive responsiveness	Train professionals on how to adapt therapies and assessments for individuals with overlapping vulnerabilities (e.g., older adults with disabilities or mental health conditions).	79,5%	89,4%	
	Affordability	Systemic financial resilience in economic crises	Ensure collaborative recovery programs that combine mental health and economic support for disaster survivors and low-income families in remote areas.	77,3%	89,4%	$< 85\%$
	Availability & Accommodation	Workforce and resource distribution	Deploy mobile and hybrid care teams to remote and rural areas.	86,4%	87,9%	
	Approachability	Healthcare system capacity for proactive, clear, and inclusive mental health information dissemination	Integrate community-based outreach (via NGOs, cultural mediators, and peer advocates) to actively engage marginalised groups and improve trust.	83,0%	86,4%	$< 85\%$
	Affordability	Person-centred and rights-based approaches	Develop rights-based policies to ensure that older adults, LGBTQ+ individuals, and ethnoreligious minorities are not subjected to discrimination or coercive practices in mental health care.	79,5%	86,4%	

5.5.4.2 High Consensus (Round 2: 75–84%)

The High Consensus tier (75–84%) captures a critical middle layer of reform priorities; strategies that are strongly endorsed but slightly more context-sensitive than the very high consensus group.








Within **Approachability**, high-consensus strategies focus on strengthening proactive engagement and reducing navigational opacity. Tailoring mental health information to literacy levels and cultural contexts (84.8%), co-creating awareness campaigns with marginalized groups (84.8%), employing community ambassadors (84.8%), and simplifying intake processes (83.3%) indicate strong agreement that system visibility and comprehensibility require active institutional design. These measures do not merely improve information dissemination; they directly influence Acceptability by building trust and cultural alignment.

In **Acceptability**, supported decision-making models (81.8%), anti-bias and stigma-reduction training (80.3%), and enforceable protections against coercive practices (80.3%) reinforce a rights-based governance orientation. These strategies extend beyond cultural sensitivity, as they structurally reshape power dynamics within care delivery.

Regarding the interdimensional megatrends, under **comprehensible, integrated and coordinated service ecosystem**, appointing care coordinators in rural areas (84.8%) and developing multi-sectoral hubs linking mental health with housing and social services (83.3%) demonstrate strong endorsement of integration as an equity lever. These strategies simultaneously affect Approachability (clarity of pathways), Availability (continuity), and Appropriateness (holistic response to complex needs). Similarly, within **systemic resilience and crisis adaptation**, cross-sector crisis response systems integrating employment, housing, and mental health (83.3%) and community-led innovation hubs (81.8%) indicate strong agreement that resilience must be structurally embedded and not treated as episodic emergency response. Under **localised climate preparedness**, long-term trauma recovery programs (80.3%) and rapid-response teams with cultural mediators (77.3%) show meaningful support for proactive disaster integration, even if climate-related barriers themselves were lower consensus in Section 5.1.2.

The high consensus tier reveals that experts strongly endorse integrative, cross-sectoral, and resilience-oriented reforms. These strategies bridge structural capacity with governance innovation and community co-creation, reinforcing that equity requires system coordination rather than isolated service improvements.

Table 13: Top Highest-Rated Barriers per Levesque dimension in High Consensus Level (75–84% agreement, Round 2)

Levesque Dimension	Item	Mitigation Strategy	Round 1	Round 2	
 Appropriateness	Comprehensible, integrated and coordinated service ecosystem	Appoint community-based care coordinators (including those from ethnic or cultural minorities) in rural areas to help users navigate fragmented care systems.	80,7%	84,8%	82% – <85%
 Approachability	Involve the community in developing culturally sensitive, inclusive healthcare information and pathways	Co-create mental health education and awareness campaigns with input from ethnic minorities, LGBTQ+ groups, and Roma communities to ensure cultural alignment.	79,5%	84,8%	
 Acceptability	Understanding and including disability in mental healthcare	Train professionals on the intersection between disability and mental health, including cultural stigma.	78,4%	84,8%	
 Affordability	Systemic financial resilience in economic crises	Develop flexible contingency financing models that prioritize services for vulnerable populations during economic instability.	77,3%	84,8%	79% – <82%
	Reducing economic disparities through resource distribution	Provide incentives for mental health providers to establish practices in socioeconomically disadvantaged areas and serve marginalised groups.	76,1%	84,8%	
 Approachability	Healthcare system capacity for proactive, clear, and inclusive mental health information dissemination	Ensure the comprehensibility of mental health information, tailoring materials to literacy levels and cultural contexts (e.g., visual aids for people with vision impairments or easy-read formats for people with disabilities).	76,1%	84,8%	75% – <79%
 Appropriateness	Cultural competence and responsiveness	Create mobile or community-based culturally aligned outreach teams for under-served rural areas, ensuring services are culturally relevant and locally trusted.	83,0%	83,3%	
 Availability & Accommodation	Inclusive mental healthcare insurance schemes	Develop mental health parity laws ensuring mental health services receive the same financial coverage as physical health, with special provisions for marginalised communities.	78,4%	83,3%	



Acceptability

Income-adjusted, educationally considerate pathways

Develop mental health parity laws ensuring mental health services receive the same financial coverage as physical health, with special provisions for marginalised communities.

78,4%

83,3%

Upholding human rights and dignity in mental healthcare delivery

Promote supported decision-making models (instead of forced interventions), ensuring cultural and gender sensitivity.

77,3%

81,8%

>
75%

5.5.4.3 Low Consensus (Round 2: <65%)

Strategies receiving below 65% agreement in Round 2 represent areas where expert opinion remains heterogeneous and where perceived impact or feasibility varies substantially across EU contexts. Unlike the very high and high consensus tiers, dominated by structural financing, workforce redistribution, disability inclusion, and coordinated service ecosystems, the low-consensus tier is characterised primarily by **governance experimentation, digital substitution models, localised institutional restructuring, and certain partnership-based financing mechanisms**.

Within **Approachability**, digital-first participation platforms and advanced digital transparency tools remained below 65%, indicating caution toward technologically mediated engagement as a primary equity lever. While improving information clarity and outreach achieved strong consensus elsewhere (≥83%), fully digital engagement ecosystems were not viewed as uniformly feasible or inclusive. This reflects concerns about digital divides and uneven digital maturity across EU.

In **Acceptability**, certain formalised governance-layer interventions, such as structured rural consultation boards and institutionalised advisory councils, also remained below 65%. Although rights-based safeguards and supported decision-making reached 80–82% in higher tiers, formal governance restructuring mechanisms appear more context-dependent. Experts may perceive these as administratively complex or variably effective depending on local institutional capacity.

Within **Availability & Accommodation**, fully virtual mental healthcare systems and telehealth-only substitution models remained under 65%. This is consistent with earlier findings: hybrid models received higher endorsement, but digital-only frameworks did not. The lower agreement suggests that digital expansion, without parallel workforce and coordination reforms, is not considered a sufficient equity solution.




In **Affordability**, certain public–private partnership models and employer-led financial wellness schemes also fell below 65%, contrasting sharply with the very high support for increasing public funding (92.4%) and reducing out-of-pocket costs (86.4%). This divergence indicates scepticism toward mixed financing arrangements and potential equity risks in privatized or employer-dependent funding streams.

Within **Appropriateness**, more complex intersectional governance reforms and highly formalised systemic redesign mechanisms similarly remained below the 65% threshold. While culturally competent and trauma-informed care received stronger support elsewhere, embedding these principles through comprehensive structural governance reform appears more contested.

Regarding **interdimensional megatrends**, lower-consensus items are concentrated in experimental institutional configurations and digital civic participation infrastructures. Notably, integrated service ecosystems (83–85%) and crisis-resilient cross-sector coordination mechanisms (81–83%) did not fall into this low tier, indicating that disagreement concerns implementation modalities rather than the overarching integration principle itself.

Overall, strategies below 65% reflect caution toward reforms that rely heavily on digital substitution, complex governance layering, or market-mediated financing, **particularly where structural capacity and equity safeguards are not clearly embedded**.

Table 14: Lowest Low-Rated Barriers per Levesque dimension in Low Consensus Level (Round 2 <65%)

Levesque Dimension	Item	Mitigation Strategy	Round 1	Round 2	
 Affordability	Person-centred and rights-based approaches	Introduce rural/remote community consultation boards to regularly review whether services are meeting the unique needs of marginalized populations in these regions.	55,7%	50,0%	< 30%
	Person-centred and rights-based approaches	Introduce rural/remote community consultation boards to regularly review whether services are meeting the unique needs of marginalized populations in these regions.	55,7%	50,0%	30% – <40%
 Appropriateness	Understanding and including disability in mental healthcare	Co-design clinically validated mental health apps and digital platforms with direct input from people with disabilities, LGBTQIA+ individuals, and migrant communities to ensure cultural and linguistic relevance.	59,1%	54,5%	40% – <55%
	 Availability & Accommodation	Telepsychiatry and digital intervention deployment	Establish feedback and usability testing loops with vulnerable groups (e.g., youth, Roma, refugees) to improve accessibility and engagement with digital tools and evaluate their effectiveness.	60,2%	54,5%
Interdimensional	Localised systemic capacities and preparedness in climate disaster response	Create culturally responsive communication strategies (e.g., using trusted local radio or faith-based networks) for rural populations or ethno-religious minorities.	55,7%	56,1%	

5.5.4.4 Highest Difference rate

The difference-rate analysis provides insight into where expert opinion converged most strongly between rounds, revealing how deliberation and feedback reshaped prioritisation. The largest positive shifts occurred primarily in strategies that integrate multiple Levesque dimensions, particularly those linking economic resilience, participatory governance, and coordinated service ecosystems.

Within **Affordability**, employer-linked financial wellness initiatives and collaborative recovery programs integrating economic and mental health support recorded some of the largest increases (above +12%). These substantial shifts indicate that experts increasingly recognized the structural interdependence between socioeconomic stability and mental health equity. While such strategies may not always have achieved the highest final consensus levels, the magnitude of convergence suggests that the second round clarified their systemic relevance.

In **Approachability**, participatory design workshops and structured co-creation processes demonstrated one of the strongest positive shifts (above +15%). This indicates that exposure to peer perspectives strengthened appreciation for structured engagement mechanisms as tools to reduce navigational and cultural barriers. The shift suggests that while participatory governance may initially have been viewed as supplementary, it became increasingly framed as integral to equity-oriented system design.







Within **Availability & Accommodation**, workforce redistribution measures and infrastructure investments showed notable positive increases (above +10%), reinforcing the stability of structural capacity as a reform priority. The strengthening of consensus around these items confirms that the Delphi process consolidated agreement on supply-side expansion as central to mitigation.

In **Acceptability**, rights-based governance mechanisms, particularly those addressing coercion, discrimination, and ethical safeguards, experienced moderate but meaningful positive shifts. This reflects increased convergence around the idea that institutional trust and ethical safety are foundational components of equitable access. Within **Appropriateness**, strategies emphasizing flexible and crisis-responsive care models demonstrated increased agreement, suggesting that experts increasingly viewed adaptability as integral to service appropriateness rather than as a secondary emergency feature.

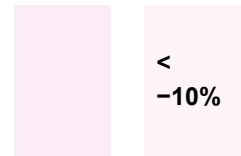
In regards to the **interdimensional megatrends**, the strongest convergence occurred in strategies that bridge financing, governance coordination, and participatory co-design. Integrated service ecosystems, crisis-resilient cross-sector frameworks, and community innovation hubs all experienced meaningful increases in agreement. This pattern demonstrates that while experimental digital or governance-specific models remained more contested, cross-sector integration and socio-economic alignment gained legitimacy through the iterative Delphi refinement. Conversely, climate-specific structural reforms and highly experimental governance innovations exhibited either limited shifts or stable disagreement, suggesting that divergence in these areas may reflect deeper contextual differences rather than ambiguity.

Overall, the difference-rate findings confirm that consensus strengthened most robustly in reforms that **integrate structural financing, workforce capacity, cross-sector coordination, and participatory system design**. The Delphi process appears to have clarified that equity in mental healthcare is best advanced through coordinated, multi-dimensional system transformation rather than isolated innovation streams.

Table 15: Highest Difference rate: top 3 highest, top 3 lowest

Levesque Dimension	Item	Mitigation Strategy	Round 1 (≥4)	Round 2 (≥4)	Δ	
 Availability & Accommodation	Employment and financial stability support	Create employer-led financial wellness programs that include mental health support, prioritising sectors with high vulnerability (e.g., migrant workers, low-wage labour).	67,0%	80,3%	13,3%	> +10%
 Appropriateness	Systemic resilience, adaptability and innovation during public health crises	Fund community-led mental health innovation hubs in under-served regions to co-develop scalable crisis interventions with vulnerable populations.	69,3%	81,8%	12,5%	> +5% - +10%
 Affordability	Systemic financial resilience in economic crises	Ensure collaborative recovery programs that combine mental health and economic support for disaster survivors and low-income families in remote areas.	77,3%	89,4%	12,1%	+5%
 Appropriateness	Person-centred and rights-based approaches	Introduce rural/remote community consultation boards to regularly review whether services are meeting the unique needs of marginalised populations in these regions.	55,7%	50,0%	-5,7%	-5%
 Appropriateness	Services responsive to demographic shifts	Conduct regular consultations with vulnerable populations (e.g., Roma, ethno-religious minorities, unaccompanied minors) to revise services according to shifting demographic needs.	78,4%	72,7%	-5,7%	< -5% - -10%
 Availability & Accommodation	Telepsychiatry and digital intervention deployment	Establish feedback and usability testing loops with vulnerable groups (e.g., youth, Roma, refugees) to	60,2%	54,5%	-5,7%	

improve accessibility and engagement with digital tools and evaluate their effectiveness.



5.5.5 Anticipated Impacts and Innovative Strategies

The third and final section of the questionnaire examined how structural, technological, demographic, and governance transformations could transform access to mental healthcare in the next 15 years. It explores the potential role of digital technologies, community-led interventions, and EU-level collaboration in addressing persistent and future challenges to equity. The goal was to support strategic foresight by identifying scalable, forward-looking solutions with the greatest potential to improve equitable access by 2040.

Findings showed that experts anticipate systemic integration, crisis resilience, demographic responsiveness, and coordinated governance reforms to exert the strongest long-term impact. In contrast, fully automated digital transformation models and highly experimental decentralization structures received more heterogeneous evaluations.

5.5.5.1 Very High Consensus (Round 2: ≥85%)

Very High consensus anticipated impacts in Section 3 overwhelmingly reflect **system-level integration and institutional preparedness**, rather than technological disruption.

The strongest endorsement was observed for the integration of mental health professionals into national disaster and crisis task forces (89.4%), signalling a decisive shift toward embedding mental health within broader public health and civil protection infrastructures. This reflects recognition that crises, whether public health emergencies, economic downturns, or environmental disasters, are no longer episodic anomalies but structural stressors requiring permanent preparedness architecture.

Similarly, strengthening EU-level collaboration and policy alignment in mental healthcare governance (86.4%) achieved very high consensus. This indicates strong expectations that cross-border harmonisation and coordinated strategic planning will significantly influence equity trajectories. Experts appear to view fragmentation at supranational and national levels as a long-term risk factor unless addressed through coordinated frameworks.

The development of integrated single-entry points to simplify cross-sector navigation (86.4%) also reached very high consensus. This finding reinforces continuity between Section 2 mitigation strategies and anticipated impacts: future equity gains are expected to depend on structural simplification of pathways and coordinated service ecosystems.

Expanding trauma-informed training across systems (87.9%) further demonstrates that the anticipated future is not only about administrative integration but also about embedding psychosocial safety and adaptability into institutional culture. This suggests recognition that population vulnerabilities, particularly among migrants, older adults, and trauma survivors will remain central to equity debates.

Finally, strengthening demographic-responsive research and adaptive service planning (86.4%) indicates that experts anticipate demographic transitions (aging populations, migration flows, socioeconomic shifts) to shape long-term system redesign. This item reflects an expectation that equity will increasingly depend on data-informed responsiveness.

Taken together, the Very High consensus items in this section reveal a coherent forward-looking vision centred on **institutional integration, crisis-embedded mental health governance, demographic adaptability, and system coordination**. Notably absent from this tier are automation-driven or purely digital transformation models. The anticipated future is therefore framed primarily as one of structural consolidation and coordinated resilience.

Table 16: Very High Consensus (Round 2: ≥85%)

Question	Anticipated Impacts and Innovative Strategies	Round 1 % Agreement (≥4)	Round 2 % Agreement (≥4)
What is the most important role for international EU collaboration in addressing these challenges?	Pan-European standards for evidence-based, inclusive care models co-developed with vulnerable groups.	80.7%	86.4%

5.5.5.2 High Consensus (Round 2: 75–84%)

The table summarises the items in the third section of the Delphi survey that achieved **high levels of expert consensus** on anticipated impacts and innovative strategies for improving mental healthcare access. Across all items, agreement levels were already high in Round 1 (ranging from approximately **72% to 77%**) and increased further in Round 2 (to **around 77%–82%**), indicating consistent convergence of expert opinion.

Among **community-based interventions**, experts showed strong agreement that establishing **local “mental health hubs”** integrating services with schools, clinics, and social services is an effective approach to improving access. Similarly, the deployment of **community health workers and peer navigators** was highly endorsed as a means of increasing service visibility and engagement, particularly for vulnerable populations.

With regard to **technological innovation**, experts reached high consensus on the value of **evidence-based, targeted digital and programmatic solutions** tailored to ageing populations and ethnic minorities, addressing emerging mental health needs linked to broader societal transitions.

Finally, in relation to **international EU collaboration**, experts agreed that **joint EU funding schemes** are essential to offset disparities in mental health investment across Member States, reinforcing the role of coordinated European action in reducing inequities.

High consensus anticipated impacts emphasise digital inclusion, community engagement, and blended innovation models.

Within **Approachability and Availability**, expanding telehealth ecosystems with hybrid safeguards (83.3%) received strong endorsement, suggesting that digital transformation is expected to remain important, but only when embedded within hybrid systems rather than fully virtual substitution. Under the interdimensional megatrend of **systemic resilience and innovation**, cross-sector crisis response models linking mental health, housing, employment, and social support (83.3%) were strongly endorsed as future drivers of equity. Similarly, community-based innovation hubs (81.8%) indicate expectations that localised experimentation will shape reform trajectories.

In **Affordability**, predictive economic monitoring and adaptive funding allocation mechanisms (78–82%) show strong agreement that future equity will depend on data-driven financing strategies capable of responding to economic volatility.

Within **Acceptability and Appropriateness**, expanding cultural competence frameworks and participatory governance mechanisms (approximately 75–81%) reflect expectations that inclusive governance structures will become more institutionalized over time.

High consensus items thus emphasize **adaptive integration**, **hybrid digitalisation**, and **participatory resilience** as anticipated drivers of equitable transformation.

Table 17: High Consensus (Round 2: 75–84%): top 3 highest

Questions	Anticipated Impacts and Innovative Strategies	Round 1 % Agreement (≥4)	Round 2 % Agreement (≥4)	
What is the most important role for international EU collaboration in addressing these challenges?	Joint EU funding schemes to offset disparities in mental health investment across Member States.	77.3%	81.8%	82%– <85%
How can technology most effectively be used to improve access to mental healthcare services?	Create evidence based targeted programs for aging populations, and ethnic minorities to address emerging mental health challenges linked to societal transitions.	75.0%	78.8%	79%– <82%
Which community-based interventions are likely to be most effective in improving mental healthcare access?	Provide local “mental health hubs” integrating services with schools, clinics, and social services.	76.1%	77.3%	75%– <79%
				< 75%

5.5.5.3 Low Consensus (Round 2: <65%)

Lower consensus included trends primarily related to automation-heavy digital transformation models and decentralised cooperative restructuring.

AI-powered mental health assistants (56.1%) and highly automated triage systems remained below 65%, indicating scepticism that algorithmic substitution will fundamentally reshape equitable access in the foreseeable future. Similarly, open-access digital self-navigation platforms (60.6%) received moderate support but did not achieve strong consensus. Low consensus levels regarding community-run cooperative financing and decentralised governance cooperatives (51–60%) are reflecting uncertainty regarding scalability and equity implications. The pattern suggests that experts anticipate technological and decentralized experimentation to play a role, but not as dominant equity drivers relative to integrated governance and crisis preparedness.

Table 18: Low Consensus (Round 2 <65%): top 3 lowest

Questions	Anticipated Impacts and Innovative Strategies	Round 1 % Agreement (≥4)	Round 2 % Agreement (≥4)	
How can technology most effectively be used to improve access to mental healthcare services?	Develop open-access digital mental health tools and educational self-help apps subsidised by public health systems.	59.10%	60.60%	< 30%
How can technology most effectively be used to improve access to mental healthcare services?	Use predictive analytics to personalise care pathways and match users to appropriate service models.	60.20%	63.60%	30% – <40%
What is the most important role for international EU collaboration in addressing these challenges?	Fund infrastructure for transnational telehealth and rural service delivery pilots.	60.20%	63.60%	40% – <55%
				55% – <65%

5.5.5.4 Highest Difference rate

The largest positive shifts between rounds occurred in participatory and integration-oriented innovation strategies. Participatory design workshops and co-creation processes increased by more than +15%, indicating strengthened convergence around inclusive system redesign. Innovation hubs and cross-sector integration frameworks also exhibited increases above +10%, reinforcing the growing consensus that coordinated systemic transformation is necessary. Crisis-resilient governance structures similarly showed meaningful positive shifts, consolidating preparedness as a future-defining feature. In contrast, AI-driven automation and fully digital substitution models exhibited minimal change, indicating stable but limited endorsement.

The difference-rate findings confirm that the Delphi process reinforced agreement most strongly around **integration, resilience, and participatory governance**, rather than technological disruption.

Table 19: Highest Difference rate: top 3 highest, top 3 lowest

Questions	Anticipated Impacts and Innovative Strategies	Consensus	Δ % Agreement (≥4)	
Which community-based interventions are likely to be most effective in improving mental healthcare access?	Conduct participatory design workshops to ensure that community services reflect local realities and identities.	Moderate Consensus	15.2%	> +10%
What is the most important role for international EU collaboration in addressing these challenges?	Pan-European standards for evidence-based, inclusive care models co-developed with vulnerable groups.	Very High Consensus	5.7%	> +5% – +10%

Which community-based interventions are likely to be most effective in improving mental healthcare access?	Deploy community health workers and peer navigators to increase service visibility and engagement.	High Consensus	5.7%	
Which community-based interventions are likely to be most effective in improving mental healthcare access?	Provide local “mental health hubs” integrating services with schools, clinics, and social services.	High Consensus	1.1%	+5% -
How can technology most effectively be used to improve access to mental healthcare services?	Use AI-powered, multilingual digital assistants to help individuals navigate services and understand options.	No Consensus	0.4%	-5%
Which community-based interventions are likely to be most effective in improving mental healthcare access?	Create community-run cooperatives that offer low-cost or donation-based counselling services.	No Consensus	-0.8%	< -5% - -10% < -10%

5.6 Policy recommendations and forward-looking insights

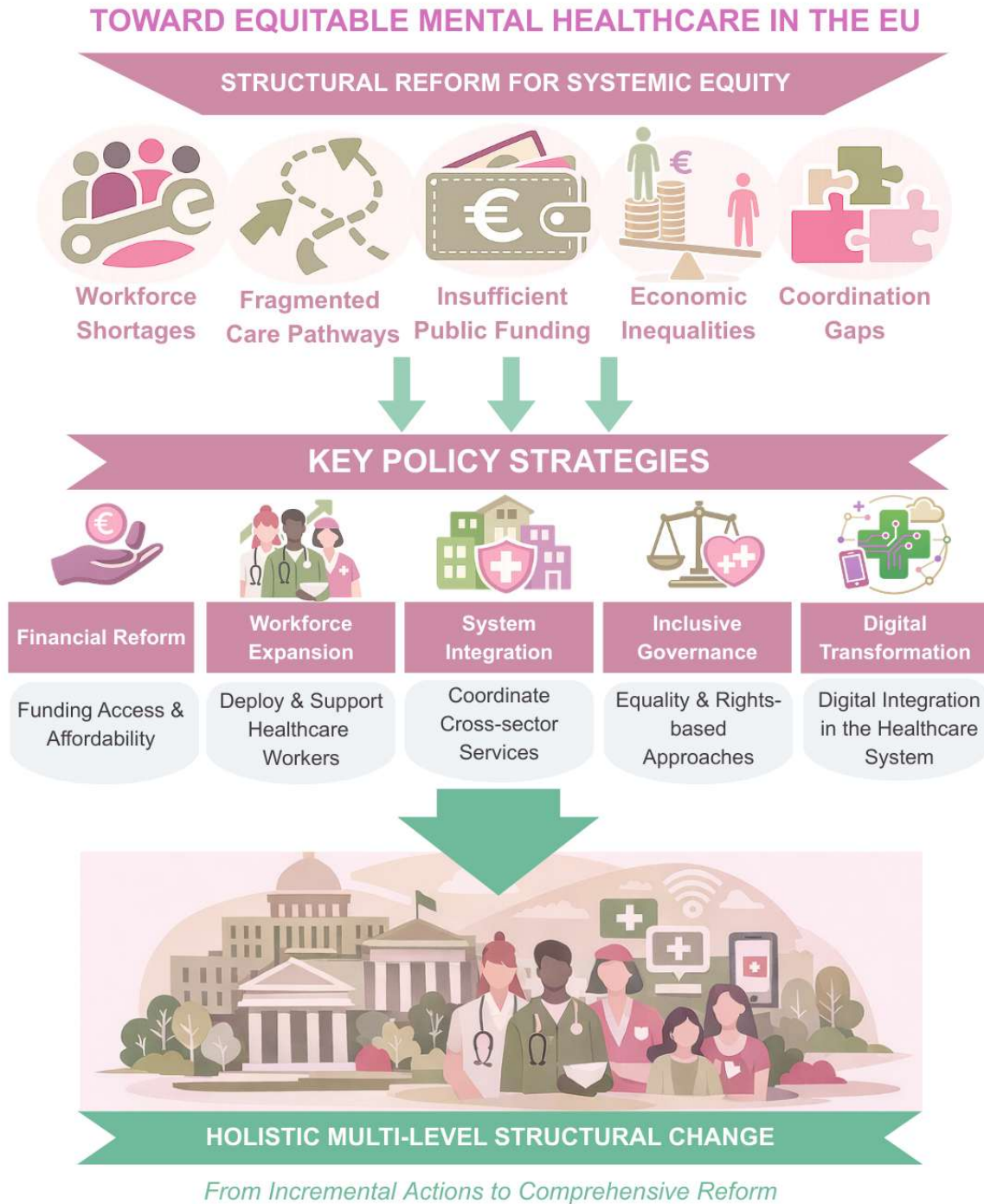


Figure 15: Key Policy Strategies

This section presents a set of recommendations derived from the combined findings of the literature review and the Delphi exercise, integrating both current evidence and forward-looking expert assessments. The Delphi results provide a structured foresight perspective by capturing expert judgements on the anticipated impact and evolution of identified structural trends, as well as the potential effectiveness of mitigation measures and innovative solutions over a 15-year horizon (up to 2040).

The recommendations therefore reflect not only existing structural trends but also their projected trajectories and future relevance, as perceived by a diverse panel of experts. In this context, particular attention is given to systemic developments related to **workforce capacity, digital transformation, service integration, and socioeconomic inequalities**, which are expected to continue shaping access to mental healthcare across European contexts.

In addition, the Delphi exercise explicitly incorporated a forward-looking dimension through the assessment of **mitigation strategies and innovative approaches**, including emerging technological solutions. Notably, the third section of the Delphi questionnaire explored **future-oriented interventions**, such as digital and AI-enabled mental health services, allowing experts to evaluate their potential role in improving accessibility and addressing structural inequalities.

The Delphi findings demonstrate that equitable access to mental healthcare in the EU is primarily **constrained by structural system architecture rather than isolated service-level deficiencies**. As shown in Section 5.5, the highest consensus barriers cluster around **workforce shortages, fragmented care pathways, insufficient public funding, economic inequality, and systemic coordination gaps**. Correspondingly, the highest-rated mitigation strategies prioritise **redistributive financing, workforce deployment, cross-sector integration, disability inclusion, and rights-based governance**. Taken together, these findings suggest that effective policy responses must move beyond incremental programmatic adjustments and instead pursue structural, multi-level reform.

Financing reform emerges as a central pillar. Very high consensus strategies include increasing public funding allocations, reducing out-of-pocket payments, strengthening inclusive insurance coverage, and embedding crisis-resilient funding mechanisms. These findings indicate that affordability is not simply a matter of individual cost burden but of systemic financial protection architecture. Policy responses should therefore prioritize mental health parity legislation, income-adjusted coverage schemes, zero co-payment mechanisms for vulnerable groups, and contingency financing frameworks capable of responding to economic downturns. The consistent strengthening of consensus around economic precarity between Delphi rounds further underscores that macroeconomic instability is perceived as a direct amplifier of mental health inequities.

Second, **workforce redistribution and capacity expansion must be operationalized as core equity strategies**. The strong endorsement of mobile and hybrid care teams, deployment incentives for underserved regions, and integrated return-to-work programs reflects recognition that geographic and socioeconomic disparities in supply significantly shape access. EU-level policy coordination could support harmonized workforce mobility frameworks, targeted investment in rural service models, and cross-sector workforce integration linking mental health, social care, and employment services.

Third, **system integration and governance coordination are critical**. High and very high consensus items emphasise the importance of single-entry access points, care coordination roles, multi-sectoral service hubs, and structured collaboration between mental health, housing, employment, and disaster-

response systems. These findings suggest that fragmentation is perceived not merely as inefficiency but as a structural barrier that actively generates inequity. EU and national policy should therefore incentivize interoperable data systems, coordinated referral networks, and institutionalized cross-sector governance platforms.

Fourth, **rights-based and inclusive governance must be embedded institutionally.** The strong consensus around, supported decision-making, anti-stigma training, cultural competence frameworks, and disability accommodations indicates that trust and ethical safety are foundational to equitable access. Policy reform should formalise anti-discrimination safeguards, institutionalize trauma-informed training standards, and integrate community co-design mechanisms into service planning processes.

Finally, **digital transformation should be pursued cautiously and inclusively.** While hybrid telehealth ecosystems achieved strong endorsement, fully digital substitution models did not. Policymakers should therefore prioritise digitally inclusive frameworks that address literacy, infrastructure disparities, and cultural alignment rather than assuming that technological expansion alone will reduce inequities.

Overall, the policy implications of the Delphi findings are clear: equity in mental healthcare requires coordinated structural reform spanning financing, workforce distribution, governance integration, and inclusive institutional design. Incremental digital innovation or awareness campaigns, without systemic redesign, are unlikely to achieve sustained impact.

6. Conclusions

This deliverable set out to identify the structural determinants shaping equitable access to mental healthcare in the European Union and to assess, through expert consensus, the most impactful mitigation strategies and future megatrends likely to influence equity over the next 15 years. By combining a structured literature review with a two-round Delphi survey, the study provides both evidence-based grounding and forward-looking expert convergence. Within this framework, Task 1.3 delivers the **macro-level analysis** of systemic megatrends shaping access, complemented by Tasks 1.4 and 1.5, which examine barriers at the **meso (health system)** and **micro (lived experience)** levels.

The literature review demonstrated that inequities in mental healthcare access are not primarily driven by isolated service gaps, but by systemic design characteristics. Workforce maldistribution, fragmented governance structures, insufficient and unstable financing, socioeconomic precarity, digital divides, and institutional mistrust repeatedly emerged across the scientific and grey literature as structural determinants of inequity. These determinants operate across the Levesque dimensions of access - Approachability, Acceptability, Availability & Accommodation, Affordability, and Appropriateness - highlighting that access is multidimensional and interdependent rather than linear.

The Delphi findings strongly reinforce and operationalise these insights. Across both rounds, the highest consensus barriers clustered around workforce shortages, fragmented care pathways, insufficient public funding, economic inequality, stigma, and coordination deficits. The convergence strengthened in Round 2 particularly around economic precarity, human rights protections, and structural workforce redistribution, suggesting increasing recognition of the interdependence between social protection systems and mental healthcare equity. Notably, affordability-related barriers achieved consistently high consensus, underscoring that financial protection architecture remains a foundational determinant of equitable access across Member States.

Correspondingly, the highest-rated mitigation strategies prioritised redistributive financing, workforce deployment to underserved areas, integration of services across sectors, disability-inclusive design, and rights-based governance. The findings indicate that experts do not perceive incremental service-level improvements or awareness campaigns as sufficient. Rather, they emphasise systemic reform: embedding mental health within broader social protection and disaster-response systems, institutionalising inclusive governance standards, strengthening cross-sector coordination, and ensuring sustainable financing frameworks resilient to economic shocks.

The anticipated impacts section further confirms that the future trajectory of equitable mental healthcare in the EU will likely be shaped by integration and resilience rather than technological substitution alone. While hybrid digital ecosystems were supported, fully automated or digital-only models did not achieve comparable consensus. Instead, experts anticipate that integrated service ecosystems, crisis preparedness structures, demographic responsiveness, and participatory governance will exert the strongest long-term influence. This aligns closely with the literature's emphasis on social determinants, structural inequalities, and institutional trust as critical levers of reform.

Taken together, the evidence suggests that equitable mental healthcare cannot be achieved through isolated digital innovation, localised pilot programs, or short-term funding injections. Sustainable equity requires coordinated structural transformation across financing, workforce planning,

governance integration, rights-based safeguards, and inclusive institutional design. Moreover, the findings highlight the importance of EU-level coordination to address cross-border disparities, harmonize standards, and strengthen system resilience in the face of economic, demographic, and environmental pressures.

One limitation of the study that should be acknowledged is that the literature review followed a scoping approach focused on thematic synthesis rather than exhaustive systematic appraisal, meaning that some relevant studies, particularly those outside the selected databases or published in languages other than English, may not have been captured. Grey literature sources often reflect policy narratives and institutional perspectives, which may not fully represent the operational realities of mental healthcare delivery across all EU Member States. Finally, the Delphi results are based on expert judgement rather than empirical measurement; although efforts were made to ensure geographic and disciplinary diversity, the findings reflect the perspectives of participating experts and may not fully represent all national contexts or stakeholder groups.

In conclusion, this deliverable demonstrates that the pathway toward equitable mental healthcare in the EU is fundamentally structural. The convergence between literature evidence and Delphi expert consensus strengthens the robustness of this conclusion. Moving forward, policy frameworks must prioritize multi-level, cross-sector, and resilience-oriented reform, recognizing that mental health equity is inseparable from broader social, economic, and governance systems. Only through such comprehensive transformation can long-term, sustainable equity gains be realized across diverse European contexts.

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8. Annexes

8.1 EQUICARES Delphi Survey participation Informed Consent Form

Information sheet

We would like to invite you to take part in a Delphi Survey being carried out by EQUICARES, a 4- year project funded by the European Union within the framework of the Horizon Europe Research and Innovation programme. Before you decide to take part in our project's activity, **please take some time to carefully read this information sheet and ask questions about anything you do not understand.**

The project is funded under the European Union's Horizon Europe Research and Innovation Programme under Grant Agreement no.101156500. The project's call is HORIZON-HLTH-2024-CARE-04-04-two-stage.

About the EQUICARES project

EQUICARES aims to enhance access to mental health services for people in vulnerable situations through research, co-creation and policy innovation. It uses cutting-edge methods to evaluate and improve mental health systems, piloting solutions in 8 areas across 7 countries, representing a range of socioeconomic settings and covering all major categories of people in vulnerable situations.

EQUICARES:

- empowers communities through Smart Health Labs, that will engage community members to co-design, assess and implement solutions that meet their needs
- introduces an AI-based mental health assistant to enhance both the mental and digital knowledge of users,
- and develops tools like a Policy Dashboard and an Atlas to support long-term impact and inform policy and strategic frameworks within the EU.

In this context, the main objectives of the EQUICARES project are to:

- Identify and analyse inequalities and barriers to accessing mental health services for people in vulnerable situations across the healthcare system.
- Identify, assess and share with policymakers and care workers innovative solutions that promote access to mental health services.
- Involve people in vulnerable situations directly in creating solutions via the local "Smart Health Labs", a health promotion programme and the AI Assistant, while also supporting and engaging the supply side actors.
- Co-design and pilot innovative solutions in the 8 pilot sites to improve both access and service quality of mental health services.
- Measure the impact and cost-effectiveness of pilot interventions including the costs of not taking action.
- Provide policymakers with high quality data and recommendations to support wider adoption of successful solutions.

- Ensure that the project's results are properly disseminated to and exploited by core stakeholder groups (e.g., policy makers, mental health care workers, service providers, representatives of disadvantaged groups).

Why have I been chosen?

You have been invited to take part in the activity of the EQUICARES project because you are a resident of one of the places that we are interested in investigating and/or implementing practical solutions. Therefore, you are identified as a “stakeholder” of the project. A stakeholder is either an individual, group or organisation that is either impacted by the outcomes of the project and or has an interest in the success of the project. You have been selected as a proposed contributor to this survey based on your expertise in mental healthcare and your active involvement in one or more of the following areas: Mental Healthcare, Policy Making and Administration, Academia / Research, Technology and Innovation, NGOs, CSOs, Advocates and Community Leaders, Business and Industry addressing mental health and vulnerable populations.

If you agree to take part, you will be asked *to participate in a 2 round Delphi Survey, which aims to identify macro-level megatrends affecting mental health service access for vulnerable populations in the European Union and analyse these barriers using the updated Levesque's framework.*

Is my participation in the project's activity voluntary?

Your participation is entirely voluntary.

If you agree to participate in the project's activity, we will ask you to **sign the EQUICARES Informed Consent Form** (provided in the next section) to collect and process your data. The project lasts for 48 months, but **your involvement would only be for this activity**: each round of the Delphi Survey is estimated to take approximately 40 to 60 minutes to complete, spread over a few weeks during September – October 2025. If you wish, you can remain involved in other project activities for the next months. In this case you need to sign the related documents again.

What are the benefits of my participation?

There may not be direct benefits for your participation in the activity (e.g., financial compensation); however, by participating, you will help shape mental healthcare policies and practices in the EU through your expert insights, contributing to a deeper understanding of key challenges and solutions. Your involvement supports efforts to improve access to mental healthcare for vulnerable populations, promoting equity and social justice. This is also a valuable opportunity for professional development, allowing you to engage with peers and stay informed on emerging trends in the field. The survey is conducted online and designed to require only a minimal time commitment over two rounds.

In the long run, you will indirectly benefit from the project's findings and results, particularly if you are a resident in one of the selected areas where the EQUICARES project members will launch interventions (e.g., Smart Health Labs) that are expected to lead to practical improvements in the wellbeing of local communities. Moreover, by participating in the Delphi Survey, you will also be connected to the project as key stakeholder, and you will be able to access first-hand our resources and results (e.g., digital tools, learning resources).

What we need from you: purpose of data collection

We are conducting a comprehensive analysis of barriers to accessible mental health and care services for vulnerable populations across the European Union, using a macro-level trend analysis approach. We aim to analyse the barriers using the updated Levesque framework to examine them from the supply/provider perspective, focusing on factors such as approachability, acceptability, availability, accommodation, affordability, and appropriateness within the vulnerability context and we will investigate how these barriers manifest at a macro level (policy, societal, economic). Finally, we will gather expert predictions (integrating the dimensions of the updated draft version of the Levesque framework)

The 2-round Delphi Survey will include:

- **Round 1:** You will complete an online questionnaire with primarily closed-ended questions, focusing on rating the impact of various megatrends and identifying potential mitigation strategies.
- **Round 2:** You will receive a summary of the Round 1 responses and have the opportunity to revise your answers based on collective feedback. This round may also include some open-ended questions for further elaboration.

The Expected Outcomes are:

- A comprehensive mapping of macro-level barriers to mental health access.
- Identification of trends impacting service provision in the EU.
- Policy recommendations based on Delphi consensus findings.

To effectively conduct this study, we need to collect and process some of your personal data, including:

- Your contact details
- Basic demographic information (age, gender, income level)
- Professional information (organisation, job position, field of expertise)
- Your opinions, insights and experiences on the subject matter

What will we do with your data?

The information you provide will be treated with the utmost confidentiality and in full compliance with data protection laws and ethical research standards.

Your consent form will be stored separately from the data observations collected during the course of the project activity (e.g. observations, interviews, responses to survey questionnaires) to ensure your anonymity. Your data will be securely shared only with authorised EQUICARES project partners who are directly involved in the data analysis and reporting process. These partners are bound by confidentiality agreements and adhere to strict data protection protocols. Once the data has been analysed, a report of the findings may be submitted for publication. The project's reports that will be derived by this activity **will not include your personal data or any other information that could identify you.**

The results of this project activity may also be shared with European Union representatives (e.g., the Project Officer evaluating the project's progress, auditing EU agencies). Only broad trends will be reported, and **no personal data or identifiable information about you will be included.** We will not share your data with 3rd parties. Data will only be accessible to the project team of Q-PLAN

INTERNATIONAL and securely stored in accordance with GDPR and national data protection regulations.

Detailed information on how the EQUICARES project handles data is provided in the EQUICARES Privacy Policy document that was shared with you or can be found online here: <https://equicares-project.eu/privacy-cookie-policy/>

Are there any ethical risks involved?

The EQUICARES project has been **evaluated as “ethics-ready” by the European Commission**. Therefore, no ethical risks are involved in the project’s activity.

Furthermore, the project has established an **Ethics Advisory Board (EAB)** from a dedicated group of partners to ensure that all project activities are conducted in accordance with high ethical standards and respect participants' rights.

An **External Ethics Advisor** has also been recruited to provide independent guidance on ethics-related matters. This advice was taken into consideration for the design and implementation of the project’s activity to safeguard participant well-being and data protection.

Finally, the project has obtained an Ethical Approval by the Ethics Committee of the CITY College, University of York Europe Campus. The Ethical Approval applies to this project’s activity.

Are there any risks involved?

There are no expected risks associated with participating in this project. However, if at any point during the project you decide you no longer wish to continue, you have the right to withdraw without any consequences. If you choose to withdraw, you may also request that any data you have provided be deleted.

Does my participation entail financial costs?

No financial costs are entailed in your participation.

Access, deletion of information or consent withdrawal

According to the **General Data Protection Regulation (GDPR)**, you have the right to:

- Access your data: request a copy of your data,
- Correct your data: Request corrections if you believe your data is inaccurate or incomplete.
- Delete your data: Request that we delete your personal data.
- Restrict data processing: Request that we limit or stop the processing of your data.
- Data portability: Request that your data be provided in a structured, commonly used, and machine-readable format, and/or transferred to another organisation.

In addition to these rights, you may also **withdraw your consent** and, therefore, your participation at any time without any consequences. Should you decide to withdraw your consent, your participation will end immediately. Please note that if you withdraw your consent, any anonymous data already collected before your withdrawal may still be used because it cannot be traced back to you. No further data collection or related activities will be carried out in connection with your information after consent is withdrawn.

In case you wish to verify the personal data that we store, have it modified, corrected, deleted or request a consent withdrawal, you may communicate with the responsible partner listed below and ask for a copy of the **EQUICARES Data Subject Request Form**. Please fill in the form, explicitly describing your request, and forward it back to the partner conducting the project activity.

Whom do I contact if there is a need to?

EQUICARES partner conducting the project activity		EQUICARES Project Coordinator	
Partner name:	Q-PLAN International Advisors PC	Partner name:	WHITE RESEARCH SRL
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Informed Consent Form

I confirm that I understand that by ticking each box below I am consenting to this element of the study. I understand that it will be assumed that unticked boxes mean that I DO NOT consent to that part of the study. I understand that by not giving consent for any one element, I may be deemed ineligible to participate in this project's activity.

If I am an individual with cognitive impairments, I understand that my authorised representative must provide consent on my behalf. In such cases, I will also be asked to provide my own agreement (assent) where possible, using language and materials appropriate to my ability, or needs.

If I am unable to read or sign this form, I understand that verbal consent may be provided instead. In such cases, verbal consent will either be audio/video-recorded (with secure storage) or witnessed by an appropriate individual to confirm my informed decision. Adequate evidence of this verbal consent will be securely maintained.

I confirm that I have been given a full explanation of the purpose of the project's activity. I have [read and] understood the Information Sheet, which I was provided with or listened to an explanation about the project by a project partner. (If you do not tick the box of this question, please do not proceed with this consent form until you are fully aware of what your participation in the project will mean).

I have had an **opportunity to consider** what information will be expected of me. I have also had the **opportunity to ask questions** which have been answered to my satisfaction.

I agree that my **anonymised research data** may be used for future research. I understand that I will not be identifiable when this data is shared.

I understand that **my participation is voluntary** and that **I am free to withdraw** at any time without giving a reason, and that any data after the time of which it is withdrawn will no longer be included as part of any future reports, unless I agree otherwise.

I understand that **my personal data will be held and processed in confidence** and in accordance with the principles laid out by **GDPR principles**.

I understand and agree that the project research team and other authorised researchers may use my data in publications, reports, and other research outputs, provided **the confidentiality of the information** is preserved.

I am aware of whom I should **contact** if I have **questions about this activity**.

I am aware of whom I should **contact** if I want to access the **transcribed content** of my interview.

I am aware of whom I should contact if I wish to **lodge a complaint** or if **I want my personal data deleted**.

I confirm that I have [read and] understood the above and freely consent to participate in this project's activity. I have been given adequate time to consider my participation.

Future activities

If you would like your contact details to be retained so that you can be contacted in the future by the project researchers who would like to invite you to participate in **further activities of this project**, or in future studies of a similar nature, please tick the appropriate box below.

Yes, I would be happy to be contacted in this way*

No, I would not like to be contacted

*Contact details

Email:

Name of participant
(optional but recommended).

Date

Signature

8.2 Delphi Questionnaire

In all sections of the questionnaire, experts were asked to assess their perceived impact of the listed structural trends during the next 15 years.

Section 1: Impact of Identified Barriers on Equitable Mental Healthcare

(For questions 1-33, please use the following scale: 1 = No Impact, 2 = Low Impact, 3 = Moderate Impact, 4 = High Impact, 5 = Very High Impact)

Approachability

Approachability is the degree to which a health service is structured and communicated in ways that make it visible, comprehensible, and perceived as trustworthy and relevant by its target population. An approachable health system does not merely inform people of its existence, it also enables individuals to recognise their own health needs, through screening, community outreach, and culturally attuned engagement, and encourages them to initiate contact by building confidence in the service's accessibility, usefulness, and ethical intent.

For each of the following barriers, please indicate the extent to which you believe they will negatively affect equitable access to mental healthcare for vulnerable groups within the EU during the next 15 years.

1 = No Impact, 2 = Low Impact, 3 = Moderate Impact, 4 = High Impact, 5 = Very High Impact

1. Insufficient public awareness and persistent **information gaps** hinder the recognition of both mental health needs and available services.
2. The **digital divide** (gap in access to digital technologies) and unequal access to telehealth limit the visibility and perceived accessibility of mental health support.
3. **Fragmented and poorly coordinated cross-sectoral mental health approaches** make service pathways less clear and more difficult to comprehend.
4. **Complex administrative, legal, and logistical processes** undermine confidence in the accessibility and relevance of services.
5. **Public health crises** (e.g., COVID-19) can disrupt traditional communication channels in mental health care services making them less visible, understandable, and trustworthy to the public.
6. Climate change and **climate-related disasters** create additional barriers to outreach and to service continuity.
7. **Lower education levels**, linked to socioeconomic inequalities, restrict the necessary knowledge to identify mental health needs and navigate available care.

Acceptability

Acceptability refers to how socially and culturally appropriate health services are perceived by individuals and communities. It is shaped by provider characteristics (e.g., gender, language, cultural background), service design (e.g., patient involvement, respectful communication), and the system's sensitivity to cultural, religious, and identity-based norms, as well as its history of inclusion or

exclusion. These factors interact with broader social norms, influencing whether care is viewed as appropriate, safe, and aligned with personal values. For some groups, services may seem alienating or inappropriate despite being formally available, especially when institutional design, communication, or provider attitudes fail to reflect community diversity.

For each of the following barriers, please indicate the extent to which you believe they will negatively affect equitable access to mental healthcare for vulnerable groups within the EU during the next 15 years..

1 = No Impact, 2 = Low Impact, 3 = Moderate Impact, 4 = High Impact, 5 = Very High Impact

8. **Stigma and discrimination** undermine trust and discourage individuals from seeking mental health services.
9. **Cultural and social determinants** (such as beliefs, traditions, and socioeconomic factors) create mismatches between service delivery and community values or norms.
10. A **lack of tailored, trauma-informed care** reduces perceived relevance and emotional safety of services.
11. **Insufficient understanding of disability** among providers leads to inappropriate or exclusionary practices.
12. **Human rights violations** such as discrimination, abuse, or neglect by service providers or institutions, undermine trust in the ethical intent and safety of the system, making individuals hesitant to engage with it.
13. **Limited respect for individual autonomy** diminishes perceptions of dignity and appropriateness of mental healthcare services.

Availability and Accommodation

Availability and Accommodation refer to the physical and temporal accessibility of health services for all in need. This includes the presence, capacity, and distribution of facilities and staff, as well as how well services align with people's living conditions, work schedules, and mobility needs. While services may formally exist, they can remain inaccessible due to uneven geographic distribution, staff shortages, rigid operating hours, or systems that exclude individuals with low literacy.

For each of the following barriers, please indicate the extent to which you believe they will negatively affect equitable access to mental healthcare for vulnerable groups within the EU during the next 15 years..

1 = No Impact, 2 = Low Impact, 3 = Moderate Impact, 4 = High Impact, 5 = Very High Impact

14. The **digital divide** (gap in access to digital technologies) limits equitable access to telehealth due to gaps in technology, digital literacy, and infrastructure.
15. **Insufficient telepsychiatry services and digital interventions** hinder the availability and effectiveness of remote mental health care.
16. **Systematic access gaps** related to health professionals and resources allocation (structural shortages or uneven distribution).

17. **Fragmented care pathways**, caused by limited integration across health and social services, reduce service accessibility.
18. **Geographic and rural disparities** restrict timely and consistent access to mental health services, especially in underserved regions.
19. **Public health crises** (e.g., COVID-19) disrupt service continuity, increase demand, and strain alternative delivery systems.
20. **Demographic shifts**, such as migration and ageing populations, require more adaptable, culturally responsive, and evenly distributed services.
21. **Climate change and climate-related disasters** damage infrastructure, displace populations, and disrupt care delivery.

Affordability

Affordability refers to the ability of individuals and households to access appropriate health services without risking financial hardship. It reflects the balance between direct and indirect costs of care (e.g., fees, medicines, transport, income loss) and a person's capacity to pay, shaped by financing models, coverage, and out-of-pocket payments. When services are only partially covered by public healthcare or rely on private provision, costs can lead to delayed care and unmet needs.

For each of the following barriers, please indicate the extent to which you believe they will negatively affect equitable access to mental healthcare for vulnerable groups within the EU during the next 15 years.

1 = No Impact, 2 = Low Impact, 3 = Moderate Impact, 4 = High Impact, 5 = Very High Impact

22. **Insufficient public funding and resource allocation** increase out-of-pocket costs and restrict service availability.
23. **Limited or fragmented public health insurance coverage** leaves essential mental health services unaffordable.
24. **Low income or /and low education levels** reduce the financial capacity to access care.
25. **Unstable employment and financial insecurity** create affordability barriers and reduce the likelihood of employer-based support.
26. **Economic inequalities** restrict access to affordable services for disadvantaged groups.
27. **Economic crises and downturns** exacerbate financial barriers and deepen existing inequities in service access.

Appropriateness

Appropriateness refers to how well health services meet individuals' specific needs, considering timeliness, quality, and the adequacy of care. Truly appropriate care is coordinated, continuous, effective, and acceptable, going beyond mere availability or affordability. Poor-quality or fragmented services do not constitute meaningful access, as alignment with needs is essential for positive outcomes and user satisfaction

For each of the following barriers, please indicate the extent to which you believe they will negatively affect equitable access to mental healthcare for vulnerable groups within the EU during the next 15 years.

1 = No Impact, 2 = Low Impact, 3 = Moderate Impact, 4 = High Impact, 5 = Very High Impact

28. **Cultural and language barriers, lack of cultural competence, and limited trust**, negatively impact equitable access to mental healthcare for vulnerable groups.
29. **Systemic gaps**, including fragmented care and lack of coordination, prevent health services from meeting the specific needs of vulnerable groups.
30. A **lack of tailored, trauma-informed care** leads to inadequate and insensitive support for those with trauma histories.
31. **Limited disability awareness and training among providers** result in inappropriate or insufficient care for people with disabilities.
32. **Demographic changes**, including migration and ageing, and services not sufficiently adapted to diverse population needs, negatively impact equitable access to mental healthcare for vulnerable groups.
33. **Public health crises** (e.g., COVID-19) expose service gaps in service delivery and the need for care models that are flexible, responsive, and better aligned with the specific, evolving needs of individuals to ensure appropriateness in care.

Section 2: Mitigation and Prevention Strategies

For each of the megatrends listed below that are related to aforementioned barriers for each dimension of the Levesque Framework, please select up to two (2) mitigation strategies you believe would be the most effective in enhancing equitable access to mental healthcare services for vulnerable populations during the next 15 years.

Approachability

34. **Healthcare system capacity for proactive, clear, and inclusive mental health information dissemination**
 - Launch targeted mental health awareness and promote culturally adapted programs (e.g., stigma-reduction campaigns) using plain language, multilingual formats, and culturally resonant messages for underserved groups such as refugees, Roma, and LGBTQ+ communities.
 - Ensure the comprehensibility of mental health information, tailoring materials to literacy levels and cultural contexts (e.g., visual aids for people with vision impairments or easy-read formats for people with disabilities).
 - Increase the visibility of services through transparent and accessible information channels (websites, community leaflets, mobile apps) providing clear entry points, expected processes, and service pathways.
 - Integrate community-based outreach (via NGOs, cultural mediators, and peer advocates) to actively engage marginalised groups and improve trust.
 - Other:

35. Streamlining systemic (administrative, legal, logistical) processes

- Simplify service application and intake forms with culturally sensitive, disability-accessible, and low-literacy-friendly designs.
- Create multilingual service directories and visual care maps, accessible both online and in print, tailored for refugees and migrants.
- Establish “one-stop” service access points (physical centres in rural areas or digital hubs for remote users) to reduce navigation barriers and increase visibility.
- Offer prevention and early screening programs integrated within administrative processes (e.g., perinatal screening for refugee women or mental health checks for disaster survivors).
- Other:

36. Involve the community in developing culturally sensitive, inclusive healthcare information and pathways

- Co-create mental health education and awareness campaigns with input from ethnic minorities, LGBTQ+ groups, and Roma communities to ensure cultural alignment.
- Increase visibility of pathways by developing visual, multilingual, and low-literacy-accessible guides explaining how to access mental health services.
- Employ community ambassadors from marginalised groups to build trust and serve as bridges between populations and the healthcare system.
- Use routine PREMs (Patient Reported Experiences) and PROMs (Patient Reported Outcomes) to evaluate whether cultural respect, transparency, and trust are achieved across diverse demographic groups.
- Other:

Acceptability

37. Cultivating a systemic culture of anti-stigma, respect, and non-discrimination

- Launch culturally tailored anti-stigma campaigns co-designed with Roma, refugee, youth, and LGBTQ+ communities to challenge stereotypes and misinformation.
- Implement mandatory stigma-reduction and unconscious bias training for all staff.
- Design welcoming facilities that reflect cultural safety, gender sensitivity, and privacy needs (e.g., for survivors of violence or people from the LGBTQ+ community).
- Promote inclusive public discourse by partnering with community leaders, minority organisations, and rural networks to normalise positive mental health narratives.
- Other:

38. Understanding and including disability in mental healthcare

- Train professionals on the intersection between disability and mental health, including cultural stigma.
- Go above universal accessibility standards by integrating rural accessibility measures (e.g., tele-health with sign language options).
- Provide reasonable accommodation, such as assistive technology, home visits for older adults, or extended consultation times.
- Use accessible communication formats, including Easy Read materials, audio guides, and multilingual disability support resources.

- Other:

39. Upholding human rights and dignity in mental healthcare delivery

- Embed human rights indicators (privacy, non-coercion, informed consent) into quality assessment frameworks.
- Implement and enforce legal protections against coercive practices and discrimination, with accountability in rural and urban areas.
- Promote supported decision-making models (instead of forced interventions), ensuring cultural and gender sensitivity.
- Strengthen informed consent through clear, multilingual, and culturally adapted processes (e.g., for refugees or older adults).
- Other:

40. Empowering autonomy and shared decision-making

- Integrate evidence-based, shared decision-making tools and practices in routine clinical workflows for youth, LGBTQ+, and culturally diverse clients.
- Provide support navigators, (trained individuals, including those from minority groups or with lived experience of rural/remote access challenges) who can guide individuals through the healthcare system, helping them access services.
- Offer diverse treatment pathways, such as telehealth for remote areas, and culturally tailored recovery programs.
- Encourage clients to set recovery goals that include the involvement of family and community support, with particular attention to youth and individuals from ethnoreligious minority groups.
- Other:

Availability and Accommodation

41. Telepsychiatry and digital intervention deployment

- Co-design clinically validated mental health apps and digital platforms with direct input from people with disabilities, LGBTQ+ individuals, and migrant communities to ensure cultural and linguistic relevance.
- Establish feedback and usability testing loops with vulnerable groups (e.g., youth, Roma, refugees) to improve accessibility and engagement with digital tools and evaluate their effectiveness.
- Integrate telepsychiatry with local peer support and community-based outreach, ensuring a hybrid model for those without digital access.
- Implement national, ethical and security protocols for online mental health care, with specific guidance on safeguarding vulnerable populations (e.g., survivors of natural disasters, unaccompanied minors).
- Other:

42. Workforce and resource distribution

- Offer financial incentives, scholarships, and loan forgiveness opportunities for mental health professionals from underrepresented communities (e.g., ethnic minorities, Roma), and/or for those who commit to serving in underserved areas.

- Deploy mobile and hybrid care teams to remote and rural areas.
- Expand the scope of practice for trained community health workers, ensuring they can provide first-line mental health support in underserved regions.
- Establish crisis response teams with rapid deployment capabilities for regions impacted by disasters or sudden mental health surges.
- Other:

43. Decentralised, culturally responsive service models

- Establish community mental health centres in remote and marginalised areas with multilingual and culturally tailored services.
- Train local community leaders, cultural mediators, and trusted stakeholders (e.g., Roma, refugee community leaders) to provide mental health first aid and advocacy.
- Deploy mobile clinics and outreach teams to reach hard-to-access populations (e.g., unaccompanied minors, survivors of disasters).
- Strengthen peer-led support networks (e.g., LGBTQ+ peer mentors, refugee survivor groups) to create safe spaces for psychosocial care.
- Other:

Affordability

44. Strategic funding and resource allocation

- Provide equity-focused funding dedicated to mental health services for high-needs groups (e.g., Roma communities, refugees, and youth), ensuring rural/remote areas receive appropriate investment.
- Ensure that community-based mental health models integrate low-cost primary care services that reduce long-term costs, particularly for people with disabilities and older adults.
- Design public-private partnerships to fund digital and community-based care for groups often excluded from mainstream services, such as ethnic minorities.
- Create performance-based funding models to improve outcomes for marginalised populations in under-resourced areas.
- Other:

45. Inclusive mental healthcare insurance schemes

- Provide mental health insurance coverage that includes preventive, digital, and community-level care, ensuring services are accessible to underserved vulnerable populations.
- Create targeted subsidies or premium assistance for low-income and rural populations, especially Roma and older adults facing fixed incomes.
- Ensure zero or minimal co-payments for vulnerable groups (e.g., unaccompanied minors, LGBTQ+ and youth) to eliminate financial barriers.
- Develop mental health parity laws ensuring mental health services receive the same financial coverage as physical health, with special provisions for marginalised communities.
- Other:

46. Income-adjusted, educationally-considerate pathways

- Create tiered or sliding scale pricing models linked to income and social vulnerability to reduce the financial burden on low-income youth, older adults, and disaster-affected families.
- Ensure financial navigation support for migrants and ethnic minorities to access grants, or aid programs that cover mental health costs.
- Provide free or low-cost mental health services for disadvantaged groups with limited education or digital literacy, especially in rural or underserved urban areas.
- Develop dedicated emergency financial assistance funds for urgent care needs of disaster survivors or newly arrived refugees.
- Other:

47. Employment and financial stability support

- Integrate employment counselling into mental health services, tailored to people with disabilities, refugees, and LGBTQ+ individuals facing workplace discrimination.
- Ensure legal protections for mental health leave and flexible workplace accommodations, especially for informal or precarious workers in rural areas.
- Develop return-to-work programs co-designed with community organisations to help older adults and survivors of trauma regain financial stability.
- Create employer-led financial wellness programs that include mental health support, prioritising sectors with high vulnerability (e.g., migrant workers, low-wage labour).
- Other:

48. Reducing economic disparities through resource distribution

- Reallocate mental health funding to prioritise underserved rural and remote regions with high concentrations of ethnic minorities and low-income communities.
- Ensure targeted infrastructure investments (e.g., transportation vouchers, mobile clinics) to reduce indirect costs for remote populations.
- Provide incentives for mental health providers to establish practices in socioeconomically disadvantaged areas and serve marginalised groups.
- Create community-led financial initiatives such as localised mental health support funds or micro-grants for migrant and disaster-affected communities.
- Other:

49. Systemic financial resilience in economic crises

- Create dedicated emergency mental health funds to protect vulnerable populations during financial downturns or post-disaster recovery.
- Develop flexible contingency financing models that prioritise services for vulnerable populations during economic instability.
- Provide rapid reallocation protocols to ensure that rural and underserved regions maintain essential mental health services during crises.
- Ensure collaborative recovery programs that combine mental health and economic support for disaster survivors and low-income families in remote areas.
- Other:

Appropriateness

50. Cultural competence and responsiveness

- Co-design culturally sensitive mental health programs with ethnic minorities, ethnoreligious communities, Roma populations, and migrants, ensuring services reflect local customs, values, and beliefs.
- Recruit and train cultural mediators or interpreters to support migrants, refugees, and asylum seekers in rural/remote areas where language barriers and cultural gaps are most pronounced.
- Offer specialised cultural competence training for providers to understand the mental health needs of LGBTQ+ communities, older people, and youth with complex intersectional identities.
- Create mobile or community-based culturally aligned outreach teams for underserved rural areas, ensuring services are culturally relevant and locally trusted.
- Other:

51. Person-centred and rights-based approaches

- Establish national guidelines that mandate participatory decision-making for vulnerable populations (e.g., involving youth, people with disabilities, or survivors of natural disasters in their care plans).
- Develop rights-based policies to ensure that older adults, LGBTQ+ individuals, and ethnoreligious minorities are not subjected to discrimination or coercive practices in mental health care.
- Introduce rural/remote community consultation boards to regularly review whether services are meeting the unique needs of marginalised populations in these regions.
- Expand training for mental health professionals on intersectional ethics and person-centred care, emphasizing autonomy and dignity for migrants and asylum seekers with uncertain legal status.
- Other:

Interdimensional megatrends

Certain megatrends may impact multiple dimensions of the Levesque Framework. For example, the digital divide can influence both the Approachability dimension—how services are structured and communicated to be visible and understandable—and the Availability & Accommodation dimension, which relates to physical and temporal accessibility. For each megatrend listed below, please identify up to three (3) mitigation strategies that you consider most effective in improving equitable access to mental healthcare services for vulnerable populations during the next 15 years.

52. Digitally inclusive and manageable telehealth system and Infrastructure

- Develop digital literacy programs and user guides specifically tailored for older adults, Roma communities and migrants, ensuring cultural and linguistic alignment.
- Collect and analyse PREMs (Patient Reported Experiences) and PROMs (Patient Reported Outcomes) from telehealth users (especially from underserved groups) to continuously improve user experience and trust.

- Fund and distribute assistive digital tools (e.g., screen readers, adaptive devices) for vulnerable populations.
- Establish multilingual telehealth platforms and mental health helplines, tailored for youth, migrants, ethnoreligious minorities and other vulnerable populations.
- Create community-based digital hubs and public Wi-Fi points to facilitate telehealth access for remote populations without personal devices or stable connections.
- Other:

53. Comprehensible, integrated and coordinated service ecosystem

- Create integrated mental health entry points through primary care, schools, and social services, ensuring early recognition and referral for migrants, refugees, and youth populations.
- Appoint community-based care coordinators (including those from ethnic or cultural minorities) in rural areas to help users navigate fragmented care systems.
- Build multi-sectoral mental health hubs that integrate mental healthcare, housing, social services, and legal aid for migrants, LGBTQ+ individuals, and people with disabilities.
- Utilise interoperable and secure digital coordination systems (capable of sharing and integrating data across different platforms) to improve communication among providers, especially across rural-urban service divides.
- Implement streamlined referral pathways for specialised services (e.g., youth counselling, refugee trauma support), minimizing delays caused by bureaucratic processes.
- Other

54. Systemic resilience, adaptability and innovation during public health crises

- Prepare multilingual emergency communication plans and culturally adapted materials targeting refugees, migrants, and underserved communities.
- Train local leaders, peer networks, and community health workers to provide reliable mental health information and initial screening during crises.
- Build emergency-ready telehealth platforms and community-based crisis hotlines with multilingual and accessible formats.
- Partner with NGOs and local networks rapidly deploy trauma-informed care programs in disaster recovery settings.
- Build integrated cross-sector crisis response systems that link mental health care with housing, social support, and employment services for at-risk groups.
- Fund community-led mental health innovation hubs in underserved regions to co-develop scalable crisis interventions with vulnerable populations.
- Other:

55. Localised systemic capacities and preparedness in climate disaster response

- Establish community-based mental health rapid response teams that include cultural mediators and multilingual support for disaster survivors and vulnerable populations.
- Create culturally responsive communication strategies (e.g., using trusted local radio or faith-based networks) for rural populations or ethnoreligious minorities.
- Fund long-term trauma recovery and community rebuilding programs, especially for marginalised and historically underserved groups.

- Include mental health professionals in national disaster task forces, ensuring services are immediately integrated post-disaster.
- Other:

56. Trauma-informed and person-centred care

- Establish national guidelines for trauma-informed care, with adaptations for unaccompanied minors, disaster survivors, and refugees.
- Co-develop individualised care plans with service users, respecting cultural and family dynamics (e.g., older adults or ethnoreligious communities).
- Train all staff to recognise trauma triggers among marginalised groups (e.g., Roma facing systemic exclusion, LGBTQ+ facing discrimination), with a focus on avoiding traumatisation among groups with historical or ongoing marginalization.
- Ensure physical and emotional safety in services, including private spaces for LGBTQ+ clients and women survivors of violence.
- Other:

57. Embedding cultural competence and disability-inclusive responsiveness

- Require continuous cultural competence and anti-racism training that reflects the realities of ethnic minorities, migrants, and older populations in rural and urban contexts.
- Involve cultural mediators and interpreters (e.g., Roma mediators, refugee interpreters) to address language and cultural gaps in care.
- Recruit and retain a diverse workforce, ensuring gender, ethnicity, and language match with community demographics.
- Co-design services with people with disabilities to ensure clinical settings, communication tools, and therapies are inclusive and meet real needs.
- Train professionals on how to adapt therapies and assessments for individuals with overlapping vulnerabilities (e.g., older adults with disabilities or mental health conditions).
- Other:

58. Services responsive to demographic shifts

- Use disaggregated data (age, gender, ethnicity, disability, migration status) to evaluate and plan mental health resource allocation and identify service gaps.
- Continuously adapt service guidelines to evolving patterns of migration, urbanization, and population ageing.
- Create evidence based targeted programs for aging populations, and ethnic minorities to address emerging mental health challenges linked to societal transitions.
- Conduct regular consultations with vulnerable populations (e.g., Roma, ethnoreligious minorities, unaccompanied minors) to revise services according to shifting demographic needs.
- Fund research into demographic-specific barriers to appropriate care in remote areas.
- Other:

Section 3: Anticipated Impacts and Innovative Strategies

(For questions 59-61, please select the two (2) most applicable options from the choices provided)

59. How can technology most effectively be used to improve access to mental healthcare services?

- Use AI-powered, multilingual digital assistants to help individuals navigate services and understand options.
- Use predictive analytics to personalise care pathways and match users to appropriate service models.
- Create culturally attuned digital therapy platforms tailored to specific communities and identity groups.
- Develop open-access digital mental health tools and educational self-help apps subsidised by public health systems.
- Other (please specify):
-

60. Which community-based interventions are likely to be most effective in improving mental healthcare access?

- Deploy community health workers and peer navigators to increase service visibility and engagement.
- Provide local “mental health hubs” integrating services with schools, clinics, and social services.
- Create community-run cooperatives that offer low-cost or donation-based counselling services.
- Conduct participatory design workshops to ensure that community services reflect local realities and identities.
- Other (please specify):

61. What is the most important role for international EU collaboration in addressing these challenges?

- EU-supported knowledge exchange networks on culturally competent care and anti-discrimination practices.
- Fund infrastructure for transnational telehealth and rural service delivery pilots.
- Joint EU funding schemes to offset disparities in mental health investment across Member States.
- Pan-European standards for evidence-based, inclusive care models co-developed with vulnerable groups.
- Other (please specify):

8.3 Delphi Results

Section 1: Impact of Identified Barriers on Equitable Mental Healthcare Approachability

Item	ROUND 1			ROUND 2			Consensus Status
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	
Fragmented and poorly coordinated cross-sectoral mental health approaches make service pathways less clear and more difficult to comprehend.	80,7%	Yes	High	90,2%	9,5%	Yes	Very High
Insufficient public awareness and persistent information gaps hinder the recognition of both mental health needs and available services.	77,3%	Yes	High	82,0%	4,7%	Yes	High
Lower education levels, linked to socioeconomic inequalities, restrict the necessary knowledge to identify mental health needs and navigate available care.	77,3%	Yes	High	82,0%	4,7%	Yes	High
Complex administrative, legal, and logistical processes undermine confidence in the accessibility and relevance of services.	70,5%	No	Moderate	75,4%	5,0%	Yes	High
The digital divide (gap in access to digital technologies) and unequal access to telehealth limit the visibility and perceived accessibility of mental health support.	61,4%	No	Moderate	67,2%	5,8%	No	Moderate
Public health crises (e.g., COVID-19) can disrupt traditional communication channels in mental health care services making them less visible, understandable, and trustworthy to the public.	60,2%	No	Moderate	65,6%	5,3%	No	Moderate
Climate change and climate-related disasters create additional barriers to outreach and to service continuity.	33,0%	No	No	26,2%	-6,7%	No	No

Acceptability

Item	ROUND 1			ROUND 2			Consensus Status
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	

Stigma and discrimination undermine trust and discourage individuals from seeking mental health services.	84.1%	Yes	High	89.4%	5.3%	Yes	Very High
Cultural and social determinants (such as beliefs, traditions, and socioeconomic factors) create mismatches between service delivery and community values or norms.	78.4%	Yes	High	78.8%	0.4%	Yes	High
Human rights violations, such as discrimination, abuse, or neglect by service providers or institutions, undermine trust in the ethical intent and safety of the system, making individuals hesitant to engage with it.	67.0%	No	Moderate	77.3%	10.2%	Yes	High
Insufficient understanding of disability among mental healthcare providers leads to inappropriate or exclusionary practices.	69.3%	No	Moderate	74.2%	4.9%	No	Moderate
A lack of tailored, trauma-informed care reduces perceived relevance and emotional safety of services.	62.5%	No	Moderate	66.7%	4.2%	No	Moderate
Limited respect for individual autonomy diminishes perceptions of dignity and appropriateness of mental healthcare services.	64.8%	No	Moderate	65.2%	0.4%	No	Moderate

Availability and Accommodation

Item	ROUND 1			ROUND 2			Consensus Status
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	
Systematic access gaps related to health professionals and resources allocation (structural shortages or uneven distribution).	80.7%	Yes	High	90.9%	10.2%	Yes	Very High
Fragmented care pathways, caused by limited integration across health and social services, reduce service accessibility.	86.4%	Yes	High	87.9%	1.5%	Yes	Very High
Geographic and rural disparities restrict timely and consistent access to mental health services, especially in underserved regions.	80.7%	Yes	High	81.8%	1.1%	Yes	High
Demographic shifts, such as migration and ageing populations, require more adaptable, culturally responsive, and evenly distributed services.	77.3%	Yes	High	78.8%	1.5%	Yes	High
Public health crises (e.g., COVID-19) disrupt service continuity, increase	60.2%	No	Moderate	63.6%	3.4%	No	Moderate

demand, and strain alternative delivery systems.							
The digital divide (gap in access to digital technologies) limits equitable access to telehealth due to gaps in technology, digital literacy, and infrastructure.	56.8%	No	Mode rate	56.1%	-0.8%	No	No
Insufficient telepsychiatry services and digital interventions hinder the availability and effectiveness of remote mental health care.	56.8%	No	Mode rate	56.1%	-0.8%	No	No
Climate change and climate-related disasters damage infrastructure, displace populations, and disrupt care delivery.	39.8%	No	No	31.8%	-8.0%	No	No

Affordability

Item	ROUND 1			ROUND 2			Consensus Status
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	
Insufficient public funding and resource allocation increase out-of-pocket costs and restrict service availability.	89.8%	Yes	High	92.4%	2.7%	Yes	Very High
Economic inequalities restrict access to affordable services for disadvantaged groups.	86.4%	Yes	High	89.4%	3.0%	Yes	Very High
Economic crises and downturns exacerbate financial barriers and deepen existing inequities in service access.	79.5%	Yes	High	84.8%	5.3%	Yes	High
Unstable employment and financial insecurity create affordability barriers and reduce the likelihood of employer-based support.	77.3%	Yes	High	83.3%	6.1%	Yes	High
Limited or fragmented public health insurance coverage leaves essential mental health services unaffordable.	76.1%	Yes	High	81.8%	5.7%	Yes	High
Low income or /and low education levels reduce the financial capacity to access care.	80.7%	Yes	High	81.8%	1.1%	Yes	High

Appropriateness

Item	ROUND 1	ROUND 2
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	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	Consensus Status
Systemic gaps, including fragmented care and lack of coordination, prevent health services from meeting the specific needs of vulnerable groups.	84,1%	Yes	High	89,4%	5,3%	Yes	Very High
Cultural and language barriers, lack of cultural competence, and limited trust, negatively impact equitable access to mental healthcare for vulnerable groups.	73,9%	No	Moderate	77,3%	3,4%	Yes	High
A lack of tailored, trauma-informed care leads to inadequate and insensitive support for those with trauma histories.	61,4%	No	Moderate	66,7%	5,3%	No	Moderate
Demographic changes, including migration and ageing, and services not sufficiently adapted to diverse population needs, negatively impact equitable access to mental healthcare for vulnerable groups.	67,0%	No	Moderate	69,7%	2,7%	No	Moderate
Public health crises (e.g., COVID-19) expose service gaps in service delivery and the need for care models that are flexible, responsive, and better aligned with the specific, evolving needs of individuals to ensure appropriateness in care.	55,7%	No	Moderate	62,1%	6,4%	No	Moderate
Limited disability awareness and training among providers result in inappropriate or insufficient care for people with disabilities.	56,8%	No	Moderate	54,5%	-2,3%	No	No

Section 1 Comments

Item	ROUND 2			
	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	Consensus Status
Limited access to financial resources and increased vulnerability in rural areas limit access to mental health care services	93.4%		Yes	Very High
Insufficient mental health services in vulnerable and isolated communities	93.4%		Yes	Very High
Dificultad de accesibilidad a especialistas	88.5%		Yes	Very High
The lack of cultural humility of mental healthcare providers diminishes service users' trust in services and limits their willingness to engage.	71.2%		No	Moderate
Lack of representation of various communities within healthcare that can understand and connect with groups that are marginalised when accessing care (for example people of colour, trans people etc)	65.6%		Yes	Moderate
Perceived Lack of Diversity Amongst Staff in Services	60.7%		No	Moderate
Unclear regulations regarding the reimbursement of costs for interpreters	48.5%		No	No

Section 2: Mitigation and Prevention Strategies

Approachability

Healthcare system capacity for proactive, clear, and inclusive mental health information dissemination

Item	ROUND 1			ROUND 2			Consensus Status
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	
Integrate community-based outreach (via NGOs, cultural mediators, and peer advocates) to actively engage marginalised groups and improve trust.	83,0%	Yes	High	86,4%	3,4%	Yes	Very High
Ensure the comprehensibility of mental health information, tailoring materials to literacy levels and cultural contexts (e.g., visual aids for people with vision impairments or easy-read formats for people with disabilities).	76,1%	Yes	High	84,8%	8,7%	Yes	High
Increase the visibility of services through transparent and accessible information channels (websites, community leaflets, mobile apps) providing clear entry points, expected processes, and service pathways.	77,3%	Yes	High	80,3%	3,0%	Yes	High
Launch targeted mental health awareness and promote culturally adapted programs (e.g., stigma-reduction campaigns) using plain language, multilingual formats, and culturally resonant messages for underserved groups such as refugees, Roma, and LGBTQIA+ communities.	70,5%	No	Mode rate	80,3%	9,8%	Yes	High

Streamlining systemic (administrative, legal, logistical) processes

Item	ROUND 1	ROUND 2
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	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	Consensus Status
Establish “one-stop” service access points (physical centres in rural areas or digital hubs for remote users) to reduce navigation barriers and increase visibility.	86,4%	Yes	High	89,4%	3,0%	Yes	Very High
Simplify service application and intake forms with culturally sensitive, disability-accessible, and low-literacy-friendly designs.	77,3%	Yes	High	83,3%	6,1%	Yes	High
Offer prevention and early screening programs integrated within administrative processes (e.g., perinatal screening for refugee women or mental health checks for disaster survivors).	83,0%	Yes	High	83,3%	0,4%	Yes	High
Create multilingual service directories and visual care maps, accessible both online and in print, tailored for refugees and migrants.	70,5%	No	Moderate	74,2%	3,8%	No	Moderate

Involve the community in developing culturally sensitive, inclusive healthcare information and pathways

Item	ROUND 1			ROUND 2			
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	Consensus Status
Co-create mental health education and awareness campaigns with input from ethnic minorities, LGBTQ+ groups, and Roma communities to ensure cultural alignment.	79,5%	Yes	High	84,8%	5,3%	Yes	High
Increase visibility of pathways by developing visual, multilingual, and low-literacy-accessible guides explaining how to access mental health services.	79,5%	Yes	High	83,3%	3,8%	Yes	High
Employ community ambassadors from marginalised groups to build trust and serve as bridges between populations and the healthcare system.	78,4%	Yes	High	84,8%	6,4%	Yes	High
Use routine PREMs (Patient Reported Experiences) and PROMs (Patient Reported Outcomes) to evaluate whether cultural respect, transparency, and trust are achieved across diverse demographic groups.	70,5%	No	Moderate	75,8%	5,3%	Yes	High

Acceptability

Cultivating a systemic culture of anti-stigma, respect, and non-discrimination

Item	ROUND 1			ROUND 2			
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	Consensus Status
Implement mandatory stigma-reduction and unconscious bias training for all staff.	72,7%	No	Moderate	80,3%	7,6%	Yes	High
Launch culturally tailored anti-stigma campaigns co-designed with Roma, refugee, youth, and LGBTQ+ communities to challenge stereotypes and misinformation.	72,7%	No	Moderate	75,8%	3,0%	Yes	High
Promote inclusive public discourse by partnering with community leaders, minority organizations, and rural networks to normalise positive mental health narratives.	71,6%	No	Moderate	74,2%	2,7%	No	Moderate
Design welcoming facilities that reflect cultural safety, gender sensitivity, and privacy needs (e.g., for survivors of violence or people from the LGBTQ+ community).	65,9%	No	Moderate	71,2%	5,3%	No	Moderate

Understanding and including disability in mental healthcare

Item	ROUND 1			ROUND 2			
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	Consensus Status
Provide reasonable accommodation, such as assistive technology, home visits for older adults, or extended consultation times.	85.2%	Yes	High	90.9%	5.7%	Yes	Very High
Train professionals on the intersection between disability and mental health, including cultural stigma.	78.4%	Yes	High	84.8%	6.4%	Yes	High
Go above universal accessibility standards by integrating rural accessibility measures (e.g., telehealth with sign language options).	73.9%	No	Moderate	75.8%	1.9%	Yes	High
Use accessible communication formats, including Easy Read materials, audio guides, and multilingual disability support resources.	72.7%	No	Moderate	74.2%	1.5%	No	Moderate

Upholding human rights and dignity in mental healthcare delivery

Item	ROUND 1	ROUND 2
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	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	Consensus Status
Promote supported decision-making models (instead of forced interventions), ensuring cultural and gender sensitivity.	77.3%	Yes	High	81.8%	4.5%	Yes	High
Implement and enforce legal protections against coercive practices and discrimination, with accountability in rural and urban areas.	73.9%	No	Moderate	80.3%	6.4%	Yes	High
Strengthen informed consent through clear, multilingual, and culturally adapted processes (e.g., for refugees or older adults).	69.3%	No	Moderate	72.7%	3.4%	No	Moderate
Embed human rights indicators (privacy, non-coercion, informed consent) into quality assessment frameworks.	67.0%	No	Moderate	71.2%	4.2%	No	Moderate

Empowering autonomy and shared decision-making

Item	ROUND 1			ROUND 2			
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	Consensus Status
Offer diverse treatment pathways, such as telehealth for remote areas, and culturally tailored recovery programs.	80.7%	Yes	High	81.8%	1.1%	Yes	High
Provide support navigators, (trained individuals, including those from minority groups or with lived experience of rural/remote access challenges) who can guide individuals through the healthcare system, helping them access services.	78.4%	Yes	High	80.3%	1.9%	Yes	High
Encourage clients to set recovery goals that include the involvement of family and community support, with particular attention to youth and individuals from ethnoreligious minority groups.	75.0%	Yes	High	78.8%	3.8%	Yes	High
Integrate evidence-based, shared decision-making tools and practices in routine clinical workflows for youth, LGBTQIA+, and culturally diverse clients (e.g., culturally adapted conversation guides, or digital tools that present treatment options in an accessible way).	68.2%	No	Moderate	71.2%	3.0%	No	Moderate

Availability and Accommodation

Telepsychiatry and digital intervention deployment

Item	ROUND 1			ROUND 2			
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	Consensus Status
Integrate telepsychiatry with local peer support and community-based outreach, ensuring a hybrid model for those without digital access.	76.1%	Yes	High	80.3%	4.2%	Yes	High
Implement national, ethical and security protocols for online mental health care, with specific guidance on safeguarding vulnerable populations (e.g., survivors of natural disasters, unaccompanied minors).	69.3%	No	Moderate	77.3%	8.0%	Yes	High
Establish feedback and usability testing loops with vulnerable groups (e.g., youth, Roma, refugees) to improve accessibility and engagement with digital tools and evaluate their effectiveness.	60.2%	No	Moderate	54.5%	-5.7%	No	No
Co-design clinically validated mental health apps and digital platforms with direct input from people with disabilities, LGBTQIA+ individuals, and migrant communities to ensure cultural and linguistic relevance.	59.1%	No	Moderate	54.5%	-4.5%	No	No

Workforce and resource distribution

Item	ROUND 1			ROUND 2			
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	Consensus Status
Deploy mobile and hybrid care teams to remote and rural areas.	86.4%	Yes	High	87.9%	1.5%	Yes	Very High
Expand the scope of practice for trained community health workers, ensuring they can provide first-line mental health support in underserved regions.	83.0%	Yes	High	86.4%	3.4%	Yes	Very High
Establish crisis response teams with rapid deployment capabilities for regions impacted by disasters or sudden mental health surges.	80.7%	Yes	High	86.4%	5.7%	Yes	Very High
Offer financial incentives, scholarships, and loan forgiveness opportunities for mental health professionals from	65.9%	No	Moderate	71.2%	5.3%	No	Moderate

underrepresented communities (e.g., ethnic minorities, Roma), and/or for those who commit to serving in under-served areas.

Decentralised, culturally responsive service models

Item	ROUND 1			ROUND 2			Consensus Status
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	
Deploy mobile clinics and outreach teams to reach hard-to-access populations (e.g., unaccompanied minors, survivors of disasters).	83.0%	Yes	High	86.4%	3.4%	Yes	Very High
Establish community mental health centres in remote and marginalised areas with multilingual and culturally tailored services.	78.4%	Yes	High	81.8%	3.4%	Yes	High
Strengthen peer-led support networks (e.g., LGBTQ+ peer mentors, refugee survivor groups) to create safe spaces for psycho-social care.	76.1%	Yes	High	81.8%	5.7%	Yes	High
Train local community leaders, cultural mediators, and trusted stakeholders (e.g., Roma, refugee community leaders) to provide mental health first aid and advocacy.	72.7%	No	Mode rate	75.8%	3.0%	Yes	High

Strategic funding and resource allocation

Item	ROUND 1			ROUND 2			Consensus Status
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	
Ensure that community-based mental health models integrate low-cost primary care services that reduce long-term costs, particularly for people with disabilities and older adults.	88.6%	Yes	High	87.9%	-0.8%	Yes	Very High
Allocate funding for mental health services in a way that prioritises high-needs groups (e.g., Roma communities, refugees, and youth) and ensures that underserved areas, such as rural and remote regions, receive fair and adequate investment.	85.2%	Yes	High	86.4%	1.1%	Yes	Very High
Create performance-based funding models to improve outcomes for marginalised populations in under-resourced areas.	63.6%	No	Mode rate	65.2%	1.5%	No	Moderate

Design public-private partnerships to fund digital and community-based care for groups often excluded from mainstream services, such as ethnic minorities.

56.8% No Mode rate 59.1% 2.3% No No

Inclusive mental healthcare insurance schemes

Item	ROUND 1			ROUND 2			Consensus Status
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	
Provide mental health insurance coverage that includes preventive, digital, and community-level care, ensuring services are accessible to underserved vulnerable populations.	83.0%	Yes	High	87.9%	4.9%	Yes	Very High
Ensure zero or minimal co-payments for vulnerable groups (e.g., unaccompanied minors, LGBTQ+ and youth) to eliminate financial barriers.	80.7%	Yes	High	86.4%	5.7%	Yes	Very High
Develop mental health parity laws ensuring mental health services receive the same financial coverage as physical health, with special provisions for marginalised communities.	78.4%	Yes	High	83.3%	4.9%	Yes	High
Create targeted subsidies or premium assistance for low-income and rural populations, especially Roma and older adults facing fixed incomes.	71.6%	No	Mode rate	69.7%	-1.9%	No	Moderate

Income-adjusted, educationally considerate pathways

Item	ROUND 1			ROUND 2			Consensus Status
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	
Provide mental health insurance coverage that includes preventive, digital, and community-level care, ensuring services are accessible to underserved vulnerable populations.	83.0%	Yes	High	87.9%	4.9%	Yes	Very High
Ensure zero or minimal co-payments for vulnerable groups (e.g., unaccompanied minors, LGBTQ+ and youth) to eliminate financial barriers.	80.7%	Yes	High	86.4%	5.7%	Yes	Very High
Develop mental health parity laws ensuring mental health services receive the same financial coverage as physical	78.4%	Yes	High	83.3%	4.9%	Yes	High

health, with special provisions for marginalised communities.							
Create targeted subsidies or premium assistance for low-income and rural populations, especially Roma and older adults facing fixed incomes.	71.6%	No	Moderate	69.7%	-1.9%	No	Moderate

Employment and financial stability support

Item	ROUND 1			ROUND 2			Consensus Status
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	
Develop return-to-work programs co-designed with community organizations to help older adults and survivors of trauma regain financial stability.	79.5%	Yes	High	90.9%	11.4%	Yes	Very High
Create employer-led financial wellness programs that include mental health support, prioritizing sectors with high vulnerability (e.g., migrant workers, low-wage labour).	67.0%	No	Moderate	80.3%	13.3%	Yes	High
Ensure legal protections for mental health leave and flexible workplace accommodations, especially for informal or precarious workers in rural areas.	71.6%	No	Moderate	77.3%	5.7%	Yes	High
Provide employment counselling within mental health services for people facing workplace discrimination (e.g., individuals with disabilities, refugees, LGBTQIA+).	69.3%	No	Moderate	77.3%	8.0%	Yes	High

Affordability

Reducing economic disparities through resource distribution

Item	ROUND 1			ROUND 2			Consensus Status
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	
Provide incentives for mental health providers to establish practices in socioeconomically disadvantaged areas and serve marginalised groups.	76.1%	Yes	High	84.8%	8.7%	Yes	High
Ensure targeted infrastructure investments (e.g., transportation vouchers, mobile clinics) to reduce indirect costs for remote populations.	71.6%	No	Moderate	83.3%	11.7%	Yes	High
Create community-led financial initiatives such as localised mental health support funds or micro-grants for migrant and disaster-affected communities.	68.2%	No	Moderate	77.3%	9.1%	Yes	High
Reallocate mental health funding to prioritise under-served rural and remote regions with high concentrations of ethnic minorities and low-income communities.	62.5%	No	Moderate	72.7%	10.2%	Yes	Moderate

Systemic financial resilience in economic crises

Item	ROUND 1			ROUND 2			Consensus Status
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	
Ensure collaborative recovery programs that combine mental health and economic support for disaster survivors and low-income families in remote areas.	77.3%	Yes	High	89.4%	12.1%	Yes	Very High
Develop flexible contingency financing models that prioritise services for vulnerable populations during economic instability.	77.3%	Yes	High	84.8%	7.6%	Yes	High
Provide rapid reallocation protocols to ensure that rural and under-served regions maintain essential mental health services during crises.	70.5%	No	Moderate	78.8%	8.3%	Yes	High
Create dedicated emergency mental health funds to protect vulnerable populations during financial downturns or post-disaster recovery.	67.0%	No	Moderate	75.8%	8.7%	Yes	High

Cultural competence and responsiveness

Item	ROUND 1			ROUND 2			
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	Consensus Status
Create mobile or community-based culturally aligned outreach teams for under-served rural areas, ensuring services are culturally relevant and locally trusted.	83.0%	Yes	High	83.3%	0.4%	Yes	High
Recruit and train cultural mediators or interpreters to support migrants, refugees, and asylum seekers in rural/remote areas where language barriers and cultural gaps are most pronounced.	76.1%	Yes	High	75.8%	-0.4%	Yes	High
Co-design culturally sensitive mental health programs with ethnic minorities, ethno-religious communities, Roma populations, and migrants, ensuring services reflect local customs, values, and beliefs.	71.6%	No	Moderate	77.3	5.7%	Yes	High
Offer specialised cultural competence training for providers to understand the mental health needs of LGBTQ+ communities, older people, and youth with complex intersectional identities.	73.9%	No	Moderate	77.3%	3.4%	Yes	High

Person-centred and rights-based approaches

Item	ROUND 1			ROUND 2			
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	Consensus Status
Develop rights-based policies to ensure that older adults, LGBTQ+ individuals, and ethnoreligious minorities are not subjected to discrimination or coercive practices in mental health care.	79.5%	Yes	High	86.4%	6.8%	Yes	Very High
Expand training for mental health professionals on intersectional ethics and person-centred care, emphasising autonomy and dignity for migrants and asylum seekers with uncertain legal status.	79.5%	Yes	High	86.4%	6.8%	Yes	Very High
Establish national guidelines that mandate participatory decision-making for vulnerable populations (e.g., involving youth, people with disabilities,	71.6%	No	Moderate	81.8%	10.2%	Yes	High

or survivors of natural disasters in their care plans).							
Introduce rural/remote community consultation boards to regularly review whether services are meeting the unique needs of marginalised populations in these regions.	55.7%	No	Moderate	50.0%	-5.7%	No	No

Appropriateness

Cultural competence and responsiveness

Item	ROUND 1			ROUND 2			
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	Consensus Status
Create mobile or community-based culturally aligned outreach teams for under-served rural areas, ensuring services are culturally relevant and locally trusted.	83.0%	Yes	High	83.3 %	0.4%	Yes	High
Co-design culturally sensitive mental health programs with ethnic minorities, ethno-religious communities, Roma populations, and migrants, ensuring services reflect local customs, values, and beliefs.	71.6%	No	Moderate	77.3 %	5.7%	Yes	High
Offer specialised cultural competence training for providers to understand the mental health needs of LGBTQ+ communities, older people, and youth with complex intersectional identities.	73.9%	No	Moderate	77.3 %	3.4%	Yes	High
Recruit and train cultural mediators or interpreters to support migrants, refugees, and asylum seekers in rural/remote areas where language barriers and cultural gaps are most pronounced.	76.1%	Yes	High	75.8 %	-0.4%	Yes	High

Person-centred and rights-based approaches

Item	ROUND 1			ROUND 2			
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	Consensus Status
Develop rights-based policies to ensure that older adults, LGBTQ+ individuals, and ethno-religious minorities are not	79.5%	Yes	High	86.4%	6.8%	Yes	Very High

subjected to discrimination or coercive practices in mental health care.							
Expand training for mental health professionals on intersectional ethics and person-centred care, emphasising autonomy and dignity for migrants and asylum seekers with uncertain legal status.	79.5%	Yes	High	86.4%	6.8%	Yes	Very High
Establish national guidelines that mandate participatory decision-making for vulnerable populations (e.g., involving youth, people with disabilities, or survivors of natural disasters in their care plans).	71.6%	No	Mode rate	81.8%	10.2%	Yes	High
Introduce rural/remote community consultation boards to regularly review whether services are meeting the unique needs of marginalised populations in these regions.	55.7%	No	Mode rate	50.0%	-5.7%	No	No

Interdimensional megatrends

Digitally inclusive and manageable telehealth system and Infrastructure

Item	ROUND 1			ROUND 2			
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	Consensus Status
Establish 24/7 multilingual telehealth platforms and mental health helplines, tailored for youth, migrants, ethno-religious minorities and other vulnerable populations.	73.6%	No	Moderate	83.3%	9.8%	Yes	High
Create community-based digital hubs and public Wi-Fi points to facilitate telehealth access for remote populations without personal devices or stable connections.	63.2%	No	Moderate	69.7%	6.5%	No	Moderate
Collect and analyse PREMs (Patient Reported Experiences) and PROMs (Patient Reported Outcomes) from telehealth users (especially from underserved groups) to continuously improve user experience and trust.	65.5%	No	Moderate	68.2%	2.7%	No	Moderate
Fund and distribute assistive digital tools (e.g., screen readers, adaptive devices) for vulnerable populations.	59.8%	No	Moderate	63.6%	3.9%	No	Moderate
Develop digital literacy programs and user guides specifically tailored for older adults, Roma communities and migrants, ensuring cultural and linguistic alignment.	55.2%	No	Moderate	57.6%	2.4%	No	No

Comprehensible, integrated and coordinated service ecosystem

Item	ROUND 1			ROUND 2			
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	Consensus Status
Create integrated mental health entry points through primary care, schools, and social services, ensuring early recognition and referral for migrants, refugees, and youth populations.	87.5%	Yes	High	86.4%	-1.1%	Yes	Very High
Appoint community-based care coordinators (including those from ethnic or cultural minorities) in rural areas to help users navigate fragmented care systems.	80.7%	Yes	High	84.8%	4.2%	Yes	High

Build multi-sectoral mental health hubs that integrate mental healthcare, housing, social services, and legal aid for migrants, LGBTQ+ individuals, and people with disabilities.	80.7%	Yes	High	83.3%	2.7%	Yes	High
Implement streamlined referral pathways for specialised services (e.g., youth counselling, refugee trauma support), minimizing delays caused by bureaucratic processes.	78.4%	Yes	High	78.8%	0.4%	Yes	High
Utilise interoperable and secure digital coordination systems (capable of sharing and integrating data across different platforms) to improve communication among providers, especially across rural-urban service divides.	71.6%	No	Mode rate	77.3%	5.7%	Yes	High

Systemic resilience, adaptability and innovation during public health crises

Item	ROUND 1			ROUND 2			
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	Consensus Status
Build integrated cross-sector crisis response systems that link mental health care with housing, social support, and employment services for at-risk groups.	80.7%	Yes	High	83.3%	2.7%	Yes	High
Fund community-led mental health innovation hubs in under-served regions to co-develop scalable crisis interventions with vulnerable populations.	69.3%	No	Mode rate	81.8%	12.5%	Yes	High
Train local leaders, peer networks, and community health workers to provide reliable mental health information and initial screening during crises.	72.7%	No	Mode rate	72.7%	0.0%	No	Moderate
Partnerships with NGOs and local networks rapidly deploy trauma-informed care programs in disaster recovery settings.	68.2%	No	Mode rate	71.2%	3.0%	No	Moderate
Prepare multilingual emergency communication plans and culturally adapted materials targeting refugees, migrants, and under-served communities.	61.4%	No	Mode rate	63.6%	2.3%	No	Moderate
Build emergency-ready telehealth platforms and community-based crisis	58.0%	No	Mode rate	57.6%	-0.4%	No	Moderate

hotlines with multilingual and accessible formats.

Localised systemic capacities and preparedness in climate disaster response

Item	ROUND 1			ROUND 2			
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	Consensus Status
Include mental health professionals in national disaster task forces, ensuring services are immediately integrated post-disaster.	81.8%	Yes	High	89.4%	7.6%	Yes	Very High
Fund long-term trauma recovery and community rebuilding programs, especially for marginalised and historically under-served groups.	73.9%	No	Moderate	80.3%	6.4%	Yes	High
Establish community-based mental health rapid response teams that include cultural mediators and multilingual support for disaster survivors and vulnerable populations.	71.6%	No	Moderate	77.3%	5.7%	Yes	High
Create culturally responsive communication strategies (e.g., using trusted local radio or faith-based networks) for rural populations or ethno-religious minorities.	55.7%	No	Moderate	56.1%	0.4%	No	No

Trauma-informed and person-centred care

Item	ROUND 1			ROUND 2			
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	Consensus Status
Train all staff to recognise trauma triggers among marginalised groups (e.g., Roma facing systemic exclusion, LGBTQ+ facing discrimination), with a focus on avoiding re-traumatisation among groups with historical or ongoing marginalisation.	77.3%	Yes	High	87.9%	10.6%	Yes	Very High
Ensure physical and emotional safety in services, including private spaces for LGBTQ+ clients and women survivors of violence.	83.0%	Yes	High	86.4%	3.4%	Yes	High
Co-develop individualised care plans with service users, respecting cultural and family dynamics (e.g., older adults or ethno-religious communities).	75.0%	Yes	High	81.8%	6.8%	Yes	High

Establish national guidelines for trauma-informed care, with adaptations for unaccompanied minors, disaster survivors, and refugees. 69.3% No Mode rate 75.8% 6.4% Yes High

Embedding cultural competence and disability-inclusive responsiveness

Item	ROUND 1			ROUND 2			
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	Consensus Status
Train professionals on how to adapt therapies and assessments for individuals with overlapping vulnerabilities (e.g., older adults with disabilities or mental health conditions).	79.5%	Yes	High	89.4%	9.8%	Yes	High
Co-design services with people with disabilities to ensure clinical settings, communication tools, and therapies are inclusive and meet real needs.	78.4%	Yes	High	87.9%	9.5%	Yes	Very High
Involve cultural mediators and interpreters (e.g., Roma mediators, refugee interpreters) to address language and cultural gaps in care.	70.5%	No	Mode rate	77.3%	6.8%	Yes	High
Recruit and retain a diverse workforce, ensuring gender, ethnicity, and language match with community demographics.	71.6%	No	Mode rate	75.8%	4.2%	Yes	High
Require continuous cultural competence and anti-racism training that reflects the realities of ethnic minorities, migrants, and older populations in rural and urban contexts.	61.4%	No	Mode rate	63.6%	2.3%	No	Moderate

Services responsive to demographic shifts

Item	ROUND 1			ROUND 2			
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	Consensus Status
Fund research into demographic-specific barriers to appropriate care in remote areas.	78.4%	Yes	High	86.4%	8.0%	Yes	Very High
Create evidence based targeted programs for aging populations, and ethnic minorities to address emerging mental health challenges linked to societal transitions.	80.7%	Yes	High	83.3%	2.7%	Yes	High

Use dis-aggregated data (age, gender, ethnicity, disability, migration status) to evaluate and plan mental health resource allocation and identify service gaps.	73.9%	No	Moderate	81.8%	8.0%	Yes	High
Conduct regular consultations with vulnerable populations (e.g., Roma, ethno-religious minorities, unaccompanied minors) to revise services according to shifting demographic needs.	78.4%	Yes	High	72.7%	- 5.7%	No	Moderate
Continuously adapt service guidelines to evolving patterns of migration, urbanisation, and population ageing.	70.5%	No	Moderate	72.7%	2.3%	No	Moderate

Section 2 Comments

Item	ROUND 2			
	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	Consensus Status
APPROACHABILITY - Improved training of researchers and healthcare professionals in mental health awareness programs	84.8%		Yes	High
AVAILABILITY & ACCOMMODATION - ability to offer training and reflective practices with peer groups to strengthen local communities	83.3%		Yes	High
ACCEPTABILITY - Involving ethical and legal experts in this process	80.3%		Yes	High
ACCEPTABILITY - offering a variety of choices and flexibility, such as reminders for appointments or extended appointments if needed. Sensory needs to be explored that as well can support trust and engagement	80.3%		Yes	High
ACCEPTABILITY - Check more often whether the government keeps these promises. For example, review each year or every six months to see if they have started implementing them.	77.3%		Yes	High
APPROPRIATENESS - Analyse data derived from the co-design phase to inform appropriate redesign	74.2%		No	Moderate
APPROACHABILITY - Outreach services	69.7%		No	Moderate
APPROACHABILITY - Initiate a legal, ethical and regulatory framework for the streamlining process	62.1%		No	Moderate

Section 3: Anticipated Impacts and Innovative Strategies

How can technology most effectively be used to improve access to mental healthcare services?

Item	ROUND 1			ROUND 2			
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	Consensus Status
Create evidence based targeted programs for aging populations, and ethnic minorities to address emerging mental health challenges linked to societal transitions.	75.0%	Yes	High	78.8%	3.8%	Yes	High
Use predictive analytics to personalise care pathways and match users to appropriate service models.	60.2%	No	Moderate	63.6%	3.4%	No	Moderate
Develop open-access digital mental health tools and educational self-help apps subsidised by public health systems.	59.1%	No	Moderate	60.6%	1.5%	No	Moderate
Use AI-powered, multilingual digital assistants to help individuals navigate services and understand options.	55.7%	No	Moderate	56.1%	0.4%	No	No

Which community-based interventions are likely to be most effective in improving mental healthcare access?

Item	ROUND 1			ROUND 2			
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	Consensus Status
Conduct participatory design workshops to ensure that community services reflect local realities and identities.	59.1%	No	Moderate	74.2%	15.2%	Yes	Moderate
Provide local “mental health hubs” integrating services with schools, clinics, and social services.	76.1%	Yes	High	77.3%	1.1%	Yes	High
Deploy community health workers and peer navigators to increase service visibility and engagement.	71.6%	No	Moderate	77.3%	5.7%	Yes	High
Create community-run cooperatives that offer low-cost or donation-based counselling services.	52.3%	No	No	51.5%	-0.8%	No	No

What is the most important role for international EU collaboration in addressing these challenges?

Item	ROUND 1			ROUND 2			
	% Agreement (≥4)	Consensus Achieved?	Consensus	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	Consensus Status
Pan-European standards for evidence-based, inclusive care models co-developed with vulnerable groups.	80.7%	Yes	High	86.4%	5.7%	Yes	Very High
Joint EU funding schemes to offset disparities in mental health investment across Member States.	77.3%	Yes	High	81.8%	4.5%	Yes	High
EU-supported knowledge exchange networks on culturally competent care and anti-discrimination practices.	67.0%	No	Moderate	69.7%	2.7%	No	Moderate
Fund infrastructure for transnational telehealth and rural service delivery pilots.	60.2%	No	Moderate	63.6%	3.4%	No	Moderate

Section 3 Comments

Item	ROUND 2			
	% Agreement (≥4)	Δ % Agreement	Consensus Achieved?	Consensus Status
Interventions build upon protocols, ethics by design and implemented by human support	80.3%		Yes	High



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