

# Patient-centred solutions to addressing **unmet**, **complex and multiple** **mental health** **needs**

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# EXECUTIVE SUMMARY

This report focuses on the unmet needs of people with complex and multiple mental health conditions, identifying the challenges and solutions needed to address them.

## What are unmet mental health needs?

This report focuses on the unmet needs of people with complex and multiple mental health conditions, identifying the challenges and solutions needed to address them. Unmet needs refer to the gap between the care an individual requires and the care they receive. It is a prominent and common issue in mental health care. Many complex unmet mental health needs go undetected and untreated, often due to structural or service barriers, fragmented services and limited resources.

## How This Report Was Developed

The report aimed to identify and understand the unmet needs of people with complex, multiple health conditions, the challenges they face, their experiences, and possible solutions. To explore these, data were gathered through a rapid literature review, focus groups with people with lived experience and clinicians, and a brief validation survey on the priorities for addressing unmet needs.



SUPPORT  
EXISTS.  
ACCESS  
DOESN'T.

The core issue is that many people with complex and multiple mental health conditions are not receiving the care they need — not because treatments don't exist, but because access, coordination and support systems are failing them.

## Key Challenges Identified

The findings highlight challenges with access to care and support, as well as the lack of a holistic, personalised approach and coordinated follow-up care. Managing co-occurring physical health conditions is also challenging.

Unmet social and economic needs are frequent (e.g., loneliness, housing insecurity, and financial insecurity) in people with complex and multiple mental health conditions.

## Barriers to Access and Effective Support

Delays in access to services and treatment are particularly challenging for those with complex needs. Access to psychotherapy, psychoeducation and psychosocial interventions is limited despite strong evidence of their effectiveness.

## What the Evidence Shows

According to the literature, approaches to meeting unmet needs for people with complex and multiple mental health conditions emphasise integrated, recovery-oriented care models, attention to the social and economic determinants, and the active involvement of people with lived experience in care and service delivery.

## Insights From Patients and Clinicians

Patient focus group participants noted poor communication between specialist departments and clinicians highlighted inconsistent information sharing between services, resulting in service gaps, lack of coordination, duplication and delays in care. There was also a mismatch in priorities between patients and clinicians, with patients emphasising the negative impact of their condition and its treatments on their lives. In contrast, clinicians were mainly concerned with managing symptoms.

## What's Needed to Address Unmet Needs

Addressing unmet needs in people with complex and multiple mental health conditions requires focus and attention. It involves mobilising services

and organisations to work together in an integrated, holistic, collaborative way, supported by digital tools.

Priorities for addressing unmet needs include improved access to and coordinated care; better treatment, day-to-day support, and recovery-focused approaches; improved communication between specialist clinicians; and more personalised, inclusive, and equitable care.

## Building a Better-Functioning System

Mental health systems take time to improve, but they need adequate resources to function effectively in caring for those with complex, multiple mental health needs. Simple changes, however, can make the most of services and workforces already in place, as well as empower patients to make the most of their own resources and strategies, with the involvement and inclusion of community organisations, peer support, and other supportive social networks and connections.

## Towards More Connected, Person-Centred Care

This includes holistic care that brings together both mental and physical health support, social and economic help, with strong psychosocial and community-based services, including peer support and voluntary organisations.

Better communication between services and specialist departments, and between patients and clinicians, can be improved with the aid of digital tools, but cannot replace human contact, empathy, and therapeutic relationships. Better coordination, fairer access and reduced stigma can move closer to meeting the unmet needs of those with complex and multiple conditions at every stage of life.



# 02

## BACKGROUND AND INTRODUCTION

This report focuses on the unmet needs of people with complex and multiple mental health conditions (referred to as complex needs in this report), identifying both the challenges and the solutions needed to address them.

Unmet needs are the gap between the care an individual requires and the care they receive. It is a prominent issue in mental health, and more so for those with complex needs, and is defined as co-occurring conditions and symptoms spanning several mental health conditions, such as depression, post-traumatic stress disorder (PTSD) and personality disorders, and can also include physical health conditions.

The prevalence of complex needs is high. In the UK, for example, it is estimated that around one in 12 people have 4+ conditions, and according to one analysis 70% of people with a mental health condition have at least one other condition.<sup>1</sup> Across Europe, there is limited research specifically estimating the extent of complex needs in this population; between 5% to 16% of people are said to have moderate to major mental health conditions (which could be an indicator of complex needs).<sup>2</sup>

Many unmet mental health needs go undetected and untreated. Common reasons include financial barriers to seeking help, a perceived lack of need, and structural barriers, such as a lack of available services and difficulties accessing them.<sup>3</sup>

The treatment implications are also complex, and health services predominantly focus on single conditions, failing to account for the impact of multiple conditions.<sup>4</sup> Multiple conditions require different treatments, leading to varying side effects. Complex needs can be challenging to diagnose and treat effectively. Alongside clinicians, patients are increasingly seen as experts in their complex mental and/or physical illnesses.

According to patient experiences, some clinicians are unable to grasp or understand their complex needs and the interplay of symptoms, treating only those they are familiar with. This leads to difficulties in managing complex needs symptoms, often leaving patients without a holistic treatment approach due to siloed and difficult-to-access specialist healthcare services.

Many patients search for and identify strategies to manage their symptoms and function day to day. These go beyond the medical model to using person-centred solutions, such as peer support, digital mental health, and complementary alternatives (e.g. meditation, mindfulness) to help manage symptoms.

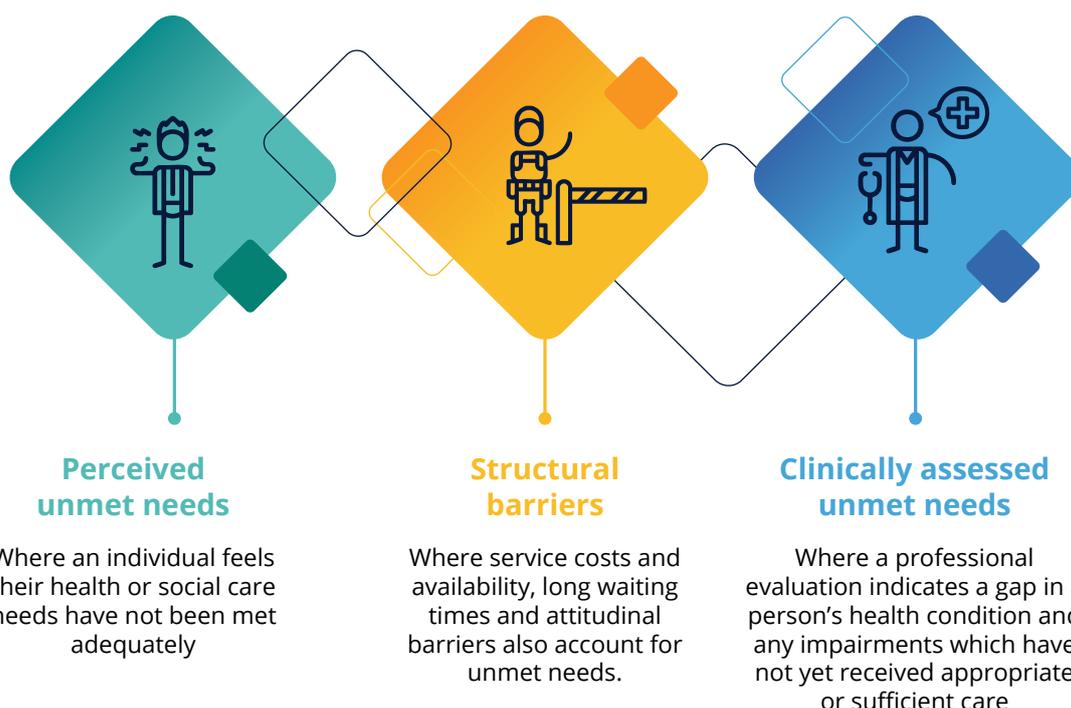
Patients often call for services that listen to and understand their experiences of symptoms and treatment side effects, even if they fall outside the

standard categories of illness listed in diagnostic manuals (e.g., ICD and DSM). There is growing recognition of the need for integrated, person-centred approaches that can provide holistic support across multiple domains.<sup>5</sup> Such a multidimensional service approach can help promote better treatment adherence when the right conditions are met<sup>6</sup>.

## Types of unmet need

Unmet needs for people with complex needs cut across the life span and population groups. They cover a wide range of areas, including service access, treatment, social determinants of health (e.g. housing, poverty) and psychosocial support. Some of the most frequent unmet needs relate to work/occupation, counselling, social support and physical health needs, with adults having the highest unmet needs and adolescents commonly experiencing barriers to care.<sup>7</sup>

**Different types of unmet needs for people with mental health conditions exist. These refer to:**



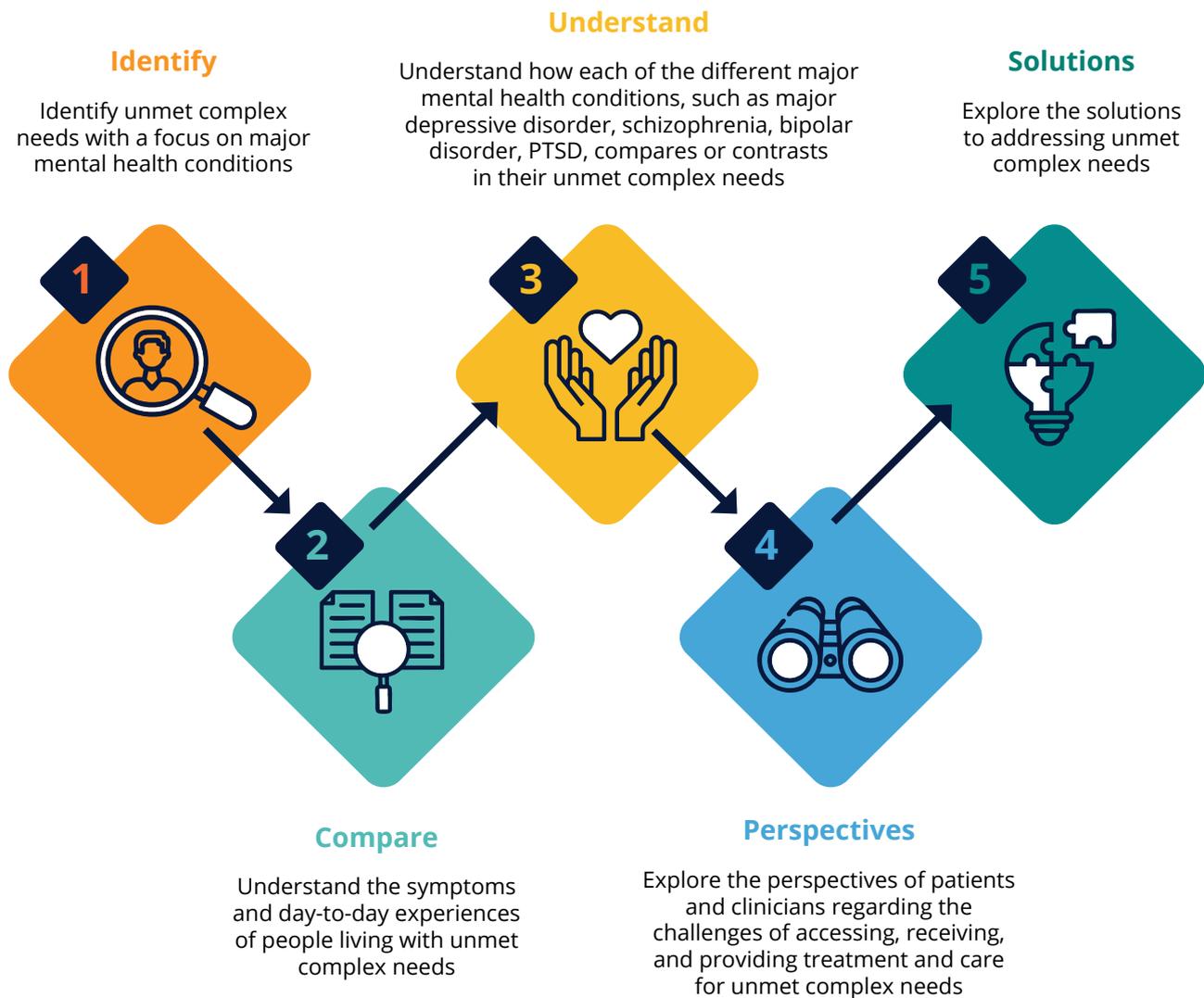


“ **70%**

of people with a mental health condition  
have at least one other condition.<sup>1</sup>

”

## Aims and brief methods



To address these aims, three methods of data collection were used: using qualitative methods, two focus groups with people with lived experience of complex needs and clinicians. Two focus groups with people with lived experience of complex needs and clinicians; and a validation survey of participants to identify their priorities for addressing unmet needs.

*Further details of the methods are provided in the appendix.*



## 03

## FINDINGS FROM THE LITERATURE REVIEW

### Health and social services

#### Access

Barriers and delays to accessing services and treatment present serious challenges for people with complex needs, particularly those requiring care for schizophrenia, post-traumatic stress disorder (PTSD) and complex PTSD.

Delays in initial assessment, long wait times for specialist care, and disparities based on socioeconomic status are persistent across Europe. These challenges not only exacerbate existing unmet needs (or their prevalence) but also create new ones.

Significant gaps remain in timely and equitable access to care. Delays in initial assessment, long wait times for specialist care, and disparities based on socioeconomic status are persistent across Europe. For example, access to early intervention for first-episode psychosis was reported to be inadequate in nine EU countries, according to one survey.<sup>8</sup>

There is also a need to ensure that the unmet needs of informal carers of people with complex needs are also addressed.<sup>9</sup> Informal carers can experience limited access to support when caring for someone with complex needs, which can impact their own mental and physical health.

Geographical inequities are also evident, with rural areas lacking psychiatric infrastructure and the urban regions experiencing overstretched services.<sup>10</sup>

### Personalised, holistic, long-term and follow-up care

Routine care for major mental health conditions often overlooks a person's complex needs, focusing mainly on symptom management. Personalised and long-term care for cognitive difficulties, social needs, and stigma are not always assessed or addressed routinely, creating more unmet needs.<sup>11</sup> These gaps limit recovery and quality of life, pointing to the need for sustained, person-centred support beyond symptom control.<sup>12</sup> There is limited or systematic implementation of innovative practices, further limiting patients' access to effective, recovery-oriented treatments.<sup>13</sup>

After acute episodes, people with bipolar disorder often lack meaningful follow-up, continuity of care or long-term recovery support. Many European mental health systems focus on managing acute symptoms but offer minimal structured support for vocational rehabilitation, social reintegration, or ongoing therapy.<sup>14</sup> Those in remission may still experience residual cognitive difficulties, low energy, and social withdrawal, which are not routinely addressed in standard care.<sup>28</sup>

Unmet needs for people with borderline personality disorder or complex emotional needs are wide-ranging and include symptoms (e.g. emotional needs and social interactions), early diagnosis/intervention and quality of life.<sup>15</sup> Personalised, specialist and holistic care is even more essential, and is shaped by patients' perspectives on treatment, support and gradual improvement over time. This also needs to include trauma-informed and holistic approaches to address past trauma, physical health and social needs. Therapeutic relationships are an essential part of treatment progress for people with complex emotional needs, and forming stable and trusting relationships with mental health professionals is crucial to prevent therapy dropout and poor outcomes.<sup>32</sup>

In some systems, access to follow-up therapy or relapse prevention programmes depends on local budgets or clinician initiative, leading to geographical inconsistencies in care quality. This fragmentation contributes to chronicity and dissatisfaction with mental health services.

### Management of Physical Comorbidities

Another unmet need includes identifying and managing co-occurring physical health conditions. People with major mental health conditions, including bipolar disorder, are at high risk of co-occurring physical comorbidities, such as metabolic syndrome, cardiovascular disease, and diabetes. These physical health conditions are frequently underdiagnosed or untreated within psychiatric settings.<sup>17,18</sup> People diagnosed with bipolar disorder receive less preventive care for physical health conditions, which contributes to a 10 to 15-year shorter life expectancy than the general population.<sup>19</sup>

### Integrated social and peer support

Social challenges and life stressors, such as financial instability, unemployment, housing insecurity, and social isolation, can worsen and affect mental health.<sup>20</sup> When unsupported, these become essential unmet needs. For people with existing mental health conditions, these challenges can exacerbate symptoms.<sup>21</sup> Across European Union Member States, social support is often insufficient. It lacks integration between mental health services, social care, housing assistance, and peer support, which can undermine recovery and increase the risk of relapse.

Peer support initiatives and community programmes are an important source of social and integrated support. Many are not embedded within mainstream health services but run by community or non-governmental groups with limited resources and operational challenges.



### Stigma and discrimination in care settings

Stigma is a substantial barrier to care and recovery, limiting help-seeking, undermining self-esteem, and reducing opportunities for housing and employment. Negative attitudes and discriminatory beliefs toward mental illness are prevalent among healthcare professionals, impacting the therapeutic relationship and potentially discouraging patients from seeking or continuing care.

Structural stigma also persists in healthcare systems through diagnostic overshadowing (where healthcare practitioners overlook the physical health concerns of people living with mental health conditions) and unequal treatment.

People diagnosed with personality disorders or complex emotional needs can be excluded from generic mental health services, and can be blamed by staff for their difficulties.

## Diagnosis and treatment

### Diagnosis

Inaccurate diagnosis is a well-documented problem in bipolar disorder care. Many people initially present with depressive symptoms, leading to misdiagnosis as unipolar depression, which delays appropriate treatment by an average of 5 to 10 years.<sup>25 26</sup>

These delays not only create unmet needs but are also associated with poorer long-term outcomes, including increased risk of suicidality and functional difficulties.<sup>27</sup>

GPs in primary care can find it challenging to diagnose those with psychosis, personality disorder, persistent depression and trauma, creating further gaps in diagnosis and treatment.<sup>28</sup>

### Psychological support

There are unmet needs in relation to psychotherapy and access to psychosocial interventions, which are present for many major mental health conditions such as schizophrenia, bipolar disorder and MDD. Good therapeutic relationships are vital for people with complex and long-term psychosocial needs, but within mental healthcare, these can be fragmented and unstable.<sup>29</sup>

Evidence-based psychosocial interventions like CBT for psychosis, family therapy, and cognitive remediation have been shown to have high acceptability and effectiveness;<sup>30</sup> however, they are not implemented systematically. Workforce shortages, long waiting lists, and inconsistent funding prevent wide access.<sup>31</sup>

Despite strong evidence for the efficacy of psychoeducation and cognitive-behavioural therapy (CBT) in reducing relapse and improving quality of life, access to these therapies remains inconsistent across Europe. In Italy, one study reported that fewer than 5% of patients with bipolar disorder received psychoeducation, while only 11.5% received any form of psychotherapy.<sup>32</sup>

Similarly, even where psychosocial services exist, they are often under-resourced and available only in urban centres or academic settings, excluding rural populations and those with lower socioeconomic status.<sup>33</sup>

### Medication Adherence and Pharmacological Treatment

Up to 87% of patients with schizophrenia and bipolar I disorder discontinue antipsychotics largely because of intolerable side effects like sedation, weight gain, and sexual dysfunction.<sup>34,35</sup> While patients often recognise the benefits of symptom reduction, side effects reduce quality of life and compromise treatment engagement.<sup>36</sup> Current pharmacological options poorly address negative and cognitive symptoms, which remain an unmet need.

### Treatment-Resistance

About 30% of patients meet criteria for treatment-resistant schizophrenia, defined as inadequate response to at least two antipsychotic medication trials. Yet clozapine, considered an optimum treatment for treatment-resistant schizophrenia, is underutilised across Europe, often because of stringent monitoring requirements and side effect concerns.<sup>37</sup>

For those diagnosed with MDD, up to 30% do not respond to first-line treatments, yet access to specialised interventions for treatment-resistant depression (TRD) remains severely limited, including maintenance psychotherapy, relapse prevention, and lifestyle interventions.<sup>38,39</sup> This contributes to prolonged illness duration, higher rates of hospitalisation, and suicide. The lack of clear treatment-resistant care pathways in many European health systems represents a critical unmet need, particularly in low-resource settings where innovative treatments are unavailable.

### Help-seeking and stigma

Some people with complex mental health needs may be reluctant to seek help. People in prison often experience complex needs, yet can be reluctant to seek or access care.<sup>40</sup>

Stigma is another barrier to seeking help.

People with bipolar disorder, for instance, experience high public and internalised stigma, which undermines self-esteem, reduces help-seeking and treatment adherence.<sup>41</sup> Low awareness of mental health can also make it difficult to understand or recognise symptoms and when professional help is needed. Some try to manage their difficulties independently or have concerns about services and treatment. More practical barriers include financial constraints or difficulties finding or travelling to services.

## Social and economic needs

### Social isolation and loneliness

A common unmet need for those with a major or complex mental health condition relates to social isolation and loneliness,<sup>42</sup> referring to the lack of meaningful social connections, contacts, and interactions, as well as feelings of loneliness and a sense of not belonging.

For those with complex emotional needs, loneliness is highly prevalent, especially for those with emotionally unstable personality disorder, and is often linked to early adversity and later traumatic experiences.<sup>43</sup> Other reasons include reduced social skills (e.g., reduced motivation, difficulties in social communication), stigma and discrimination (feeling judged or misunderstood), strained relationships with friends and family, and a comorbid physical health condition that prevents participation in social activities, noted in the research literature.<sup>44</sup>

### Income, housing and employment

There are significant unmet needs for mental health care for people with low incomes and less education.<sup>45</sup> Economic insecurity, poverty, poor housing and unemployment impact mental health considerably.

Among others, adequate and stable income, housing, employment opportunities, and education/training are essential foundations for preventing poor mental health.<sup>46</sup> Addressing these social determinants is vital to improving outcomes.<sup>22</sup>

Financial barriers are prominent in countries with co-payment systems. For example, lower-income individuals in one study reported 23 times more unmet mental health care needs compared to wealthier peers.<sup>47</sup>

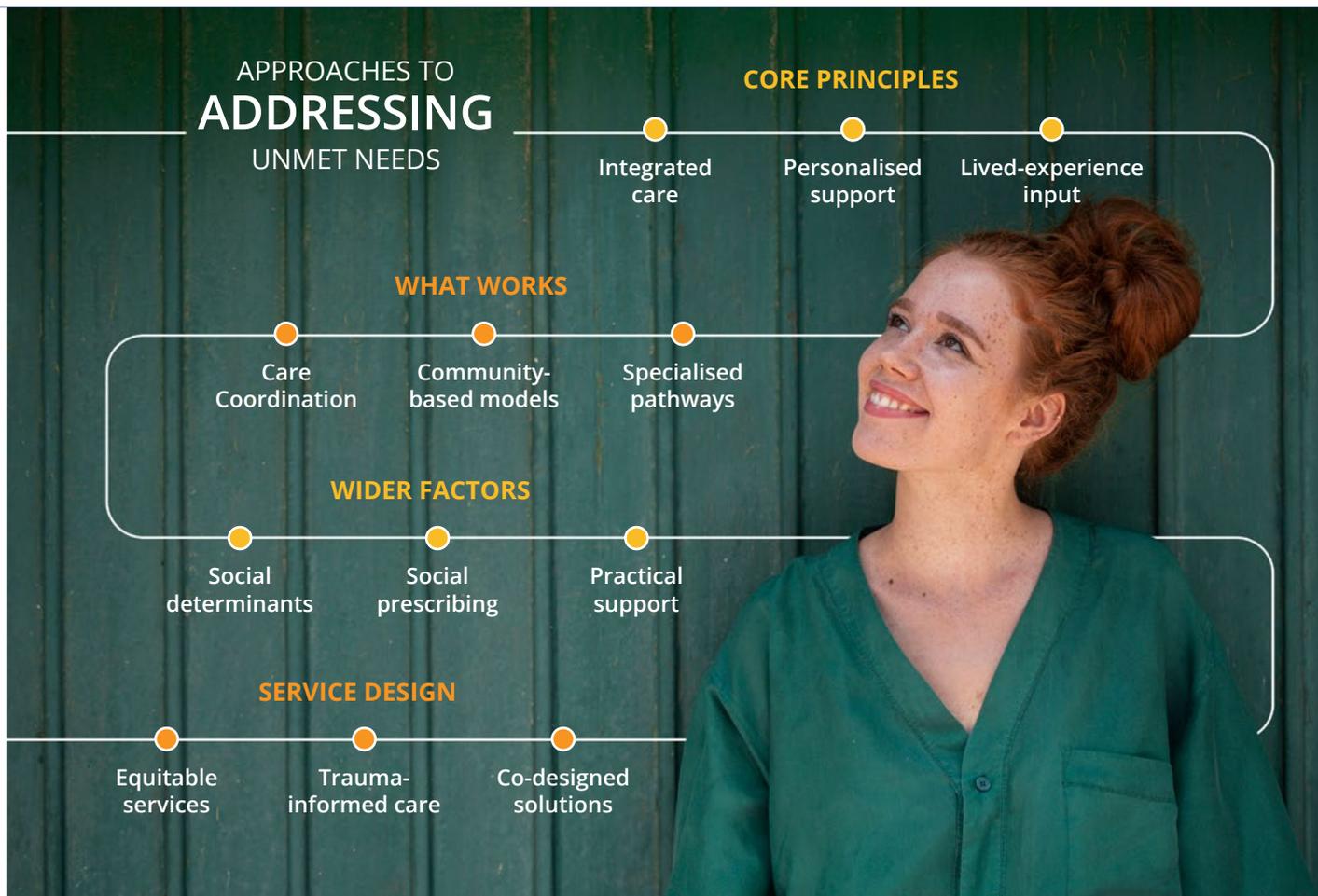
Employment rates among individuals with major mental health conditions remain below 20% in most European countries. Despite strong patient interest in working, access to supported employment models is limited.<sup>48</sup>

## Approaches to addressing unmet needs

According to the literature, approaches to meeting unmet needs for people with complex needs emphasise integrated, recovery-oriented care models, the social determinants, and the active involvement of people with lived experience in care and service delivery.

Core themes include the need to shift towards personalised and multidimensional services that support not only symptom management but also recovery, identity, and meaningful daily life; areas that patients often identify as unmet needs.<sup>49</sup>

Care coordination models reduce unmet needs in people with persistent mental health conditions and complex needs. For example, the Partners in Recovery initiative, coordinated between clinical and other supports, made its most significant reduction in unmet needs for psychological distress, daytime activities, loneliness, and financial needs.<sup>50</sup>



Community-based services which integrate clinical, functional and personal recovery for people living with persistent complex mental health needs offer promising results, where patient goals and priorities are central.<sup>51</sup>

Addressing social determinants of health is a key area for integrated and collaborative support, with the potential to improve the well-being of people with major mental health conditions.

Practices that involve personalised care, such as social prescribing, that meet practical and social needs via link workers who can help improve quality of life.<sup>23</sup>

Health and social care professionals highlight the importance of targeted and equitable care for people with complex conditions that routine psychiatric services cannot address.<sup>3</sup>

One suggestion includes disorder or problem-specific services across service boundaries, for example, early psychosis, offering specialised pathways to enable better access, assessment and management of unmet needs.<sup>52</sup>

Standardised treatments often fail people with complex needs. For those with a personality disorder, for instance, a service should combine many different approaches, such as continuity of care, trauma-informed care, empathetic and non-stigmatising support for therapeutic relationships, better symptom control, treatment and quality of life improvements.<sup>53</sup> There is also a need to co-design and shape services that involve patients in testing strategies within care systems to improve long-term support and treatment, especially for those with complex emotional needs.<sup>54</sup>



# 04

## FINDINGS FROM THE FOCUS GROUPS WITH PATIENTS AND CLINICIANS

### Profiles of patient participants

**Graphic 1** lists the patient participant profiles. A total of 11 patients, residing in 7 countries, participated in the first focus group. Their ages ranged from 18 to 55 years, with each listing their conditions (see Table 1). Seven patient participants were female.

#### COUNTRIES

7



Nederland



Belgium



Germany



Slovenia



Croatia



Hungary



#### PATIENT PARTICIPANTS



#### AGE RANGE 18-55



#### GENDER



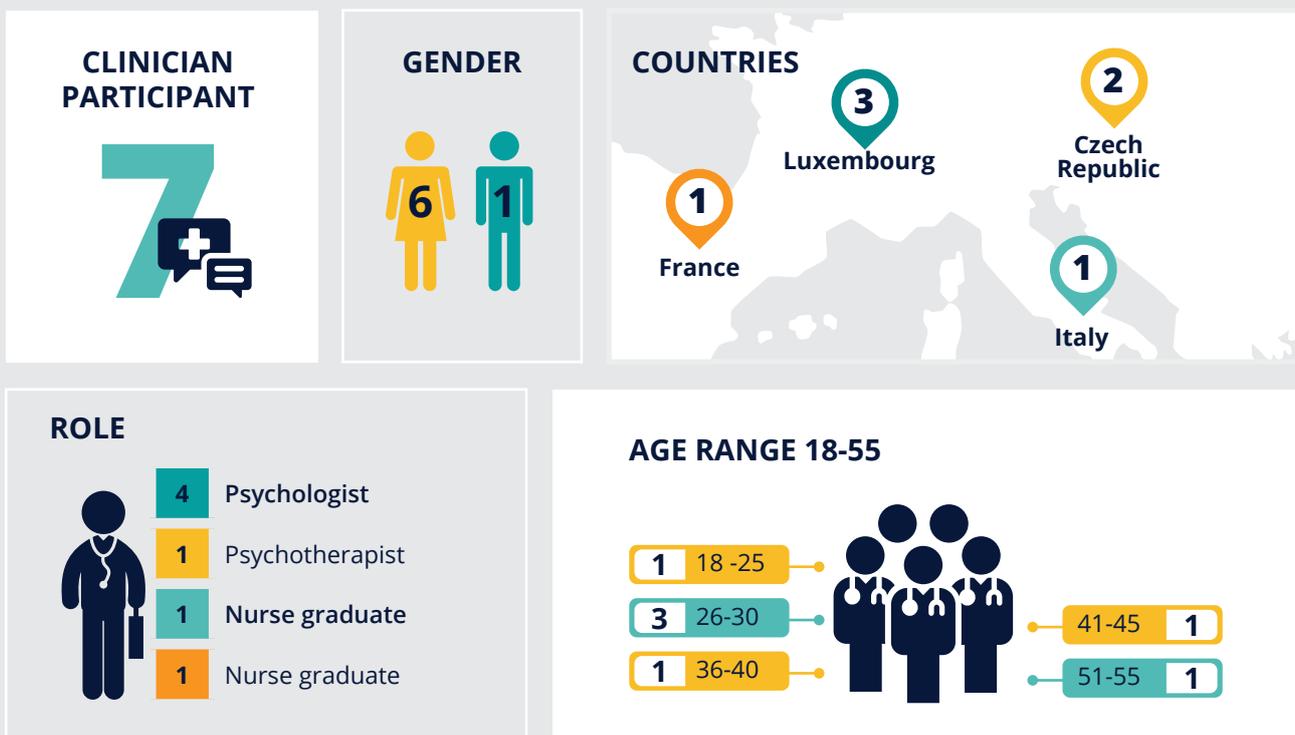
Table 1

**CONDITIONS LISTED BY PATIENT PARTICIPANTS**

1	Bipolar disorder, PTSD
1	Chronic major depressive disorder, Complex PTSD, anxiety disorder, dissociative disorder/borderline personality disorder
1	Complex PTSD, depression, and neurodivergent
1	Eating disorder (in recovery)
1	Major depressive disorder
1	MDD, generalised anxiety, autism spectrum disorder
1	Psychosis, autism and poor energy
1	Schizoaffective disorder
2	Schizophrenia
1	Uncategorised (depression, substance abuse, borderline)

**Clinician participant profiles**

A total of seven clinician participants attended a second focus group; they resided in four different countries. **Table 2** details their ages, roles, and genders. Six were female, and four were psychologists.





## Challenges of unmet needs

Patient participants with complex needs discussed a broad range of challenges, similar to those described in the research literature, including service barriers and personal difficulties associated with complex needs and treatments.

**Patient participants discussed the reality of managing either multiple mental health conditions and/or physical health issues. They noted numerous unmet needs from their lived experience of using services and their treatments for complex needs.**

**Clinician participants shared their perspectives on the challenges of identifying and addressing unmet needs, which are presented here.**

### Communication, coordination and time pressures

For patient participants, a crucial unmet service need included the lack of communication between specialist departments for those with multiple conditions. This highlighted the lack of coordination between services, leading to patients receiving inappropriate or conflicting treatments. For example, separate services could prescribe medications with harmful interactions or where patients are asked to discontinue one treatment while undergoing tests for another.

*'...If [the services] could just talk to each other, they would actually be able to give me a treatment that is more appropriate.'* (P11, female, Slovenia)

Clinician participants highlighted inconsistencies in information sharing between services, resulting in service gaps, the lack of coordination, duplication and delays in care.

*'We have to improve the coordination between services. It's not just about getting an appointment for a doctor or specialist, but it's about receiving continuous care. I noticed that there's not much sharing of information or communication between GPs, psychologists, psychiatrists and social workers, because they're important. So, we have to work on improving collaboration and service coordination.'* (C4, clinician, France)

Time pressures for clinicians (with limited time for consultations) worsen the situation, where patients often have to relay their clinical history to every clinician they meet. In the midst of an episode of illness, this is not easy.

*'I went to 10 different speciality doctors, and I had to repeat my story over and over. I was not in a good place. I forgot important things... They have notes from the previous doctor...but they usually don't have the time to read them.'* (P1, female, Germany)

Some were unable to articulate their symptoms in the short consultation time.

*'The communication is the worst part when the doctors are talking to us because we, by ourselves, don't know what the symptoms are and what we are experiencing.'*  
(P8, female, Croatia)

Participants acknowledged the pressure clinicians were under, but the brevity of their meeting meant their needs might not be fully identified, assessed and treated.

*'If they had more time for me... they would have recognised I had a panic disorder.'*  
(P2, male, The Netherlands)

Clinician participants recognised the challenges regarding short consultation times, which made it harder to explore and address complex conditions. Clinician participants acknowledged they were under pressure and noted that patient consultations were often rushed. Heavy workloads meant that some needs were not fully identified or treated. This situation worsened during crisis-oriented interventions, which left little room for the holistic care that patient participants said they needed.

*'[While working in a psychiatric hospital] I saw a lot of unmet needs, especially emotional needs... In the hospital, doctors are often overwhelmed; they have little time for in-depth psychological support.'*  
(C4, clinical psychologist, France)

These were seen as failings of systems rather than individual clinicians, but could lead to patients being dehumanised in crisis or hospital settings.

## Competing priorities for care and treatment

Often, there was a mismatch of priorities between patients and clinicians. There was a sense of a different focus and motivation according to patient participants. Clinicians appeared mainly concerned with managing symptoms and the treatments available to them. Patients, however, emphasised the negative impact of their condition and its treatments on their lives.

*'Doctors see only the clinical view, and they only see symptoms... As a patient, when I go to the doctor, I am worried 24/7 about all my symptoms and how the treatment will affect me in my daily life and what it will do to my body.'* (P1, female, Germany)

There was pressure to adhere to treatment plans without question, even though some of the side effects were problematic. There were concerns about questioning the treatment due to its side effects.

*'At the beginning [of my illness] when I was not well, I was... considered non-compliant to not take [medication]...So I took it and I had severe side effects.'* (P1, female, Germany)

Clinicians might portray side effects as a price worth paying to relieve symptoms, but these side effects can have significant consequences for patients, thereby generating unmet needs. Clinician participants recognised patients' concerns about side effects and that these can interfere with adherence.

With a narrow focus on symptoms and medication, other important aspects of recovery were missed, such as maintaining physical and mental well-being. Patient participants noted that clinicians overlooked lifestyle factors, such as nutrition or physical activity, even though these could provide significant benefit for some.

*'They look at you on the surface level... most professionals didn't say anything about how nutrition or sport can help.'* (P3, male, Israel)



For some, sport and exercise were important for maintaining stability and mood, but some medication side effects could interfere with their ability to keep this going.

Similarly, patient participants reporting physical symptoms were sometimes overlooked and interpreted by clinicians as part of their mental health condition. This diagnostic overshadowing would dismiss patients' accounts of physical health symptoms as imagined or a result of starting or stopping medication.

*'[Mental health] practitioners are sometimes biased. When you talk about another problem, something physical, and they are aware of your mental situation, they sometimes don't really believe you or don't take you as seriously, especially if there's any change in medication. They say it's psychosomatic, placebo or nocebo.'* (P5, female, Belgium)

### Consequences of unmet needs

Unmet needs such as low self-esteem, past crises, abuse or stigma can sometimes prevent people from engaging with or seeking help from services.

*'I've met several women who, following abuse, have difficulty reaching out, asking for help that is available...'* (P9, female, Croatia)

One clinician participant also highlighted the challenges around seeking help.

*'...It takes a lot of courage to seek help from mental health services, to get people to the right places, and then you're on the waiting list for six months to a year. And in between, there's a lack of services. People with personality disorders or more severe cases face a lot of stigma. Some professionals say they can't work with personality disorders or something like that, which is okay, ... but there should still be some accountability.'*

(C5, clinician, Luxembourg)

Other unmet needs arise regarding acceptance of diagnosis and/or medication.

*'Many patients don't want to take their medications because they will not accept that they have a problem. They don't accept that they have a diagnosis and that their quality of life has decreased. If people don't accept the problem, then the treatment will be very...very difficult.'*

(P2, male, The Netherlands)

This highlights the importance of working with patients to gain a shared understanding of their whole experience, including any unmet needs, to help them with the treatments being offered. This is particularly pertinent if they are experiencing medication side effects or adverse interactions from multiple medications.

This is also true for people with primary physical health conditions, where their mental health may be neglected or overlooked by services.

*'I was working as a nurse... in the hospital with older patients with cancer, just diagnosed and stuff like that. And no one was... taking care of their mental health. The doctors or the nurses just told them their diagnosis, and that was all. They didn't care how the patient reacted...no one saw that they're struggling mentally.'* (C2, nurse and formal carer, Czech Republic)

## Treatment costs and systemic barriers

Both patient and clinician participants repeatedly cited the cost of care as a key obstacle. Even where psychological support is available, waiting lists are long, and online options remain limited for those relying on public services. Costs were seen as a filter; those who can pay receive faster and more consistent care, while those who cannot afford private care face long waits or no care.

*'I think it's always about money because in the Czech Republic it's really hard to get support from a psychotherapist through health insurance. A lot of people can't afford it.'* (C1, psychotherapist, Czech Republic)

The out-of-pocket charges or paying for private mental healthcare meant some patients needed some form of income to access the care they needed, whether through employment or other means.

*'It would be good if I could access therapy [online], but that is only available if you pay. Free group talks are not available [in Croatia]. If I didn't have a backup in terms of money, I wouldn't have been able to access many services that I've been able to.'* (P9, female, Croatia)

The lack of information about service availability was another reason for the continuation of unmet needs. Several participants described this, particularly those who are isolated or who lack advocates.

*'Some people aren't aware ...they don't know what help they can get.'* (P3, male, Israel)

*'Many people that I've talked to about my issues who are dealing with similar issues say, I never heard of that [service].'* (P9, female, Croatia)

High demand for services and long waits to see specialist clinicians were other key issues highlighted by clinician participants. Also, the high demand for mental health services meant that clinicians were not always addressing some of the main issues patients presented with.

*'We're not touching the root problem, or we're not really evaluating the needs of people...We're... probably just sticking to one diagnosis or one condition and treating them in a standard way...you medicate, and you treat the symptom, but you don't go to the root cause of them.'* (C3, clinician, Luxembourg)

While waiting for specialist care, patients may receive treatment from their General Practitioner (GP) or family doctor. For those with complex needs, this is not ideal.

*'When it's not urgent, a person can wait one year to go to the psychiatrist, who might not be taking on new cases. They can wait six months or a year to see a psychotherapist, and during this time, I noticed, they [the person] goes to the GP, and they're allowed to prescribe some medications. But after the medications, the GP realises that the trauma is not treated only by medication, but with psychotherapy as well.'* (C4, clinician, France)





## Perspectives to address unmet needs

### Social, family, community and peer support

The need to talk about complex conditions and who to talk to about them was paramount. This pointed to support from other sources, often outside health services, such as peers, friends, family, and community organisations.

Being isolated, without close family or being older were also seen as risks, potentially leading to being overlooked by services. Family and friends often help navigate services and access care, which emphasises the importance of this informal support.

*'[Being an older person] could mean they have fewer relatives and not much support... If they have family, friends who support them, they also could reach out to those different supports.'* (P6, female, Hungary)

This reinforces the importance of being connected to a social and care network, which helps to address or prevent unmet needs. Without these connections and peer support, unmet needs can remain unaddressed.

Patient participants described the peer support and community work they do to support people with mental health conditions. One had created a community organisation where people with lived experience could come together for support, learning and creative projects. Through various activities, focus groups, and festivals, they were able to learn, build skills, gain confidence and potentially earn an income while supporting and educating others.

*'Users would join a work group and work together. [In doing this] they are healing themselves and improving their self-esteem. They would earn money through their work and could organise festivals and stuff. They could educate people...'* (P8, female, Croatia)

Patient participants noted the value of peer support. Peers with similar experiences of their conditions and services could offer insight, empathy, validation, and guidance, often missing in brief clinical meetings. One patient participant described how they approach peer support in their setting.

*'Because I've been through comparable struggles, people listen to my perspective differently—it feels more personal and tailored. We start with a single meeting to see if we click. If they want to keep talking, great; if not, that's fine too.'* (P3, male, Israel)

Importantly, peer support could allow more time to explore the range of needs individuals may be experiencing. This support can be offered by the same person at a single location, providing continuity and avoiding the need to repeat one's history, as a complement to the services and treatment they receive.

Peer support was also described as a bridge between service users and professionals. Peer supporters with lived experience of treatment and service use were in a unique position to help patients improve their communication with mental health services.

Charitable and non-governmental organisations based in the community provide an essential source of support and information to fill the gaps left by specialist services.

*'We're now seeing upwards of 75% of services [in Ireland] being offered by community and voluntary organisations... [for individuals with complex needs]. They're very responsive and innovative, but they're also really restricted to the funding that they have or they're able to secure.'* (C6, psychologist, Ireland)

**Encouraging and teaching self-representation or self-advocacy are essential skills for helping people to present themselves effectively to services. Patient participants identified three main skills for this:**

- **Knowing how and when to ask for services**
- **Feeling confident to disagree with clinicians politely**
- **Being patient and allowing time for treatment to work**

Clinician participants also noted that the key to addressing complex needs was to have solutions or strategies in place, utilising the patient's own resources when possible.

*'I'm just afraid of opening all the other [patient] needs instead of coming up with solutions... but I think it's better to, from the beginning, activate whatever resources the person has or whatever can expand and extend the limited amount of time we have together.'* (C3, clinician, Luxembourg)

## Holistic approaches

A holistic healthcare system is essential for addressing complex needs. It becomes even more critical where combined physical and mental health needs are concerned. Health services are often disconnected, working in silos, leaving people with complex needs cared for by discrete, separate services. Drug interactions, emotional distress arising from treatment, and physical reactions from medications can go unrecognised. Patient participants wanted guidance and emotional continuity from clinicians, not just medication management.

*'For me, one big unmet need is the holistic approach because of the multiple conditions, both mental and physical health conditions, from my own experience... These two should be considered in any treatment...'* (P1, female, Germany)



One clinician participant described a vital way to address complex needs.

*'For me, the key is really to identify those needs first. Our role as professionals is to guide patients in identifying and sometimes reflecting [on their needs] because some things might not be really conscious. But once those things are more evident, then trying to pick or let the patient [decide] what feels or seems to be more urgent [or not].'* (C3, clinician, Luxembourg)

Both patient and clinician participants felt services worked better when they collaborated and communicated well. For example, when multidisciplinary teams arrived at accurate diagnoses and provided adequate support, treatment and medication. Patients valued transparency and being treated with compassion as people rather than a set of diagnoses.

Patient participants noted some of their positive experiences with services, including when clinicians work well together, receive a correct diagnosis, and are treated with compassion.

*'[I had] a GP for like 13 years. She was very understanding, and she did everything in her power to help me find whatever I said I needed.'*

*(P4, female, Portugal)*

One patient valued their clinician's honesty and being seen as a person rather than a diagnosis. Some participants talked about positive experiences in group sessions and receiving practical help, such as finding work, which then opened up other opportunities.

Some talked about positive experiences in group sessions and receiving practical help in achieving goals, such as finding work, which opened up other opportunities.

Challenges included navigating disjointed systems, communication gaps, and limited access to care. They saw these as failings of systems rather than individual clinicians.

## Stigma

Breaking stigma on all levels was another vital aspect of addressing and preventing unmet needs. Patient and clinician participants agreed on this. It was essential to empower patients and health professionals through education, training, and effective campaigns to promote the lived experience of complex needs. Equally important is to ensure people are connected to relevant groups and organisations that understand their experiences.

*'People talked about stigma for any mental health, and although it's getting better, there's still a lot of taboo... When people join groups or associations, it makes them feel that they are really not alone or the only one, and I think it's a huge step out of a lot of struggles. (C3, clinician, Luxembourg)*

## Digital tools to address unmet needs

Patient participants highlighted the value of digital tools and proposed tools that could potentially reduce unmet needs. Digital tools were seen as having the potential to improve communication between clinicians and between patients and clinicians. One suggestion was for an integrated digital care plan that summarises health information (symptoms and medical history) across services to aid communication between patients and clinicians.

*'If there was a program that could... [unravel] all the information in my ramblings and make it easier for a doctor to understand who doesn't have time — that would be a great tool.' (P1, female, Germany)*

Other participants expanded on this, suggesting an app that would allow patients to record their medications, symptoms, and relevant social, practical, or lifestyle factors, such as exercise or sleep, to provide clinicians with context.

*'You could tag something like that in the app, and the doctor sees it before the next session — okay, there's a new thing coming up, and this might affect your treatment.' (P10, male, Germany)*

Practical support for handling bureaucracy, navigating services, and self-representation could be simplified with AI, including assistance with writing letters to official agencies and health and/or social security services

*'Patients can use AI for writing various letters to health authorities, for example, for sickness benefits... which they may not be able to write themselves because of their poor state of health. That's a useful tool — to automate the writing of letters.' (P4, female, Portugal)*

This, however, came with a caveat that the use of AI (Artificial Intelligence) was not a replacement for human connection, which was considered central to healthcare services.

*'I want to advocate for doctors to have time for me, not to replace what the system cannot provide with AI.' (P4, female, Portugal)*

Importantly, patients need to be viewed as people, and the use of AI may undermine this if it is used to replace relational care, such as talking therapy, companionship, or peer support.

Clinician participants described digital hubs and online crisis-response apps as promising, provided they connect users to services and do not compromise human interaction. There was a need to ensure that patients had the skills to use AI or other digital tools.

*'AI is something that we cannot escape anymore. And there is potential there once people are educated on how to use the tools.' (C3, clinician, Luxembourg)*



# 05

## FINDINGS FROM THE VALIDATION SURVEY

Ten focus group participants rated the importance of 22 'statements' about their experiences of unmet needs on a 1-to-5 scale (see the appendix for the complete list of statements). Statements were ranked from 1 to 22 in order of priority.

The statements were grouped into four key themes emerging from the focus groups and the literature review.

These included:

- 1. access and coordination of care, 2. communication and relationships between patients and clinicians, 3. treatment and recovery, and 4. equity, inclusion and personalisation of care.

Means (averages) and standard deviations (spreads) were calculated to describe how participants rated or ranked each statement. *More details are provided in the appendix.*

### Grouped theme averages

The average rating (mean and spread) for each grouped theme is listed in **Table 3**. No item was rated as unimportant. The ratings show the relative priorities, not the extent to which these issues are experienced in participants' lives. **Table 4** in the appendix provides a full breakdown of the individual statements by theme, their average score, spread, rank and other figures.

1		Access & Coordination	
		Average	Spread
		4.1	0.24
2		Communication & Relationships	
		Average	Spread
		3.3	0.33
3		Treatment & Recovery	
		Average	Spread
		3.7	0.38
4		Equity, Inclusion & Personalisation	
		Average	Spread
		4.1	0.17

Table 3.

## 1 Access and coordination of care

This was the highest-rated grouped theme (average 4.1), with six statements about the ease of navigating services, the clarity of pathways, and the flow of information between services. On average, each statement scored close to 4.0, and individual statements were ranked between 3 and 9 out of 22 (see Table 4 in the appendix).

**This group includes the joint highest-ranked of all the statements:**

**Rank 1:** *"Different services don't share information, so I have to repeat my story"* (average 4.4, min 4- max 5)

**Rank 3:** *"Care isn't joined up across my mental and physical needs"* (average, 4.2, min 3, max 5)

**Rank 3:** *"It is hard to find the right services"* (average 4.2, min 3, max 5)

**The lowest average rating for a statement in this group was still relatively high.**

**Rank 9:** *"My care feels inconsistent – different clinicians give different advice"* (average 3.7, min 2, max 5)

## 3 Treatment and recovery

This theme included seven statements about managing medication, support for day-to-day self-management and the extent to which conditions are considered together. Averages for this group were relatively high, ranging from 3.4 to 4.4, and ranked by participants as very important.

**Rank 1:** *"The healthcare system focuses more on managing crises than preventing them"* (average 4.4, min 3–max 5).

**The statement** "Managing medication is difficult" elicited the widest variation in ratings, from low to high.

**Other essential items highlighting the need for holistic care included:**

**Rank 7:** *"I don't feel supported to manage my condition day-to-day"* (average 3.9, min 1, max 5)

**Rank 8:** *"Professionals don't consider how my different conditions interact"* (average 3.8, min 3, max 5)

## 2 Communication and relationship with clinicians

This theme included five statements about communication and interactions with professionals, including involvement in decisions, feeling believed, and the time available for consultations.

Averages for this theme were moderate, ranging between 3.2 and 3.6. Statements were ranked in the lower half of the survey, between 11 and 22 (out of 22). While these issues remain important, they were ranked lower in priority than the others.

**The highest rated statements were.**

**Rank 11:** *"There's not enough time in appointments to discuss what really matters to me"* (average 3.6, min 1, max 5)

**Rank 19:** *"Professionals are too busy to understand my situation"* (average 3.6, min 2, max 5)

The lowest-ranked item in the survey was:

**Rank 22:** *"Professionals don't involve me in decisions"* (average 2.8, min 1, max 5)

## 4 Equity, inclusion and personalisation

This theme included four statements about feeling judged or defined by a diagnosis; about acknowledging personal values or cultural background; and about access to personalised and digital services.

Averages ranged from 3.3 to 3.5, with greater variability than in the other groups. This theme was a lower priority than Access & Coordination and Treatment & Recovery.

**The highest rated items in this group were:**

**Rank 14:** *"I feel judged or defined by my diagnosis"* (average 3.5, min 1, max 5)

**Rank 15:** *"Digital or online services aren't accessible or personal"* (average 3.4, min 2, max 5)

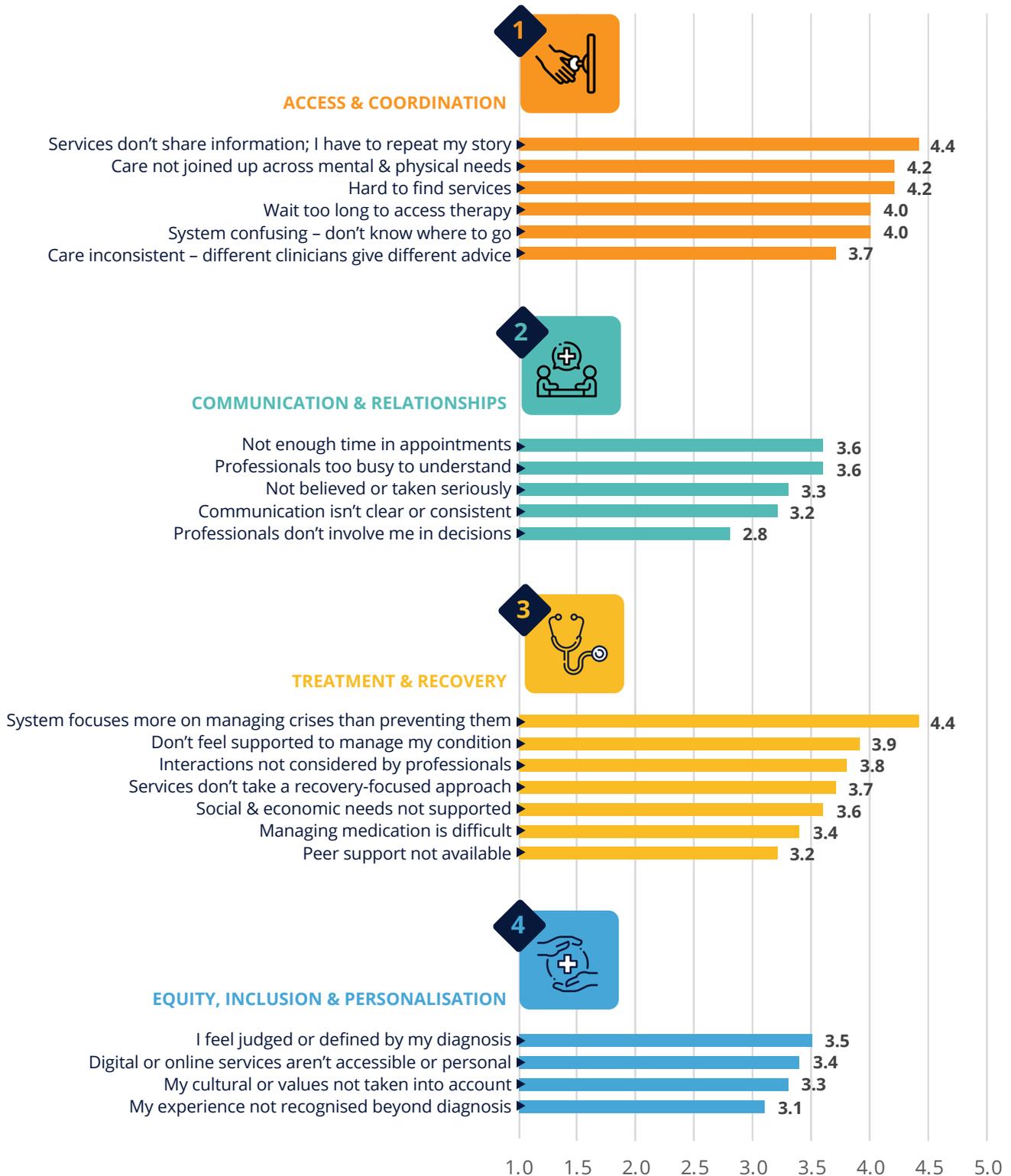
## Individual statement averages

The averages for individual statements revealed that the top six ranked four or higher (out of 5) concerned access and coordination of care, and treatment and recovery. **Figure 1** shows how the lack of information sharing and joined-up care, difficulty navigating services, and services that focus mainly on crisis rather than preventive care are key challenges.

Figure 1:

Figure 1

**Averages for individual statements by grouped theme**





## 06

## DISCUSSION AND CONCLUSION

The findings from all elements of the project highlighted the challenges and solutions to addressing unmet needs for people with complex needs.

The main challenges included access to services, wait times to see clinicians, and services that lacked coordination and continuity of care to meet complex needs. Each of the major mental health conditions reviewed encountered considerable difficulties, particularly those diagnosed with a personality disorder. Standard or routine care is insufficient to address the needs of those with complex, multiple conditions. Unmet needs often persist due to service gaps, barriers to access, a lack of personalised/ integrated care, and the high demand for services.

Psychosocial support and addressing social and economic determinants are critical ways to address many unmet needs that are often overlooked. There are many reasons why psychosocial needs remain unmet, much of it due to a lack of resources, usually focused in urban rather than rural areas. Yet the evidence for their effectiveness is strong, and the emphasis on medication-based treatments continues to dominate.

Young and older age groups have particular unmet needs that require additional attention, not least because they often fall through the gaps during service transitions.

### Making a difference in addressing unmet needs

#### Personalised, Holistic and Stigma-Free Care

The literature emphasises the need to shift towards personalised, multidimensional services that go beyond symptom management and focus on recovery and meaningful quality of life. Integrated models of care have been evaluated and shown to improve psychosocial outcomes. Somehow, these service models fail to be implemented on a wide scale.

Addressing the stigma of complex needs is another area needing attention, which can better empower patients to join groups or associations, making them less isolated and feeling alone. Co-designing services and their delivery with patient experts is another essential feature for addressing complex unmet needs.

## Digital Tools and Better Coordination

Digital tools have the potential to address some of the main service challenges faced by those with unmet, complex and multiple needs. The most significant potential was viewed as improving communication between clinicians and between patients and clinicians. This could include digital care plans that summarise the patient's clinical history, so patients do not have to repeat it. Many other suggestions in the focus groups included using apps to monitor and summarise symptoms, navigating services and handling bureaucracy. However, patient participants made it clear that digital tools could not replace human input and contact. AI has its limits, and many patients are wary of it replacing talking therapy, companionship or peer support.

The survey of focus group participants highlighted the importance of prioritising access and coordination of care, treatment, and recovery to address unmet needs for complex and multiple conditions. The focus groups emphasised the need for more holistic approaches, especially in integrating care for physical and mental health conditions.

## Strengthening Systems and Resources

Mental health systems take time to improve, but they need adequate resources to function effectively in caring for those with complex, multiple needs. Practical changes, however, can make the most of services and workforces already in place.

Focus group participants noted the importance of communication between specialist health and social departments. Similarly, clinicians working together more cohesively can make all the difference in avoiding many of the difficulties patients with complex needs encounter day to day.

## Joined-Up, Whole-Person Support

Broadening service practices to adopt a more holistic approach that spans across service departments, encourages better communication and information sharing, the involvement and inclusion of community organisations, peer support, and other supportive social networks and connections, can make all the difference in addressing unmet needs for complex conditions, as well as empower patients to make the most of their own resources.

In conclusion, getting the right help at the right time for people with complex and multiple mental health needs can start by using practical initiatives to enable services to be more joined up, more personalised and geared towards people's whole lives rather than just managing their symptoms. Holistic care that brings together both mental and physical health support, social and economic help, with strong psychosocial and community-based services, including peer support and voluntary organisations. Involving people with lived experience in the design and delivery of services can ensure these services are more relevant and supportive.

Better communication between services and specialist departments, and between patients and clinicians, can be improved with the aid of digital tools, but cannot replace human contact, empathy, and therapeutic relationships. Better coordination, fairer access and reduced stigma can move closer to meeting the unmet needs of those with complex and multiple conditions at every stage of life.



## 07

# APPENDIX

## Methods

### Literature review

The key word terms were used (both individually and in combination) to find the research literature included:

Unmet needs, complex and multiple needs, mental health services, gaps, challenges or barriers, PTSD, personality disorder, schizophrenia, bipolar disorder, major depressive disorder, treatment, carers, lived experience and/or service user experience, psychosocial support/interventions, service gaps, personalised care, treatment, comorbidity, access, barriers, access inequities, service gaps, social needs, social support, and approaches/solutions/strategies to address unmet needs.

Academic research papers were accessed via databases such as PubMed, Google Scholar, ScienceDirect, and SpringerLink. Grey literature was searched via OECD, the European Commission and the WHO. Supplementary searches were also conducted using Perplexity and ChatGPT.

Studies of European populations published between 2020 and 2025 were prioritised. The most salient literature was cross-referenced to identify other relevant sources.

Studies were selected based on relevance to quality of care and management, diagnostic challenges, treatment gaps in medication and services, stigma and discrimination, condition-specific needs and availability of holistic care or psychosocial support, age or gender-specific findings in schizophrenia, bipolar disorder, PTSD, personality disorders and MDD treatment.

### Focus groups

A qualitative approach was employed to address the project's aims by convening two focus groups to gather the lived experiences of patients with complex needs and the perspectives of clinicians supporting patients with major mental health conditions. GAMIAN-Europe invited people with lived experience and clinicians to participate in the focus groups.

Two focus group programmes were devised to explore the challenges and approaches to addressing unmet needs for people with complex mental health conditions. The programmes included predefined themes such as identifying unmet patient needs, the impact on daily life, access to care, and working together to design better services.

**Focus group questions included the following:**

- What are the main issues with unmet complex needs?
- How do unmet complex needs impact day-to-day living?
- What are the experiences and perspectives of patients with unmet complex needs regarding their interactions with the healthcare system?
- What treatment journeys have patients experienced? What are the treatment gaps?
- What strategies and solutions have patients found useful?
- What are the difficulties clinicians face in identifying and delivering treatment/care for patients with unmet complex needs? What do clinicians see as the solutions to addressing the treatment gaps for unmet complex needs?

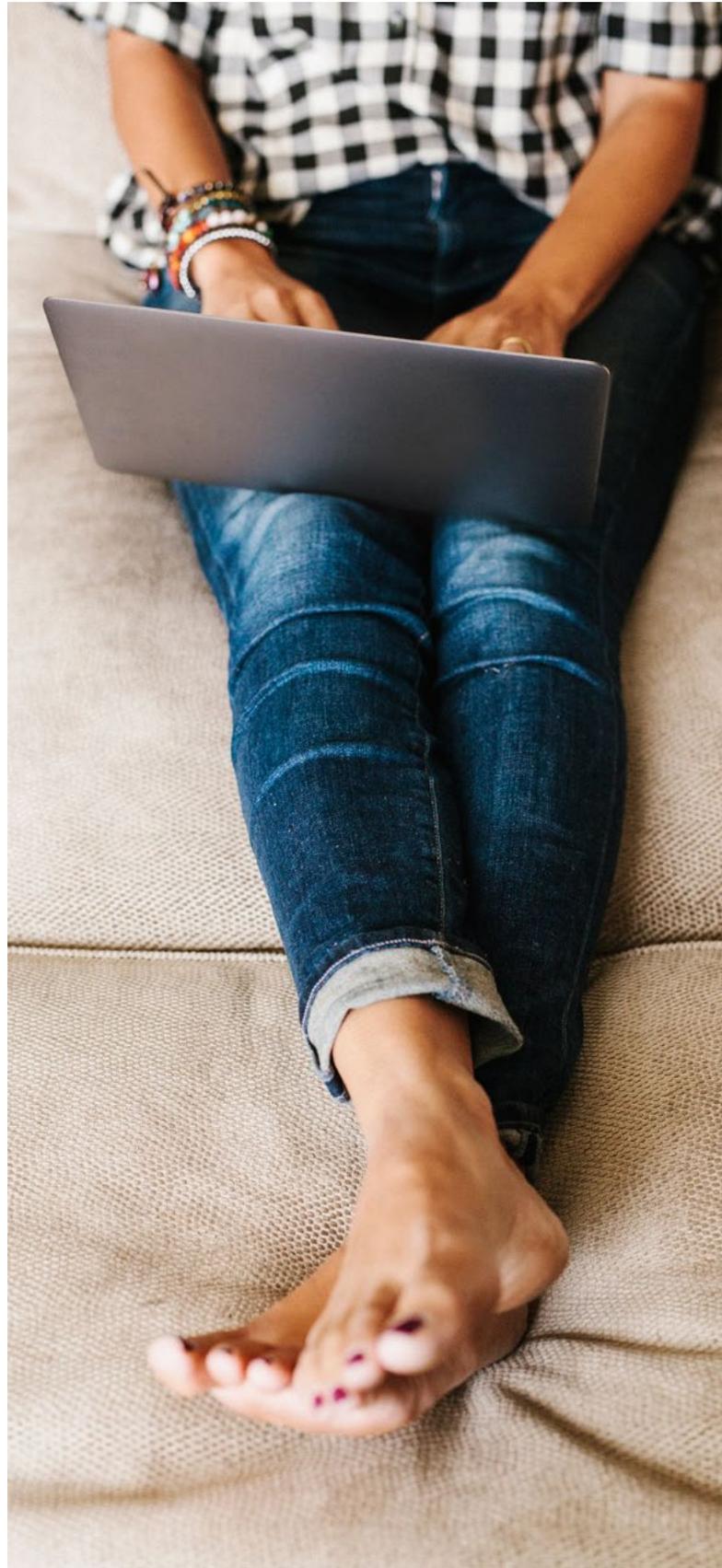
The focus groups lasted 2.5 hours and were conducted online via Zoom, with recordings made with participants' permission. Transcripts from the recordings were coded and analysed thematically.

**Validation survey**

Participants who attended the focus groups were invited to complete a validation survey. Using Microsoft Forms, participants were asked to complete a survey to prioritise the importance of several items related to complex, unmet needs.

A series of statements was devised listing the 22 salient themes drawn from the literature review and focus groups. Participants were asked to rate (on a scale of 1 to 5) a series of statements in order of importance to address unmet needs (see a copy of the validation questionnaire below).

Averages, ranges, and spreads were calculated using Excel. For simplicity, this summary report uses mean and standard deviation ("average" and "spread") to describe how participants rated or ranked each statement.





## Copy of the validation questionnaire

Below is a list of statements regarding people with complex, unmet mental, social, and physical health needs. These were developed from two focus groups with patients and clinicians, and some key themes from the research literature.

Please select a number from 1 to 5 to rate the importance of each statement for addressing unmet needs.

**This should only take a few minutes to complete.**

- 1 = Not important at all
- 2 = Not important
- 3 = Neutral
- 4 = Important
- 5 = Extremely important

### Access & Coordination

1. It's hard to find the right services.
2. The system is confusing – I don't know where to go for help.
3. Different services don't share information, so I have to repeat my story.
4. Care isn't joined up across my mental and physical needs.
5. I have to wait too long to access therapy or specialist care.
6. My care feels inconsistent – different clinicians give different advice

### Communication & Relationships

7. Communication between professionals and me isn't clear or consistent.
8. Professionals are too busy to understand my situation.
9. Professionals don't involve me in decisions.
10. I have to fight to be believed or taken seriously.
11. There's not enough time in appointments to discuss what really matters to me.

### Treatment & Recovery

12. Managing medication is difficult (too many drugs, side effects).
13. Services don't take a recovery-focused approach.
14. Professionals don't consider how my different conditions interact.
15. I don't feel supported to manage my condition day-to-day outside of appointments.
16. The healthcare system focuses more on managing crises than preventing them.
17. Services don't have support for social and economic needs (e.g. isolation, finance, employment, housing support)
18. Peer support is not available.

### Equity, Inclusion & Personalisation

19. I feel judged or defined by my diagnosis.
20. My experience isn't recognised beyond my diagnosis.
21. Digital or online services aren't accessible or personal.
22. My cultural background or personal values aren't taken into account.

Are there any other issues you think are important that aren't listed here?

*(Please write below)*

**Thank you for responding to this questionnaire.**

Table 4

**Full results for the validation survey by grouped theme and individual statements**

	RANK OUT OF 22	AVERAGE	SPREAD	GROUP MEAN	GROUP SPREAD	TOTAL	MIN	MAX
<b>Access &amp; Coordination</b>								
It's hard to find the right services	3	4.2	0.6	4.1	0.2	42	3	5
The system is confusing – I don't know where to go for help	5	4	0.7			40	3	5
Different services don't share information, so I have to repeat my story	1	4.4	0.5			44	4	5
Care isn't joined up across my mental and physical needs	3	4.2	0.6			42	3	5
I have to wait too long to access therapy or specialist care	5	4	0.9			40	2	5
My care feels inconsistent – different clinicians give different advice	9	3.7	1.1			37	2	5
<b>Communication &amp; Relationships</b>								
Communication between professionals and me isn't clear or consistent	19	3.2	1.3	3.3	0.3	32	1	5
Professionals are too busy to understand my situation	11	3.6	1.2			36	2	5
Professionals don't involve me in decisions	22	2.8	1.0			28	1	5
I have to fight to be believed or taken seriously	17	3.3	1.2			33	2	5
There's not enough time in appointments to discuss what really matters to me	11	3.6	1.3			36	1	5
<b>Treatment &amp; Recovery</b>								
Managing medication is difficult (too many drugs, side effects)	15	3.4	1.5	3.7	0.4	34	1	5
Services don't take a recovery-focused approach	9	3.7	1.1			37	2	5
Professionals don't consider how my different conditions interact	8	3.8	0.6			38	3	5
I don't feel supported in managing my condition day-to-day outside of an appointment	7	3.9	1.2			39	1	5
The healthcare system focuses more on managing crises than preventing them	1	4.4	0.8			44	3	5
Services don't have support for social and economic needs (e.g. isolation, employment, housing support)	11	3.6	1.1			36	2	5
Peer support is not available	19	3.2	1.3			32	1	5
<b>Equity, Inclusion &amp; Personalisation</b>								
I feel judged or defined by my diagnosis	14	3.5	1.4	3.3	0.2	35	1	5
My experience isn't recognised beyond my diagnosis	21	3.1	1.4			31	1	5
Digital or online services aren't accessible or personal	15	3.4	1.0			34	2	5
My cultural background or personal values aren't taken into account	17	3.3	0.9			33	2	5



## 08

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