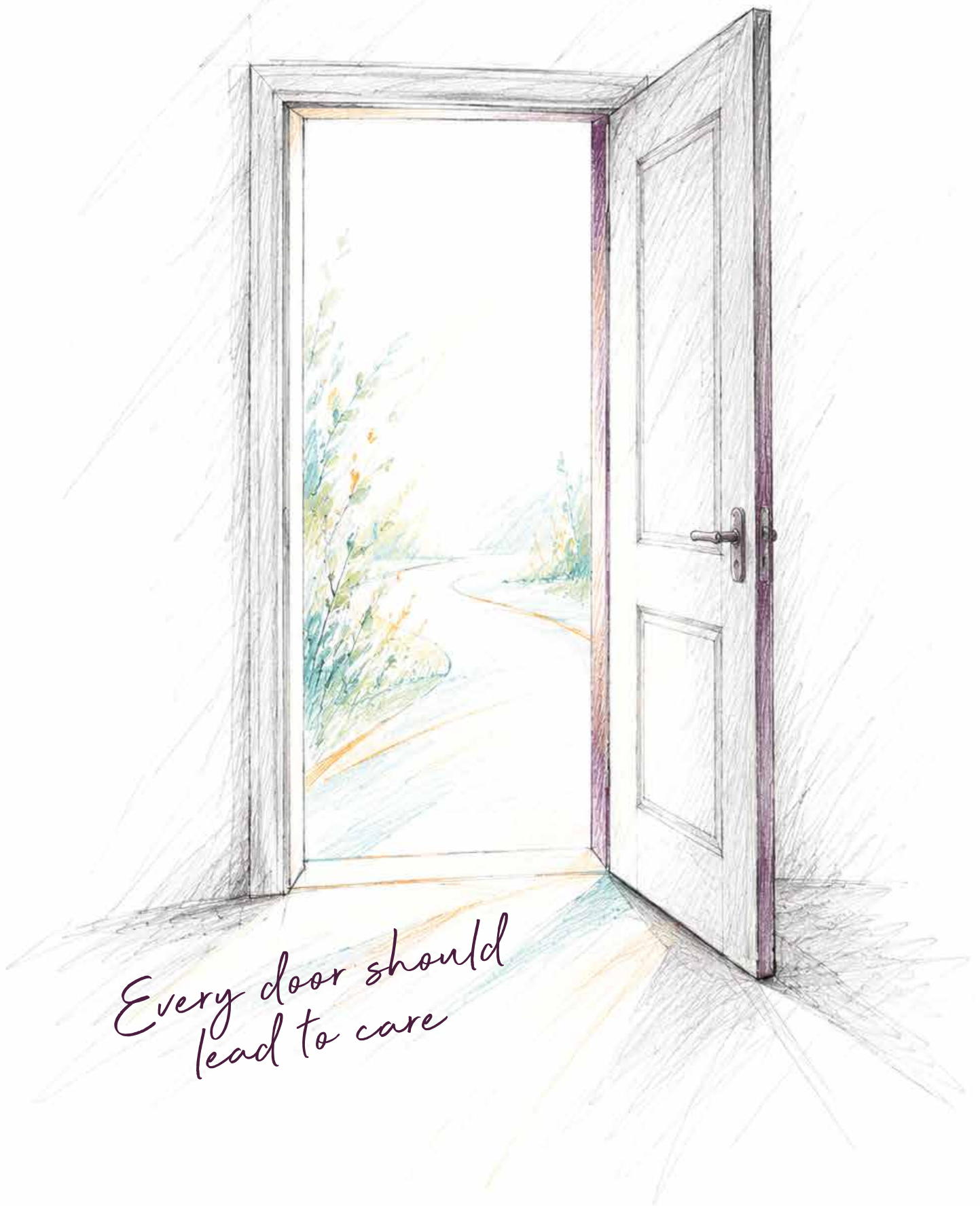


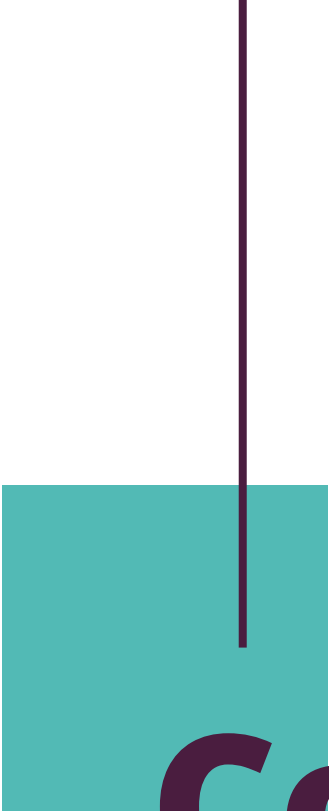


MIND THE GAP

A Toolkit for Building Bridges to Accessible Care

September 2026





Contents

Acknowledgements	2
Summary.....	3
Introduction.....	5
About this toolkit.....	7
Key challenges and tools for action – perspectives from the experts	8
What matters for coordinated care	13
What coordinated care looks like in practice	15
Conclusion	21

APPENDICES

A short guide for people with complex mental health care needs and their informal carers	23
Definition of Terms.....	26
References	27

TABLES

Table 1: System and workforce changes	9
Table 2: Improved patient and carer support	10
Table 3: Considerations for complex and multiple conditions	11
Table 4: Elements for coordinated care for people with complex needs	14
Table 5: Definition of terms used	26

ACKNOWLEDGEMENTS



01

Recognising those who made it possible

We sincerely thank all participants who generously contributed their time, experiences, and perspectives to the focus groups. Their insights were invaluable and formed the foundation of this toolkit.

We also thank Nigel Olisa, Executive Director, and Elysie Nguyen, Community Engagement and Project Officer at GAMIAN-Europe, for their contributions to project coordination, research, and organising the focus groups. Special thanks go to Chiara Samele and Norman Urquía for facilitating the focus groups and authoring the toolkit.

We are grateful to Nina Hovén, Elpida Minadaki, and Peter Keri for reviewing the draft and providing valuable feedback.

This project received financial support through grants from Boehringer Ingelheim, Teva Pharmaceuticals, and Johnson & Johnson, who had no influence on the content.

Thank you

Summary

This toolkit offers a practical guide to delivering accessible mental health care for people with mental health needs, touching on those with neurodevelopmental and mental health conditions. It draws on experts (people with lived experience, informal carers and clinicians) and examples of existing practices for coordinated care for complex mental health conditions. It summarises these sources to identify key challenges and ways forward. Experts highlight the importance of accessible, coordinated, collaborative, inclusive care, and reducing stigma.

The toolkit is designed for anyone who delivers and designs mental health services. It also provides a short, suggested guide for people with complex mental health conditions and their informal carers on how to maximise their appointments with clinicians and contact with services.

02

**A practical guide to
delivering accessible
mental health care.**

MIND THE GAP



INTRODUCTION

03

**A practical guide to
delivering accessible
mental health care.**

Gaps in services

Mental health systems across Europe have considerable service gaps. These are gaps in service coverage, capacity, accessibility, equity and continuity. Access is often a major challenge for those who need them.¹

Service gaps mean that people who need support either do not receive it or receive it after a long delay. The main reasons include long-term underfunding, staff shortages and a lack of trained staff, rising demand, poor service coordination, and poor integration with primary and social care.²

Closing gaps

Bridging the gaps in mental health services is an urgent priority. The European Psychiatric Association emphasises the importance of improving and personalising mental healthcare by addressing the challenges around access to care, for example by reducing long waiting times, treatment costs and addressing discriminatory attitudes among health care professionals.³

Coordinated care

A recurring theme in this toolkit is that improving coordination of services forms part of improving access to care, and so it focuses on this.

Complex and multiple mental health needs

People with unmet, complex or multiple mental health needs are a particular concern and have needs that do not fit within a single service, often having to navigate many different services at their most vulnerable.⁴

Key Statistics



UP TO 6%

Up to 6% of Europeans report unmet mental health needs.⁵



30-42%

30-42% of adults in Europe have two or more chronic conditions, including mental health conditions.⁶



22%/20%

Of the people using mental health services, 22% are estimated to meet the criteria for attention deficit hyperactivity disorder (ADHD), and 20% for autism spectrum disorder (ASD).⁸



13x

People with mental health conditions such as bipolar disorder or schizophrenia are 13 times more likely to have physical health problems.⁷

ABOUT THIS TOOLKIT

This toolkit outlines the key challenges, solutions and essential ingredients for accessible care for people with complex and multiple mental health needs.

It is for:

Service providers and managers: to improve pathways, coordination and day-to-day delivery.

Policy makers and commissioners: to design, fund and scale integrated models.

Clinicians and practitioners: to coordinate training, assessment, treatment and recovery support.

People using services, families and informal carers: to understand what good coordinated care should involve.

The toolkit was informed by people with lived experience, informal carers and clinicians working in mental health services through two workshops and a brief review of research on innovative models of care for complex and multiple mental health needs.

04

**Key challenges, solutions
and essential ingredients**

05

Perspectives from the experts

Key challenges and tools for action

The experts we spoke to highlighted the main challenges and tools for action from their perspectives (see Tables 1-3). Delays in seeing a specialist were a key concern.

'When we are in distress, time is a very sensitive thing... the main thing is the time...For the GP, I can wait up to two months...being referred to the psychiatrist, I can wait another two months. So overall it can be four months.'

(Person using services)

Clinicians were acutely aware of the rising demand for mental health care, which increased the pressure on services.

'There has been a massive increase in mental health needs, in numbers of referrals...Initially we thought it could be linked to the pandemic, but now we see that it's only growing and the ability to meet those needs is often not the best.'

(Psychiatrist)

People using services and clinicians agreed on the importance of coordinating and personalising services for the people using them. Many things need to be addressed at different levels to achieve this, such as more resources (e.g. more funding for services), staff training and recruitment, reducing stigmatising attitudes within services, better communication systems, using digital technology in a complementary role and offering peer support.

'Peer support is very important both for patients and for carers... It's a place where you can express yourself and feel that they understand you, because you're talking the same language...and then you don't feel alone.'

(Informal carer)



Key challenges

Fragmented services

overlooking individuals and vulnerable groups

TABLE 1: SYSTEM AND WORKFORCE CHANGES

TOOLS FOR ACTION

Hold regular **multidisciplinary meetings** across mental/ physical health, education, housing and social care; co-produce a shared care plan with patients and informal carers.

Funding models

incentivising hospitalisation over community care

Secure adequate **community-service funding**; advocate population-based budgets with one institution accountable for a catchment area.

High staff burnout

risk under high demand and limited resources

Include a burnout **self-assessment and guidance** in professional toolkits (early signs, self-care, raising workload concerns).

Long wait times

to access services

Provide **community outreach** during waits; signpost to local services; give early digital/written info on what to expect and self-care options.

Improve **staff deployment** and training; expand early intervention and prevention to reduce specialist demand; raise awareness to avoid crisis presentations.

Poor communication

among clinicians leaves people using services lost in services

Assign each person a **care coordinator** as main contact, responsible for care planning and navigation.

Physically isolating

mental health services increases stigma

Integrate mental health within primary and community care settings to **normalise access**.

Stigmatising attitudes

and language; need for rights-based approach

Use normalising, **rights-respecting language** in public communications; avoid defining people by diagnosis; co-design materials with people with lived experience.

TABLE 2: IMPROVED PATIENT AND CARER SUPPORT

TOOLS FOR ACTION

Key challenges

Informal carers

lack guidance, information and support

Include patients, families and informal carers in care planning; share plain-language meeting summaries; produce a dedicated informal carers' guide with realistic timelines, service info, key contacts and a crisis card.

Peer support

Lack of peer support in the community

Develop **peer support** within health services and signpost clearly what it offers and how to access it.

Lack of practical help

with appointments and daily routines

Use **digital tools** to support routines, monitoring, information, appointments and peer connection.

Lack of support

to find and navigate services

Provide link workers or **peer support workers** to help navigate health, housing, finance and employment/ education services.

Patients not included

in decisions about their own care

Make shared decision-making standard: explain options, benefits and side effects; elicit what matters most; document and review regularly.

Patients struggle to self-manage

due to poor understanding of condition, treatment or services

Give every patient a **plain language explanation** of their condition, treatments, timelines, challenges and contacts at start and at key points (e.g. medication changes, transfers).

Key challenges

Neurodiversity

often unrecognised; masking and sensory differences hinder access and diagnosis

Physical health

symptoms misattributed to mental health conditions (diagnostic overshadowing)

Unmet needs

Unmet physical health needs

TABLE 3: CONSIDERATIONS FOR COMPLEX AND MULTIPLE CONDITIONS

TOOLS FOR ACTION

Adopt a neurodiversity-informed approach; introduce routine screening; co-produce services with neurodivergent people to set reasonable adjustments; create sensory-friendly environments; provide clear/visual information; offer flexible, longer appointments; train staff on masking/camouflaging and group-specific presentations; use a strengths-based narrative.

Include diagnostic-overshadowing training in CPD using real cases; implement a physical health checklist at every mental health appointment to integrate physical-health checks.

Routinely check physical health in mental-health services (especially where treatments raise physical health risks); include standard health-promotion advice within mental health settings.



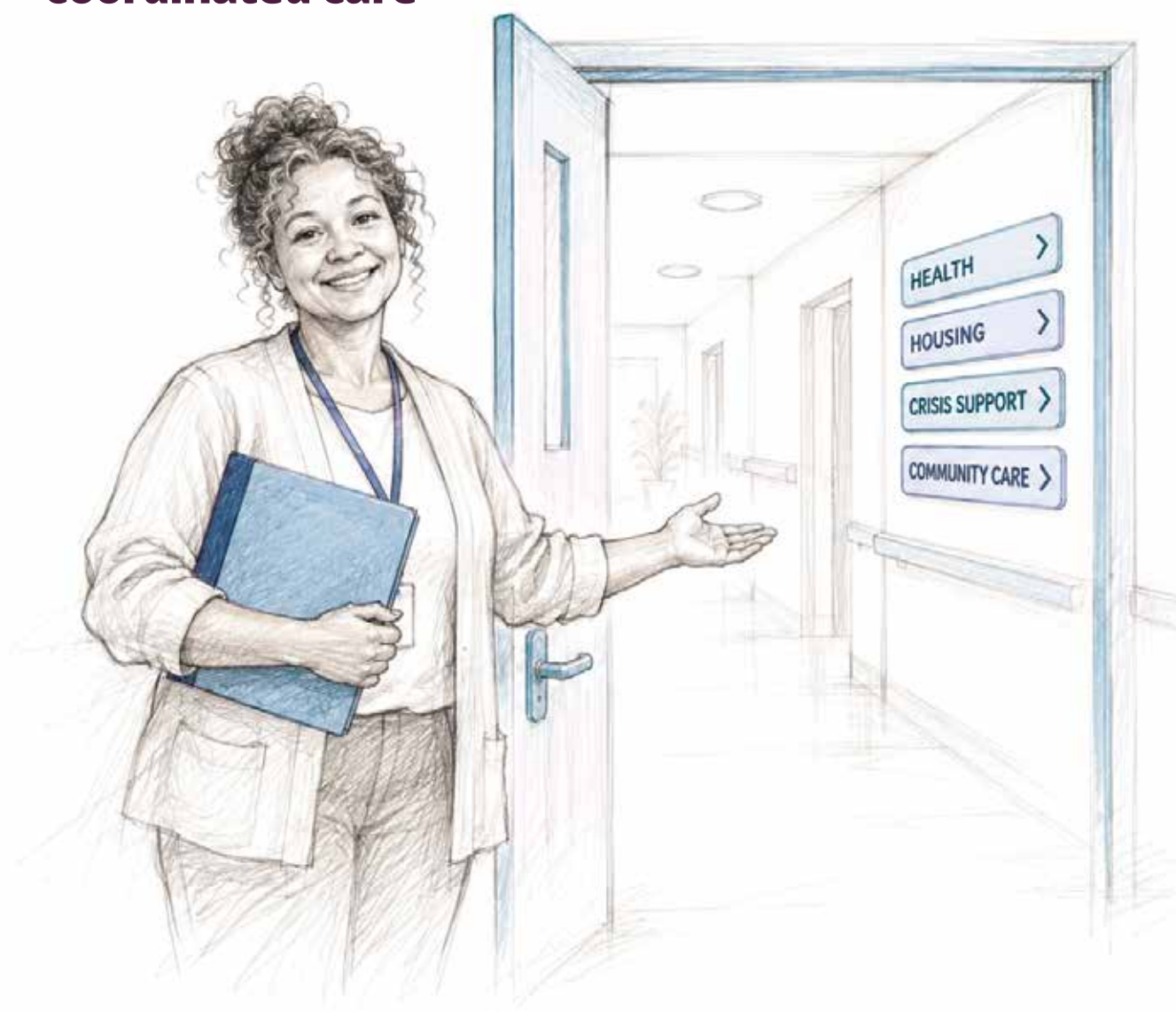
06

What matters for coordinated care

Table 4 contains elements that matter for coordinated care for people with complex and multiple mental health needs.

This list is based on the research literature and existing guidance.^{9 10 11 12}

Coordinated care should include carer-inclusive approaches that recognise family and informal caregivers as essential partners in care (with the person's consent).



**TABLE 4: ELEMENTS FOR COORDINATED CARE
FOR PEOPLE WITH COMPLEX NEEDS**

Elements that matter

WHAT IT MEANS IN PRACTICE

'No wrong door' access	Wherever a person presents for help (GP, crisis service, housing or emergency department), they are welcomed, rapidly assessed and supported to reach the right help without being sent away.
All needs treated together	Mental health, neurodiversity, physical health and other conditions are coordinated and cared for holistically by the same or closely linked teams, so people do not repeat their story or receive conflicting advice.
Care is built around the person, and informal carers are seen as essential partners	Care starts from the person's goals, strengths, culture and life story; services listen, adapt and treat the whole person, not just the diagnosis, and offer peer support where available. With consent, actively involve family and informal carers in assessment, planning and reviews, valuing their knowledge of the person's needs and routines.
Clear information sharing (with consent)	With the person's agreement, key information (care plan, risks, medications) is shared across involved services so everyone has a shared understanding.
Leadership and funding that support coordinated services	Managers prioritise coordination and collaboration between services; contracts and budgets reward services for working together and achieving outcomes that matter to people using services.
Links to practical support	Teams and the named lead worker help connect people to housing, benefits, work or education support, legal advice, and community or peer groups, not just clinical care.
One clear care plan, owned by the person	The person and their supporters co-write a simple plan covering goals, roles, crisis steps and review dates; it is reviewed regularly to track progress, update goals and make changes.
One main contact	A named lead worker coordinates care and is the main point of contact, arranging appointments, explaining options, supporting transitions between hospital, community teams or other services, and staying involved through changes.
Physical health is part of the plan	Routine checks (blood pressure, weight, blood tests, smoking support) are built into care routines, with clear responsibility for who arranges and follows up physical health care.
Trusted and stable relationships	People see the same key staff where possible; teams are trained for complex and multiple needs, receive supervision, and include people with lived experience in care, service design and delivery.

07

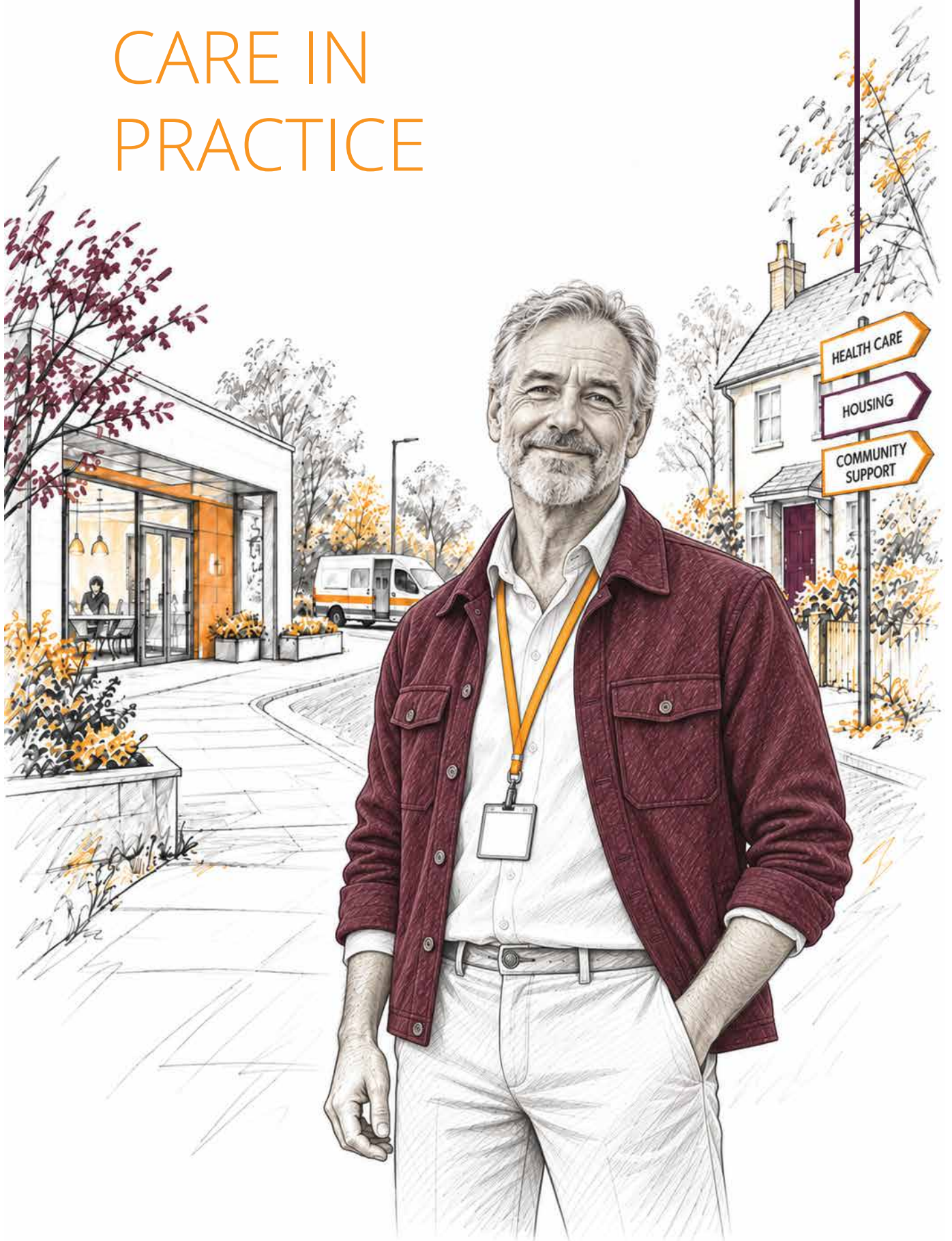
What coordinated care looks like in practice

Newer models of care for people with complex mental health needs focus on how care is delivered rather than a single intervention; they use peer involvement and co-production, outreach and community models for greater flexibility, digital technology (e.g., telepsychiatry, digital apps), and integrated pathways. These new models aim to improve continuity of care, reduce barriers, extend access, and keep the person's goals central to care.

Digital mental health has become a rapidly expanding area, with its own challenges and potential solutions for complex mental health needs.¹³

Also important is 'social-determinants-informed care', which emphasises housing, work, isolation and other rehabilitation and recovery-oriented approaches.¹⁴

COORDINATED CARE IN PRACTICE



HERE ARE SOME SELECTED EXAMPLES OF COORDINATED CARE FOR COMPLEX MENTAL HEALTH NEEDS:

As part of its 2020-2030 mental health strategy, Finland has focused on earlier access and intervention, low-threshold crisis support, school and young people and moving more care into primary care and community settings to reduce fragmented pathways.

EXAMPLE

A

Integrated hubs or centres in the community

Integrated regional service hubs combine health and social care under one roof, making it easier to coordinate housing, rehabilitation, crisis support and mental health follow-up. Peer support and arts-based approaches are also included, helping to increase engagement and create meaning for people using services.¹⁵

A Neighbourhood Mental Health Model pilot in the UK aims to provide access to specialist services and holistic support in community locations (hubs) available 24/7. It will create 85 new mental health emergency departments to avoid hospitalisation. New digitised therapies and technology are being introduced to provide personalised self-care, a single patient record to avoid repeated descriptions of symptoms, and more investment in preventing and detecting long-term physical and mental conditions.¹⁶



**EXAMPLE****B**

Integrated care programmes for complex and multiple health needs

People using services receive a “whole life” assessment that considers physical health, mental health, and social circumstances together.

A single contact person (for example, a care manager or community nurse) helps people navigate between GPs, specialists, mental health teams and social services. The team communicates regularly, involves people in setting goals, and aims to make different services work as one joined-up plan.¹⁷

Examples of these services include: the Sociomedical Centre Liebenau, Austria; Better Together in Amsterdam North, Netherlands; Salford Integrated Care, UK

Autism specialist hub within adult community mental health services

EXAMPLE

C

A small team of autism-trained specialists works inside the adult mental health service.

Based in Dublin Mid Leinster (Ireland), teams assess and support adults with autism experiencing mental health conditions such as depression, anxiety or psychosis. The service offers specialist assessment and diagnosis, group and individual help, and ongoing follow-up care and coordination over time. They also advise and train other mental health staff, building autism expertise across the whole mental health service.¹⁸





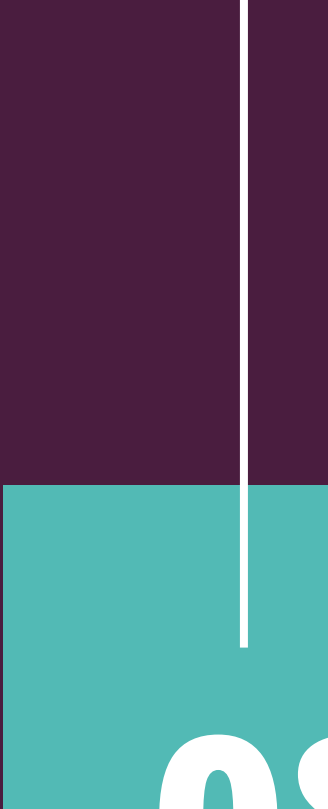
EXAMPLE

Local multisectoral mental health networks

Belgium's broader mental health reforms aim to integrate and connect community-based services to housing, social rehabilitation, recovery and social inclusion.

Person-centred local networks integrate medical, psychological, and social interventions, with continuity of care as a central goal. Multidisciplinary teams and intersectoral collaboration networks offer outreach services, prevention, in-and outpatient mental health services, primary care, day care, and vocational, housing and social care services. A mobile, multi-disciplinary team carries out home visits and helps coordinate all aspects of care. People using services, families and informal carers have a real say in how the network is run and in designing care.^{19 20}

CONCLUSION



08

Closing the gap can no longer wait

Access to mental health care remains a key concern for many people using services and informal carers, with clinicians and service providers aware of the difficulties. Closing the gap in accessing services is a major priority and can no longer wait.

The challenge is not simply meeting the high demand for mental health services, but ensuring the best services are delivered at all times. The key is personalised, flexible, integrated, well-coordinated, and collaborative community care, with multidisciplinary teams, well-trained staff, and stable funding for services that can meaningfully address complex mental health needs.

This can include crucial support during wait times and between appointments, supported by lay peer support workers, signposting to community resources outside health and social care, and providing information and access to digital technology where appropriate. Maximising what we know, thinking creatively and working flexibly can go a long way.



APPENDICES

09

A short guide for people with complex mental health care needs and their informal carers

This guide gives practical suggestions for people with complex mental health needs and their informal carers to make the most of appointments and contact with services.

People with overlapping conditions may see more than one service. It is essential that these services talk to each other. However, in practice this does not always happen, so patients and informal carers should ensure each service has the correct, up-to-date information. A lot of this requires keeping good records and being clear about what you need.

Before and during the wait

Waiting for your first appointment with a psychiatrist can take weeks or months after your referral. This can be a difficult time, especially if you are confused about your symptoms and don't have information about what support and treatment you can get.

Don't delay

- Approach services as soon as your difficulties arise. Avoid adding to the waiting time by putting off asking for help.
- Contacting services early means they can give you information and help you find community and voluntary services who can help while you wait for assessment or treatment.
- Ask your GP for information about your symptoms and managing while you wait.

Appointments

- Be clear about what you want help with. Write a list of the things you want services to know and what you need, what you are concerned about and any specific requests. This should include:
- The main things you want from services, such as a referral, assessment, medication review.
- Specific examples of your symptoms, when they happen, when they started, and how they affect your daily life.
- Current medications and any treatment and care you have already had.
- If you have any other diagnosed conditions or think you might have another condition.
- If you have communication preferences (e.g. written information, 'I need time to process').

During the appointment

- Make a copy of your written summary for the clinician; they can read it, add it to your notes and share with other services if you want.
- Ask for plain language explanations, or extra time if you need to understand what is being said or a written summary of the conversation afterwards.
- Check you have understood by repeating back what you have heard.
- Ask what the next steps are, who you will see next and if you require further assessment.
- Ask for details of who to contact in an emergency, and what out-of-hours support is available.

After the appointment

- As soon as the appointment is over, add any follow-up appointments to your diary.
- Update your written summary, include all changes, the services you have been referred to and their contact details - your new medications, dosage and dates.
- Keep all letters and forms together.

Further support

- If you are unclear about anything, do ask for information.
- If you disagree with a diagnosis, respectfully ask for a second opinion explaining your doubts.
- Ask for details of any available local peer support. Consider online support groups if face-to-face seems too much.

Reasonable adjustments

- Some people, including those with neurodevelopmental conditions, may ask for reasonable adjustments regarding the physical environment, communication style, or structure of the consultation or appointment if this is difficult. This may include:
 - Quieter waiting areas
 - Written information
 - Extra time to understand information
 - Clear information about what to expect from services

Writing a crisis plan

Before a crisis

- Prepare a crisis plan while you are well; include:
 - Your early warning signs
 - What helped before and what to avoid
 - Key contacts: crisis team, GP, trusted person
 - Medication and records — where they're kept
 - What you would like your care to be during a crisis

In a crisis

- If you or the person you care for are at risk of serious harm:
 - Don't wait for your next appointment; contact your crisis team or local mental health crisis line.
- If there is immediate danger to life, call emergency services or go to the emergency department.
- If you're unsure if it counts as an emergency, ask anyway; it is better to check than wait.

For informal carers

- Services may not be able to share information with you without consent from the person you care for. Ask them if they would name you as someone services can talk to, and ask the service directly what they can tell you even without consent.
- You may be the one holding continuity and coordinating care. If the person you care for finds it hard to keep track of appointments, medication changes, or which service said what, keep a copy of the written summary and crisis plan, and update it after appointments if they can't.
- You are entitled to your own carer's assessment. This looks at your needs as a carer, separate from the patient's care. This can lead to support or respite being arranged for you.
- Look after your own wellbeing. Carer-specific peer support groups exist alongside general peer support.
- Know your role in the crisis plan. Be clear on what you are expected to do, what you're not expected to do, and who to contact if you need support yourself in a crisis.



10

**List of terms and
their definitions
used in this toolkit.**



TABLE 5: DEFINITION OF TERMS USED

DEFINITION OF TERMS USED

TERM	DEFINITION
Access to care	Being able to get the right mental health help when needed, including services that are available, affordable, and timely.
Complex and multiple mental health needs	More than one mental health difficulty, often alongside other problems, requiring support from several services.
Continuity of care	Receiving consistent, joined-up support over time, including when moving between services.
Coordinated or integrated services	Services that work together and share information to support a person.
GP (General Practitioner)	A local family doctor who can refer to other services, especially specialist services.
Informal carer	An informal carer is a family member, friend, partner or neighbour who provides unpaid emotional or practical support to someone experiencing mental health difficulties.
Masking and camouflaging	When someone hides or covers up traits linked to neurodiversity (like social or sensory differences), making it harder for others to notice their needs or diagnose them.
Neurodiversity / neurodivergent people	Having a brain that works differently from what is considered typical, for example through autism, attention deficit and hyperactivity disorder (ADHD) or dyslexia.
Service gaps	Missing or insufficient services that leave people without the help they need.
Unmet needs	Help that a person needs but cannot get, or receives too late or in an unsuitable form.

References

- ¹ Barbui, C., Alonso, J., Chisholm, D. et al. (2025) 'Mental health service coverage and gaps among adults in Europe: a systematic review', *The Lancet Regional Health – Europe*, 57, 101458. Available at: <https://doi.org/10.1016/j.lanepe.2025.101458>
- ² Lester, H. et al. (2020) 'Healthcare professionals' perspectives on mental health service provision: a pilot focus group study in six European countries', *International Journal of Mental Health Systems*, 14, 20. Available at: <https://doi.org/10.1186/s13033-020-00350-1>
- ³ Fiorillo, A. (2025) 'A roadmap for better and personalized mental health care in Europe – the action plan of the European Psychiatric Association', *European Psychiatry*, 68(1), pp. 1–7. Available at: <https://doi.org/10.1192/j.eurpsy.2025.2456>
- ⁴ Sashidharan, S.P., Vincent, S. and Aria, F. (2026) '24/7 Neighbourhood Mental Health Centres: early lessons from Birmingham, UK', *The British Journal of Psychiatry*, pp. 1–3. Available at: <https://doi.org/10.1192/bjp.2026.10760>
- ⁵ Lopez-Morinigo, J.-D., Arango, C., Fiorillo, A. et al. (2025) 'Responsiveness of European countries to the population mental health needs: a cross-national comparison study', *European Psychiatry*, 68(1), e102. Available at: <https://doi.org/10.1192/j.eurpsy.2025.2448>
- ⁶ Palladino, R., Pennino, F., Finbarr, M. et al. (2019) 'Multimorbidity and health outcomes in older adults in ten European health systems, 2006–15', *Health Affairs*, 38(4), pp. 613–623. Available at: <https://doi.org/10.1377/hlthaff.2018.05273>
- ⁷ Aguinaga-Ontoso, I., Brugos-Larumbe, A. and Guillén-Aguinaga, S. (2019) 'Comorbidity associated with severe mental illness (the APNA study)', *European Journal of Public Health*, 29(Supplement 4), ckz187.195. Available at: <https://doi.org/10.1093/eurpub/ckz187.195>
- ⁸ Critchley, H., Minnis, H., Gajwani, R. et al. (2026) 'The elephant in the room: neurodivergence in psychiatry', *The British Journal of Psychiatry*, 229(3), pp. 253–255. Available at: <https://doi.org/10.1192/bjp.2026.10563>
- ⁹ Davidson, L. and Tondora, J. (2022) 'Person-centred care planning as foundational to clinical practice', *World Psychiatry*, 21(1), pp. 1–2. Available at: <https://doi.org/10.1002/wps.20922>
- ¹⁰ Grattidge, L., Haywood, D., Hart, N.H. et al. (2026) 'Putting lived experience at the centre: a critical review of multidisciplinary, person-centred mental health care', *Journal of Multidisciplinary Healthcare*, 19. Available at: <https://doi.org/10.2147/JMDH.S600579>
- ¹¹ Australian Government Department of Health (2022) National guidelines to improve coordination of treatment and supports for people with severe and complex mental illness. Canberra: Australian Government Department of Health. Available at: https://www.health.gov.au/sites/default/files/documents/2022/05/national-guidelines-to-improve-coordination-of-treatment-and-supports-for-people-with-severe-and-complex-mental-illness_0.pdf
- ¹² Williams, B., Charleston, R., Innes, S. & McIver, S. (2024) 'Understanding collaborative and coordinated care in a mental health and well-being context: Essential elements for effective service integration'. *International Journal of Mental Health Nursing*, 33, 397–408. Available from: <https://doi.org/10.1111/inm.13244>
- ¹³ Smith, K., Hardy, A., Vinnikova, A. et al. (2024) 'Digital Mental Health for Schizophrenia and Other Severe Mental Illnesses: An International Consensus on Current Challenges and Potential Solutions', *JMIR Mental Health*, 11, e57155. Available at: <https://doi.org/10.2196/57155>
- ¹⁴ Bajraktarov, S., Kalpak, G. and Jovanovic, N. (2020) 'Community mental healthcare: new developments and innovative strategies', *Current Opinion in Psychiatry*, 33(5), pp. 491–500. Available at: <https://doi.org/10.1097/YCO.0000000000000629>
- ¹⁵ Ministry of Social Affairs and Health, Finland (2020) National Mental Health Strategy and Programme for Suicide Prevention 2020–2030. Available at: <https://julkaisut.valtioneuvosto.fi/items/6e057a36-dd00-4c1a-8ce5-9231e0414f9f> (Accessed: 16 July 2026).
- ¹⁶ Department of Health and Social Care (2026) 10 Year Health Plan for England: fit for the future. Available at: <https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future> (Accessed: 10 July 2026).
- ¹⁷ Czipionka, T., Kraus, M., Reiss, M. et al. (2020) 'The patient at the centre: evidence from 17 European integrated care programmes for persons with complex needs', *BMC Health Services Research*, 20(1), 1102. Available at: <https://doi.org/10.1186/s12913-020-05917-9>
- ¹⁸ Crowley, N., O'Connell, H. and Gervin, M. (2022) 'Autistic spectrum disorder without intellectual impairment in adult mental health services – fostering new perspectives and enhancing existing services', *Irish Journal of Psychological Medicine*, 39(3), pp. 312–318. Available at: <https://doi.org/10.1017/ipm.2018.41>
- ¹⁹ Rens, E., Dom, G., Remmen, R. et al. (2020) 'Unmet mental health needs in the general population: perspectives of Belgian health and social care professionals', *International Journal for Equity in Health*, 19(1), 169. Available at: <https://doi.org/10.1186/s12939-020-01287-0>
- ²⁰ Borgermans, L., Jacob, B., Coture, M. et al. (2018) Multisectoral mental health networks in Belgium: an example of successful mental health reform through service delivery redesign: good practice brief. Copenhagen: World Health Organization Regional Office for Europe. Available at: <https://iris.who.int/handle/10665/345626> (Accessed: 16 September 2026).



MIND THE GAP

Coordinated Care at a Glance



NO WRONG DOOR ACCESS

Wherever a person asks for help, they are welcomed and connected to the right support.



ALL NEEDS TREATED TOGETHER

Mental, physical and social needs are addressed together by closely connected services.



CARE BUILT AROUND THE PERSON

Care reflects the person's goals, strengths, culture and life story, with carers involved where appropriate.



CLEAR INFORMATION SHARING

With consent, key information is shared so everyone involved has the same understanding.



SUPPORTIVE LEADERSHIP AND FUNDING

Leadership, contracts and funding enable services to collaborate and focus on shared outcomes.



LINKS TO PRACTICAL SUPPORT

Care connects people with housing, benefits, education, work, legal advice and community support.



ONE CLEAR CARE PLAN

The person and their supporters create one practical plan that is reviewed and updated regularly.



ONE MAIN CONTACT

A named lead worker coordinates care, explains options and remains involved through changes.

Closing the gap can no longer wait

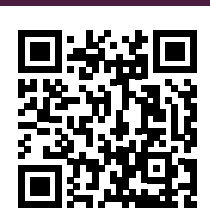


CONTACT US

GAMIAN-Europe

Avenue Marnix 17, 1000
Brussels, Belgium

www.gamian.eu



www.gamian.eu/publications/