

COMMENT

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Bridging the gap by improving access to psychological services in low resource settings

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Abstract

The burden of mental disorders is rising globally, but services remain highly unequal. Low- and middle-income countries (LMICs) carry most of this burden yet have far fewer resources and spending on mental health than high-income countries. Social and cultural barriers including stigma, poverty, and lack of trained staff further block timely access to care. This commentary maps the literature on innovative models and strategies to expand equitable psychological services in LMICs. We highlight best practices such as task-sharing with non-specialists and stepped-care models that link community and clinical support. Integrating mental health into primary care and using digital tools can extend services in low-resource settings. Support from trained supervisors and national policies helps improve quality and sustainability. Evidence gaps include limited data on long-term outcomes, scale-up strategies, and how to support and retain frontline mental health workers. Cultural adaptation and stakeholder engagement are essential to make interventions acceptable and sustainable. However, challenges remain such as weak infrastructure, stigma, and governments spending less than two percent of health budgets on mental health. Scaling up must be driven by local contexts and global commitments including Sustainable Development Goal (SDG) 3 to ensure that no one is left behind.

Keywords Psychological services, Access, Low-resource settings, Task-sharing, Digital mental health, Global mental health equity

1 Introduction

Mental disorders are a leading cause of disability worldwide. Recent World Health Organization (WHO) estimates indicate nearly one billion people worldwide lived with a mental disorder in 2019 [1, 2]. Mental disorders (especially depression and anxiety) are leading causes of disability, second only to cardiovascular disease globally. In absolute terms, this means tens of millions of people in every low- and middle-income country (LMICs) are affected. For example, Global Burden of Disease (GBD) findings show the burden of mental disorders in LMICs grew markedly over 1990–2017 [3]. In 2021, over 444 million new cases and 155 million disability-adjusted life years (DALYs) were



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attributed to mental illnesses globally [4]. Importantly, an estimated 82% of people with mental disorders live in LMICs, yet these countries have the fewest services [4, 5]. Survey data confirm high prevalence across LMIC regions. For instance, a recent community survey in Pakistan found 57% of urban outpatients screened positive for depression and 19.5% for anxiety [1]. Systematic reviews in Africa report lifetime prevalence ranges for mood disorders around 5–10% and anxiety disorders 6–16%. Suicide, often linked to depression, claimed an estimated 727,000 lives in 2021 [2] and roughly 78% of suicides occur in LMICs. Adolescents who comprise approximately 90% of the world's youth in LMICs face particularly acute challenges: globally almost one in five young people meet criteria for a mental disorder, and self-harm is a leading cause of death [6].

LMICs often lack the necessary infrastructure and workforce because their governments spend a far lower share of health budgets on mental health and they have far fewer psychiatrists, psychologists, and nurses per capita than high-income countries (HICs) [7]. As a result, the treatment gap which refers to the proportion of people needing care but do not get it, exceeds 75% in many LMICs [7]. For example, although about 200 million Indians could benefit from services, fewer than 30 million actually seek care [8]. This inequity is exacerbated by poverty, conflict and social disadvantage, which worsen mental health but limit access to care [9].

Disparities also occur within rural, indigenous and marginalized communities who often have limited access to psychological services. Cultural factors and stigma may discourage people from seeking help or identifying symptoms [10, 11]. Women and the poor suffer higher rates of disorders like depression, but they are least likely to obtain care [12]. These gaps undermine global goals as they run counter to Sustainable Development Goal (SDG) 3 on health equity and to the Sustainable Development Agenda on universal health coverage (UHC) [13]. There is an urgent need to tailor services to local needs and to scale up psychological care delivery and access in low-resource settings.

2 Barriers to access and service quality

Multiple barriers keep psychological services out of reach in LMICs. A major issue is the severe shortage of trained mental health professionals. Most LMICs have fewer than one psychiatrist per 100,000 people, compared to dozens in HICs [14, 15]. Few community mental health centers exist but primary care workers often lack training in psychosocial care [16]. Finance is also a barrier because mental health only receives less than 2% of health spending whereas in low-income countries (LICs) it can be less than 0.1% [17].

Social barriers compound these gaps. High stigma surrounds mental illness in many societies. People often hide symptoms or prefer traditional healers which tend to delay professional help [7]. Low literacy and poverty mean that psychoeducation and outreach are limited [18]. In addition, health systems in LMICs frequently struggle with overall underfunding, weak governance, and competing priorities (e.g. infectious diseases, malnutrition) [19]. These structural issues mean that even when effective interventions exist, they are not implemented. A recent expert review noted that LMIC health systems “are often centralized and institutionalized; relying on scarce specialist manpower,” creating “a major treatment gap” [20].

Finally, interventions cannot be simply imported from HICs. There is no one solution that fits all [7]. Language, culture and community structures differ. For example, Western style individual therapy may need modification for collectivist societies. Without

adaptation, therapies can fail to engage people [21, 22]. Thus, any effort to expand services must consider cultural relevance.

3 Conceptual frameworks to guide service strategies

The WHO “pyramid” model envisions a broad base of community and self-care support beneath a narrow apex of specialized services [20]. At the base are self-help and informal community networks; above that is primary care integration; higher up are outpatient specialist services; and at the top are inpatient and emergency psychiatric services. In this framework, successive levels correspond to higher intensity and cost of care [20]. The pyramid stresses building capacity at lower levels (e.g. training PHC workers under mhGAP) and gradually reducing reliance on costly psychiatric hospitals [20].

Another organizing principle is the socio-ecological framework, which considers determinants of mental health across individual, interpersonal, community and societal levels. For example, Jenkins et al. (2023) describe how mental health promotion and service delivery can operate simultaneously at multiple tiers: building personal coping skills (individual), strengthening family support, enhancing social cohesion (community), and reforming policies or addressing social inequities (societal) [23]. This multi-level lens helps integrate diverse strategies (e.g. psychotherapy, family interventions, school programs, advocacy) so that improving access involves not just clinics but also education, legislation and community mobilization. Related models like stepped-care pyramids overlap with above mentioned ideas. For instance, one proposed Comprehensive Community Care (C4) framework explicitly aligns worker roles, training and referral pathways across community, non-specialist, and specialist levels [19].

In practice, combining the WHO pyramid’s focus on service tiers with the socio-ecological emphasis on multiple influence levels can ensure that initiatives from self-help groups to policy reform work together to expand access comprehensively [20, 23].

4 Community-based and task-sharing models

Community engagement and task-sharing are promising strategies to reach underserved populations [19]. In this model, non-specialist providers such as nurses, lay counselors, teachers or community health workers (CHWs) are trained to deliver evidence-based psychosocial interventions [24, 25]. Few reviews in LMICs have shown that cognitive-behavioral and psychosocial therapies can be safely delivered by non-specialists with good outcomes for depression, anxiety and trauma [26, 27]. For example, the “Friendship Bench” program in Zimbabwe trained grandmothers in problem-solving therapy, leading to major reductions in depression symptoms [28].

Our review of literature highlights key lessons for community interventions. Successful programs tend to *integrate* psychological services into existing primary health or social services, rather than building parallel systems [29]. They enlist existing community networks such as community volunteers, peer support groups, or faith-based organizations as delivery agents. Including local stakeholders in design and implementation helps tailor services to real needs [7]. Experts stress that psychological interventions must address practical barriers such as providing transport, building trust, and ensuring sustainable local leadership. Common facilitators include strong training and supervision of lay providers, and ongoing public outreach to reduce stigma [29]. Table 1 lists various strategies from the literature.

Table 1 Various strategies for improving access to psychological services in low-resource settings

Strategy area	Key approaches	Examples and tools
Conceptual frameworks	Use multi-level models to structure care and planning	WHO Service Pyramid (community → specialist care), Socio-ecological model
Task-sharing and stepped care	Train non-specialist providers to deliver basic psychological care; use referral tiers	WHO mhGAP, C4 Framework, Friendship Bench
Community-based integration	Integrate mental health into primary care, schools, and social services; build on local networks	Peer groups, CHWs, support via maternal-child or HIV clinics
Use of digital tools and telehealth	Expand access through mobile phones, tele-counseling, and digital apps	Mobile CBT, smartphone-based supervision, telepsychiatry during COVID-19
Cultural adaptation	Tailor interventions to local language, beliefs, and norms	Local idioms in therapy content, community engagement to design interventions
Policy and system reform	Create supportive legislation, financing, and national strategies to embed services in health systems	Mental Health Acts, UHC policies, decentralized care planning
Workforce development	Scale up training and create incentives for rural deployment; establish supervision systems	Formal task-sharing policies, rural retention programs, continuous in-service training
Legislation and financing	Increase budget for mental health; legislate right to care; align with global aid and commitments	SDG 3, WHO Action Plans, Global Fund, national mental health laws
Decentralization of services	Shift focus from institutional care to community-based and outpatient models	Community clinics, day centers, recovery-oriented care
Addressing implementation gaps	Improve research on scale-up, monitoring, and real-world application; focus on underserved populations	Studies on youth, refugees, women; outcome evaluation in LMICs

Evidence suggests these community-based models can *scale up* treatment. A systematic review of LMIC showed that such interventions can achieve meaningful symptom reduction even when delivered by non-specialists [26]. However, challenges remain in maintaining quality and coordinating with formal health systems. Funding for continual training and supervision is often lacking, so sustainability depends on integrating these programs into national health strategies.

5 Digital and telepsychology interventions

Digital technologies are transforming psychological service delivery in LMICs. Mobile phones and internet use have grown rapidly even in low-resource settings, creating new channels for care. Digital mental health interventions (DMHIs) such as smartphone apps, online therapy platforms and telepsychiatry can extend reach where specialists are scarce [30, 31]. Recent evidence shows DMHIs can be effective in LMICs [32]. A recent meta-analysis of trials found that digital interventions (guided or unguided) significantly reduced depression and anxiety symptoms compared to controls. The pooled effect size was large indicating substantial benefit [33]. Importantly, gains were seen even in low-resource settings, suggesting technology can “effectively bridge the gap between treatment supply and demand in LMICs”. Quality of life also improved with digital care [33].

Telepsychology refers to real-time services via phone or video which has also expanded. During COVID-19, many LMICs rapidly adopted teleconsultation for mental health to maintain services while reducing infection risk [34]. Studies indicate that remote counseling and telepsychiatry were acceptable and sometimes preferred by

patients in LMIC settings, especially where travel is difficult [35, 36]. Digital platforms also allow task-shared interventions to reach many people at low cost. For example, computerized cognitive-behavior therapy programs have shown effectiveness on par with face-to-face therapy [37].

However, digital approaches have caveats. Many report mixed user engagement and high dropout rates. Limited digital literacy, sporadic connectivity, and privacy concerns can hinder use [38]. Programs must be culturally adapted (e.g. language, idioms, mobile accessibility) and often require some human support to maintain engagement [22]. Moreover, evidence is still emerging; more large-scale trials are needed in diverse LMIC contexts. Technology is a powerful enabler but not a panacea. It should complement, not replace, face-to-face and community care [39]. These disparities underscore the need for gender-sensitive and context-specific service models.

6 Policy frameworks and health systems reform

Sustained improvement requires supportive policies and systems. Many LMICs have begun reforming mental health policy but often lag in implementation [17]. Key system-level strategies include:

1. Integration into primary care: Embedding mental health assessment and treatment into general health services is crucial. WHO's Mental Health Gap Action Programme (mhGAP) provides training modules and guidelines for non-specialist care in primary settings [20]. Such integration improves access and helps address comorbid physical health issues.
2. Decentralization and community care: Moving resources away from large psychiatric hospitals to community clinics and day programs can increase access. WHO's "optimal mix of services" pyramid promotes community-based care and recovery-oriented services at the base, reserving specialist and inpatient care for complex cases [40].
3. Workforce development: Governments should scale up training for psychologists, counselors and allied workers, and consider incentives to retain staff in rural areas. Task-sharing policies should be formalized (e.g. allow nurses or social workers to deliver therapy under supervision) [41].
4. Legislation and financing: Passing mental health laws that protect rights and guarantee access can drive investment. Equitable financing allocating more budget to mental health is needed [42]. International aid and global funds can be leveraged to co-fund mental health programs [43].

Evidence on system reforms in LMICs is mostly qualitative or programmatic. Many LMICs still have less than 10% of the needs met, far below WHO's target of universal coverage. Achieving UHC for mental health will require new funding models and mainstreaming mental health in all levels of health planning [44, 45].

7 Conclusion

This commentary highlights that transforming psychological services in LMICs depends on multi-pronged innovation. Community-based task-sharing and digital tools are promising routes to reach the underserved. But success hinges on contextual adaptation such as interventions that must align with local beliefs, languages and needs. Stakeholder engagement involving patients, families and community leaders improves uptake.

Research should continue to evaluate how interventions perform in rural areas, among minority groups, and for less-studied disorders such as substance use and trauma. Psychological services must be seen as part of social development. Addressing social determinants such as poverty, violence, education and reducing stigma are as crucial as providing therapy. Partnerships across sectors of education, justice, labor can help integrate mental wellness into community life. At the same time, global frameworks such as SDG 3 and UHC should prioritize mental health as a basic human right. Only then can services become truly accessible and equitable.

We urge researchers, practitioners and policymakers to collaborate, share lessons, align on standards such as WHO's mhGAP and co-create solutions that amplify local voices. Through culturally competent, community-rooted and technology-enabled strategies; psychological services can be transformed to serve all communities, advancing global health equity.

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References

1. Malik M, Rehman H, Hussain A, Hashmi A, Al-Sunaidar KA, Balogh G, et al. Psychological burden and coping strategies among Pakistani adults: a cross-sectional survey study. *Epidemiologia (Basel)*. 2025;6(3):30.
2. World Health Organization. Over a billion people living with mental health conditions—services require urgent scale-up. 2025. <https://www.who.int/news/item/02-09-2025-over-a-billion-people-living-with-mental-health-conditions-services-require-urgent-scale-up#:~:text=Mental%20health%20conditions%20such%20as,losses%20on%20a%20global%20scale>. Accessed 4 Feb 2026.
3. GBD 2019 Mental Disorders Collaborators. Global, regional, and national burden of 12 mental disorders in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019. *Lancet Psychiatry*. 2022;9(2):137–50.
4. Fan Y, Fan A, Yang Z, Fan D. Global burden of mental disorders in 204 countries and territories, 1990–2021: results from the global burden of disease study 2021. *BMC Psychiatry*. 2025;25(1):486.
5. Liu W, Zhang Y, Chen J, Li X, Huang Y, Zhao F, et al. Global burden and trends of major mental disorders in individuals under 24 years of age from 1990 to 2021, with projections to 2050: insights from the Global Burden of Disease Study 2021. *Front Public Health*. 2025;16(13):1635801.
6. Galagali PM, Brooks MJ. Psychological care in low-resource settings for adolescents. *Clin Child Psychol Psychiatry*. 2020;25(3):698–711.
7. Giebel C, Gabbay M, Shrestha N, Saldarriaga G, Reilly S, White R, et al. Community-based mental health interventions in low- and middle-income countries: a qualitative study with international experts. *Int J Equity Health*. 2024;23(1):19.
8. Rej S, Sasi N. World Mental Health Day 2023: Increasing awareness of mental health in India & exciting opportunities for the future. *Indian J Med Res*. 2023;158(4):334–7.
9. Knifton L, Inglis G. Poverty and mental health: policy, practice and research implications. *BJPsych Bull*. 2020;44(5):193–6.

10. Zhang L, Hou X-Y, Liu Y. Measuring mental health service accessibility for indigenous populations: a systematic review. *J Racial Ethn Health Disparities*. 2025;12(1):594–612.
11. Driver R. Mental health service accessibility for young people in rural, regional, and remote areas and its implications for social work practice: a scoping review protocol. *Soc Work Ment Health*. 2024;22(5):734–53.
12. Srivastava K. Women and mental health: psychosocial perspective. *Ind Psychiatry J*. 2012;21(1):1–3.
13. Votruba N, Thornicroft G, FundaMentalSDG Steering Group. Sustainable development goals and mental health: learnings from the contribution of the FundaMentalSDG global initiative. *Glob Ment Health (Camb)*. 2016;3:e26.
14. Patel NM, Savaliya GV, Mehta PJ, Kataria LR. Global disparities in mental health systems: a comparative cross-sectional study of ten countries with different income levels. *Indian J Psychol Med*. 2025;15:02537176251379999.
15. Rathod S, Pinninti N, Irfan M, Gorczynski P, Rathod P, Gega L, et al. Mental health service provision in low- and middle-income countries. *Health Serv Insights*. 2017;28(10):1178632917694350.
16. Rameez S, Nasir A. Barriers to mental health treatment in primary care practice in low- and middle-income countries in a post-covid era: a systematic review. *J Family Med Prim Care*. 2023;12(8):1485–504.
17. World mental health today. Over a billion people living with mental health conditions – services require urgent scale-up. World Health Organization; 2025. <https://iris.who.int/server/api/core/bitstreams/31714489-1345-4439-8b37-6cbdc52e15ca/content>. Accessed 30 Nov 2025.
18. Evans GW, De France K. Childhood poverty and psychological well-being: the mediating role of cumulative risk exposure. *Dev Psychopathol*. 2022;34(3):911–21.
19. Bolton P, West J, Whitney C, Jordans MJD, Bass J, Thornicroft G, et al. Expanding mental health services in low- and middle-income countries: a task-shifting framework for delivery of comprehensive, collaborative, and community-based care. *Glob Ment Health (Camb)*. 2023;27(10):e16.
20. Saraceno B, Gater R, Rahman A, Saeed K, Eaton J, Irbijaro G, et al. Reorganization of mental health services: from institutional to community-based models of care. *East Mediterr Health J*. 2015;21(7):477–85.
21. Nagayama Hall GC, Kim-Mozeleski JE, Zane NW, Sato H, Huang ER, Tuan M, et al. Cultural adaptations of psychotherapy: therapists' applications of conceptual models with Asians and Asian Americans. *Asian Am J Psychol*. 2019;10(1):68–78.
22. Koç V, Kafa G. Cross-cultural research on psychotherapy: the need for a change. *J Cross Cult Psychol*. 2019;50(1):100–15.
23. Jenkins E, Daly Z, McAuliffe C, McGuinness L, Richardson C, Hill TG, et al. Advancing socioecological mental health promotion intervention: a mixed methods exploration of phase 1 Agenda Gap findings. *Front Public Health*. 2023;16(11):1066440.
24. Bunn M, Gonzalez N, Falek I, Weine S, Aciri M. Supporting and sustaining nonspecialists to deliver mental health interventions in low- and middle-income countries: an umbrella review. *Intervention*. 2021;19(2):155.
25. Boustani MM, Frazier SL, Marin D, Bashoura D. A qualitative review of community health workers' training, supervision, and service delivery needs. *Adm Policy Ment Health*. 2025;52(6):1061–75.
26. Verhey IJ, Ryan GK, Scherer N, Magidson JF. Implementation outcomes of cognitive behavioural therapy delivered by non-specialists for common mental disorders and substance-use disorders in low- and middle-income countries: a systematic review. *Int J Ment Health Syst*. 2020;29(14):40.
27. Cuijpers P, Miguel C, Harrer M, Plessen CY, Ciharova M, Papola D, et al. Psychological treatment of depression: a systematic overview of a "Meta-Analytic Research Domain." *J Affect Disord*. 2023;15(335):141–51.
28. Fernando S, Brown T, Datta K, Chidhanguro D, Tavengwa NV, Chandna J, et al. The Friendship Bench as a brief psychological intervention with peer support in rural Zimbabwean women: a mixed methods pilot evaluation. *Glob Ment Health (Camb)*. 2021;26(8):e31.
29. Mauer-Vakil D. Approaches to integrate mental health services in primary care: a scoping review of system-level barriers and enablers to implementation [undergraduate thesis]. 2021.
30. Torous J, Linardon J, Goldberg SB, Sun S, Bell I, Nicholas J, et al. The evolving field of digital mental health: current evidence and implementation issues for smartphone apps, generative artificial intelligence, and virtual reality. *World Psychiatry*. 2025;24(2):156–74.
31. Montgomery R. Digital mental health: opportunities and challenges in clinical practice. *J Biomed Sci*. 2025;24(61):1–18.
32. Chau LW, Lam RW, Minas H, Hayashi K, Nguyen VC, O'Neil J. Digital health interventions for depression and anxiety in low- and middle-income countries: rapid scoping review. *JMIR Ment Health*. 2025;22(12):e68296.
33. Karyotaki E, Miguel C, Panagiotopoulou OM, Harrer M, Seward N, Sijbrandij M, et al. Digital interventions for common mental disorders in low- and middle-income countries: a systematic review and meta-analysis. *Glob Ment Health (Camb)*. 2023;15(10):e68.
34. Mahmoud K, Jaramillo C, Barteit S. Telemedicine in low- and middle-income countries during the COVID-19 Pandemic: a scoping review. *Front Public Health*. 2022;22(10):914423.
35. Ndabwe H, Basu A, Mohammed J. Post pandemic analysis on comprehensive utilization of telehealth and telemedicine. *Clin eHealth*. 2024;7:5–14.
36. Nazemi M, Kiani S, Zakerabasali S. Tele-mental health during the COVID-19 pandemic: a systematic review of the literature focused on technical aspects and challenges. *Health Sci Rep*. 2023;6(10):e1637.
37. Liu Z, Qiao D, Xu Y, Zhao W, Yang Y, Wen D, et al. The Efficacy of computerized cognitive behavioral therapy for depressive and anxiety symptoms in patients with COVID-19: randomized controlled trial. *J Med Internet Res*. 2021;23(5):e26883.
38. Giebel GD, Speckemeier C, Abels C, Plescher F, Borchers K, Wasem J, et al. Problems and barriers related to the use of digital health applications: scoping review. *J Med Internet Res*. 2023;12(25):e43808.
39. Hamblin KA. Technology in care systems: displacing, reshaping, reinstating or degrading roles? *New Technol Work Employ*. 2022;37(1):41–58.
40. WHO. Improving health systems and services for mental health. 2009. <https://iris.who.int/server/api/core/bitstreams/bbbdb581-edb2-4eea-a6f8-3f1524aa21ea/content>. Accessed 30 Nov 2025.
41. Russell D, Mathew S, Fitts M, Liddle Z, Murakami-Gold L, Campbell N, et al. Interventions for health workforce retention in rural and remote areas: a systematic review. *Hum Resour Health*. 2021;19(1):103.
42. Abdulmalik J, Olayiwola S, Docrat S, Lund C, Chisholm D, Gureje O. Sustainable financing mechanisms for strengthening mental health systems in Nigeria. *Int J Ment Health Syst*. 2019;31(13):38.
43. Lemmi V. Global collective action in mental health financing: allocation of development assistance for mental health in 142 countries, 2000-2015. *Soc Sci Med*. 2021;287:114354.

44. Ranjan A, Crasta JE. Progress towards universal health coverage in the context of mental disorders in India: evidence from national sample survey data. *Int J Ment Health Syst.* 2023;17(1):27.
45. Mori Y, Sourander A, Mishina K, Ståhlberg T, Klomek AB, Kolaitis G, et al. Unmet need for mental health care among adolescents in Asia and Europe. *Eur Child Adolesc Psychiatry.* 2024;33(12):4349–59.

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