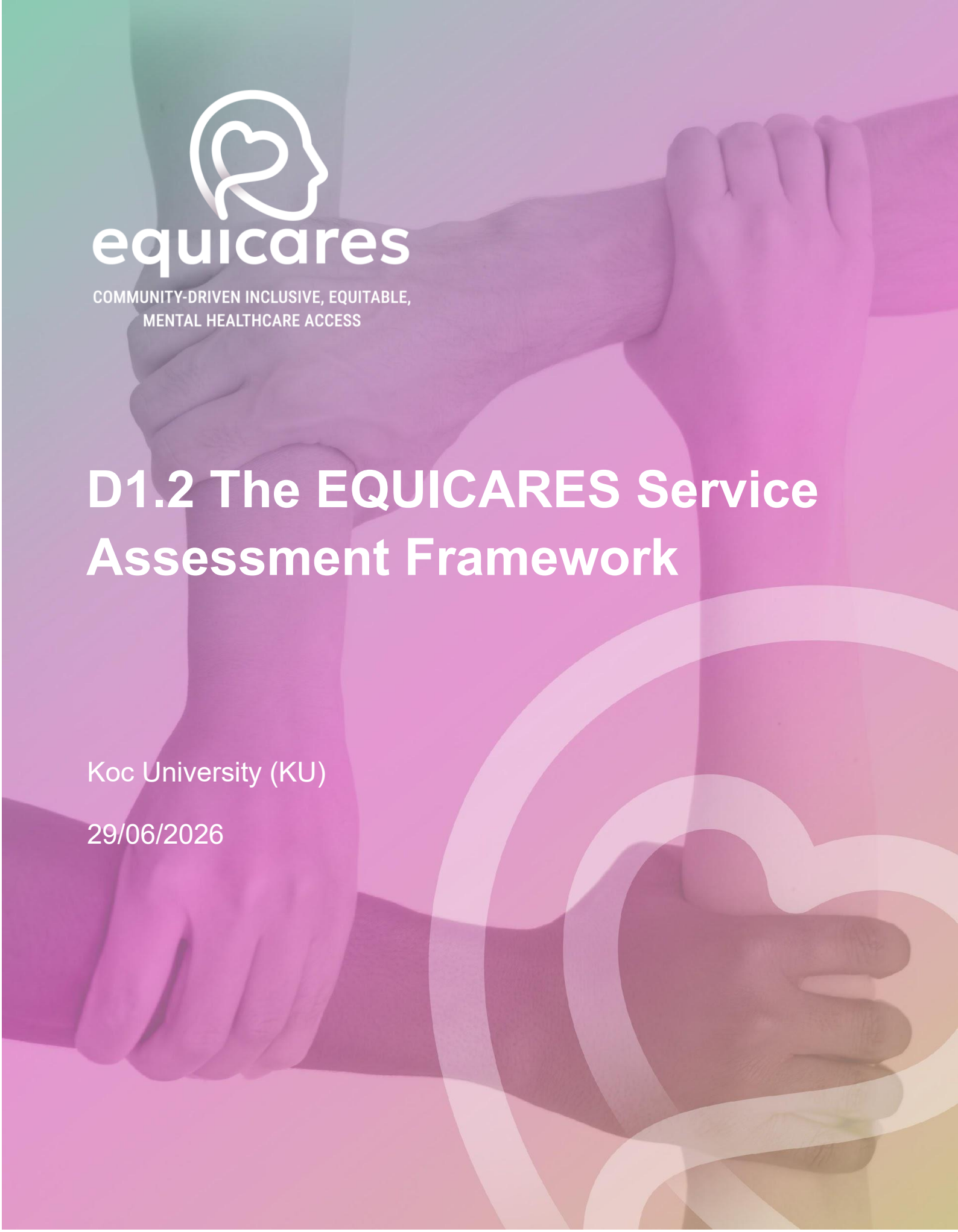

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COMMUNITY-DRIVEN INCLUSIVE, EQUITABLE, MENTAL HEALTHCARE ACCESS

D1.2 The EQUICARES Service Assessment Framework

Koc University (KU)

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Executive Summary

Access to mental health and care services remains inequitable across Europe, and the burden falls hardest on people in vulnerable situations, who face compounded and intersecting barriers. Task 1.2 of the EQUICARES project developed a comprehensive framework to assess that accessibility, adapting the patient-centred conceptual framework of Levesque, Harris and Russell (2013) for mental health and for people in vulnerable situations. This deliverable (D1.2) presents the consolidated framework.

The framework was built through five complementary activities: a scoping review of how the Levesque framework has been applied in mental health contexts; a targeted review of Health System Performance Assessment (HSPA) documents; an Indicator Mapping Workshop with consortium partners; the participatory “Map the Gap” Hackathon with people of relevant lived and professional experience; and consolidation against the framework’s application in the macro-, meso-, and micro-level studies of WP1 (T1.3–T1.5).

Conceptually, the framework reconstructs access as a person-centred journey and grounds it in Amartya Sen’s capability approach (Sen, 1992, 1999): the five supply-side dimensions describe the *opportunities* a system makes available, the five demand-side abilities describe the *capacity* to convert those opportunities into use, and access achieved is a *functioning* (an achieved state in Sen's terms, care actually obtained and used) realised only when opportunity and capability meet. Each Levesque dimension is resolved into defined **components** (approximately eighty in total) positioned across macro, meso, and micro levels.

A methodological focus of the framework is to address a conflation observed in the applied literature, in which instruments intended to measure a service characteristic instead capture an individual ability, or vice versa. The framework’s person-centred assessment logic anchors all measurement in the individual while measuring supply as *experienced opportunity* and demand as *capacity to act*. Two interpretive **distinctions** are intended to help distinguish a service that does not exist from one that fails to reach the person, and a person who is excluded from one who freely declines, so as to respect agency and avoid conflating non-use with inaccessibility.

The framework is intended as an assessment strategy rather than a fixed scale. It standardises the components, their definitions, and the side on which each is measured, while leaving item wording free for local adaptation; comparability across contexts is supported through a scoring approach (a pragmatic common-metric tier and an optional psychometric tier). A recommended, adaptable item bank operationalises the strategy with paralleled individual and provider items on the supply side and a journey-staged instrument on the demand side. Throughout, equity is integrated through

intersectionality, understood as the conversion factors that determine how much real opportunity a given service confers on a given person.

The framework operates at two complementary levels. The micro–meso level described above assesses access as realised by the person. A meso–macro level assesses whether the system is governed, resourced, financed, and organised to produce accessible care, using the established architecture of Health System Performance Assessment, with its indicators mapped back to the same Levesque dimensions and components. This level carries the system-performance requirements of the task: it makes assessment sensitive to care tiers (primary, secondary, and specialised care) and treats efficiency not as resource accounting but as equity-anchored utilisation, disaggregating standard metrics, such as avoidable or involuntary admissions, by vulnerable group to reveal where the system inefficiently and inequitably fails to provide accessible care. Realising this level points to a key recommendation: that registries and information systems capture intersectional identifiers, with appropriate data-governance and participatory safeguards.

The framework has already been applied across WP1 and now feeds WP2, T3.1, and T5.1. The next steps are its validation and refinement in the pilots, the development of equity-disaggregated information systems, its continued participatory development, and its use to support the project's economic analysis of inequitable access.

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List of abbreviations and acronyms

Abbreviation	Definition
ADHD	Attention Deficit Hyperactivity Disorder

ARFID	Avoidant/Restrictive Food Intake Disorder
CHE	Current Health Expenditure
CMHT	Community Mental Health Team
CPD	Continuing Professional Development
CRTHT	Crisis Resolution and Home Treatment Team
DAG	Directed Acyclic Graph
DNA	Did Not Attend
ED	Emergency Department
EIS	Early Intervention in Psychosis Service
EQUICARES	Equity in Community and Accessible Research and Services (GA 101156500)
GAD-7	Generalised Anxiety Disorder 7-item scale
GP	General Practitioner
HSPA	Health System Performance Assessment
IAPT	Improving Access to Psychological Therapies
JBI	Joanna Briggs Institute
LGBTQ+ / LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, and others
LMIC	Low- and Middle-Income Country
MAIHDA	Multilevel Analysis of Individual Heterogeneity and Discriminatory Accuracy
MH	Mental Health
MHLS	Mental Health Literacy Scale
NCD	Non-Communicable Disease
NCRMD	Not Criminally Responsible on account of a Mental Disorder
NGO	Non-Governmental Organisation
NHS	National Health Service

NUTS	Nomenclature of Territorial Units for Statistics
OB/GYN	Obstetrics and Gynaecology
OECD	Organisation for Economic Co-operation and Development
OOP	Out-of-Pocket
PaRIS	Patient-Reported Indicator Surveys
PHQ-9	Patient Health Questionnaire 9-item scale
PREM	Patient-Reported Experience Measure
PROM	Patient-Reported Outcome Measure
PRISMA-ScR	Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews
PTSD	Post-Traumatic Stress Disorder
SARC	Sexual Assault Referral Centre
SMI	Severe Mental Illness
SSSD	Severe Stigmatising Skin Disease
TGD	Transgender and Gender-Diverse
UHC	Universal Health Coverage
WHO	World Health Organization

Introduction

This deliverable (D1.2) presents the EQUICARES Service Assessment Framework, developed through Task 1.2 of the EQUICARES project. The framework adapts the patient-centred conceptual framework for access to health care developed by Levesque, Harris and Russell (2013) for mental health and care services, with a specific focus on people in vulnerable situations.

The deliverable is organised in three parts. **Part I: Evidence Synthesis** presents the four complementary activities through which the framework's evidence base was built: a scoping review of empirical studies applying the Levesque Framework in mental health contexts; a targeted review of Health System Performance Assessment (HSPA) documents; an Indicator Mapping Workshop conducted with consortium partners; and the participatory Map the Gap Hackathon. **Part II: The EQUICARES Service Assessment Framework** presents the consolidated framework at two complementary levels: a micro–meso, person-centred level and a meso–macro, health-system performance level. **Part III: Integrated Interpretation** sets out how the framework connects to the other tasks of Work Package 1 and feeds into subsequent project activities (Figure 1).

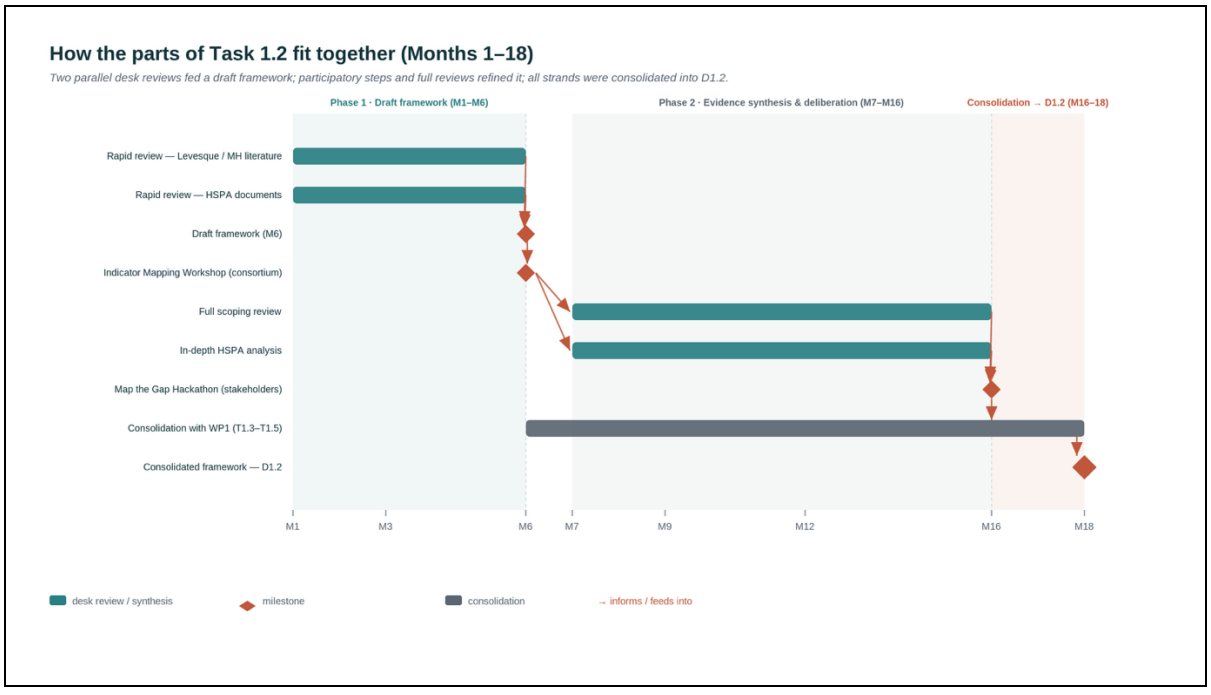

Figure 1. Sequence and interdependence of Task 1.2 activities

Objectives of the T1.2

This task relates to T1.2 of the EQUICARES Grant Agreement, and is structured to achieve the following:

- Modify the existing Levesque Framework to suit the unique challenges of mental health services, focusing on people in vulnerable situations, considering both the supply side (service provision) and the end-user side. Design tailored indicators for evaluating mental health and care services across different healthcare system levels (e.g., primary, secondary).
- Review previous studies applying the Levesque Framework and national Health System Performance Assessment (HSPA) frameworks to inform the adaptation process.
- Design tailored indicators for evaluating mental health and care services across different healthcare system levels (e.g., primary, secondary), covering effectiveness, efficiency, quality, and equity.
- Produce a draft Framework (D1.2) to support data collection across WP1 tasks and calibrate a final version to inform WP2, T3.1, and T5.1, including the project's economic analysis model.
- Organise a deliberation hackathon in Brussels with representatives of vulnerable groups, mental health service providers, and policymakers to validate and fine-tune the Framework in line with the principle of equality of voices.

Part I

Evidence Synthesis

1. Methodological Approach of Evidence Synthesis Part

T1.2 followed a sequential, multi-phase methodology to develop and validate the accessibility assessment framework.

1.1. Phase 1 Draft Framework Development (M1–M6)

A rapid review was conducted on two streams of literature: (i) studies examining access to mental health services that applied the Levesque Framework, with a focus on conceptual and operational definitions of accessibility, and (ii) existing Health System Performance Assessment (HSPA) documents, to map indicator types and structures used across national frameworks. Drawing on these findings, a draft framework was developed by Month 6, adapting the Levesque Framework to the mental health context.

1.2. Phase 2 Full Evidence Synthesis and Stakeholder Deliberation (M7–M16)

The draft framework was examined through a participatory mapping workshop at the M6 consortium meeting, in which consortium partners collaboratively reviewed and refined the component structure across the framework's ten dimensions. Following this, the rapid review was expanded into a full scoping review and the HSPA document analysis was completed in depth. At Month 16, a deliberation hackathon was organised with a multidisciplinary group of stakeholders, including representatives of vulnerable groups, mental health service providers, and policymakers, to identify additional concepts, develop measurement questions, and produce a prioritised draft accessibility assessment tool.

2. Scoping Review

2.1. Introduction

Access to healthcare is a fundamental global concern for policymakers, planners, administrators, and consumers alike, with continuous efforts, including initiatives like Universal Healthcare Coverage (UHC), aimed at improving it (Cu et al., 2021; Davis, 1991). Despite a sustained increase in the Global Healthcare Access and Quality Index Scores, substantial disparities persist, with billions still unable to access essential health services (Cu et al., 2021). Issues such as rising costs, aging populations, market failures, and pervasive inequalities contribute to a widespread perception of poor value for money spent on healthcare (Arah et al., 2006).

Historically, the concept of "access" to medical care has been ill-defined, often functioning more as a political ideal than an operational one. While early conceptualizations varied, sometimes equating access with characteristics of the population (e.g., income, insurance) or delivery system (e.g., distribution of manpower and facilities), other perspectives emphasized evaluating access through outcome indicators like utilization rates or satisfaction scores, arguing for "external validation" of system and individual characteristics (Aday & Andersen, 1974). Aday and Andersen (1974) crucially highlighted that access should be understood as whether individuals who need care actually *get into* the system, proposing the ratio of health care utilization to disability days as an indicator of equitable access (Aday & Andersen, 1974). Donabedian (1972) similarly asserted that "the proof of access is use of service, not simply the presence of a facility," and that access should be measured by the level of use in relation to need (Donabedian, 1972). Beyond mere existence, access encompasses various barriers: financial, psychological, informational, social, organizational, spatial, and temporal (Aday & Andersen, 1974; Donabedian, 1972). Penchansky and Thomas (1981) introduced access as a "fit" between the needs of patients and the capacity of healthcare systems, identifying dimensions such as availability, accessibility, accommodation, affordability, and acceptability (Penchansky & Thomas, 1981). While these frameworks significantly advanced the understanding of access, its inherent complexity and multifaceted nature necessitated a more comprehensive and integrated approach (Cu et al., 2021; Gulliford et al., 2002).

The Levesque Conceptual Framework for Access to Health, introduced in 2013, provides a comprehensive and patient-centered perspective that integrates both demand and supply-side factors to address the complexities of healthcare access (Cu et al., 2021; Levesque et al.,

2013). Levesque et al. (2013) define access as "the opportunity to identify healthcare needs, to seek healthcare services, to reach, to obtain or use health care services, and to actually have a need for services fulfilled". This framework is notable for its ability to equally account for both the health system's perspective and the patient's perspective regarding access.

The framework is structured around two main components (Levesque et al., 2013):

- Five dimensions of accessibility (supply-side factors), which describe the characteristics of healthcare services provided by the health system, organizations, and providers:
    - Approachability
    - Acceptability
    - Availability and Accommodation
    - Affordability
    - Appropriateness
- Five corresponding abilities of populations (demand-side factors), which describe the characteristics and capacities of individuals, households, and communities that enable them to interact with the healthcare system:
    - Ability to Perceive
    - Ability to Seek
    - Ability to Reach
    - Ability to Pay
    - Ability to Engage

Importantly, the Levesque framework does not equate access with mere utilization; instead, utilization is viewed as "realized access" (Levesque et al., 2013). As defined by Arah et al. (2006), "Accessibility is the ease with which health services are reached. Access can be physical, financial, or psychological and requires that health services are a priori available" (Arah et al., 2006, p9). This is consistent with earlier conceptualizations by Donabedian (1973), who described accessibility as the "degree of adjustment between resources and populations," encompassing financial and physical aspects (Donabedian, 1973). Penchansky and Thomas (1981) specifically linked accessibility to the geographic relationship between clients and facilities, involving transportation resources, travel time, and physical distance (Penchansky & Thomas, 1981). Gulliford et al. (2002) also emphasized that access measured

in terms of utilization is dependent on the affordability, physical accessibility, and acceptability of services, not merely the adequacy of supply (Gulliford et al., 2002). The Levesque framework's *Availability and Accommodation* dimension directly addresses this by including physical existence of resources, density, distribution, building accessibility, and urban context, while the *Ability to Reach* focuses on personal mobility and transportation (Levesque et al., 2013). However, some research applying the Levesque framework noted a potential weakness in accounting for *time-related components* of access, such as patient waiting time and travel time not solely due to distance, suggesting room for improvement in this area (Cu et al., 2021).

The Levesque framework views access as a dynamic and cumulative process, where the dimensions of accessibility interact with the population's abilities to generate access. Barriers or facilitators can emerge at various stages of the care-seeking process, from the initial perception of need to actually benefiting from care (Cu et al., 2021; Levesque et al., 2013). This patient-centered approach, focusing on the actual process of seeking care, is particularly valuable for identifying specific barriers in mental health service access.

A scoping review of empirical studies applying the Levesque framework by Cu et al. (2021) found that it has been successfully used to explore, assess, and measure access in various healthcare services and settings, including eight quantitative studies on mental healthcare. According to their findings, researchers used the framework either *a priori* to develop data collection tools or *a posteriori* to organize and analyze collected data. While the framework's comprehensive assessment of the complex and dynamic process of access from both health system and population contexts was appreciated, challenges were noted. The most common challenge was difficulty in categorizing questions or responses into specific dimensions or abilities, as responses sometimes fit into more than one category. Another challenge was an imbalance in the representation of dimensions and abilities, with *Availability*, *Affordability*, and *Appropriateness* being more frequently explored, while *Approachability* and the *Ability to Engage* received less attention (Cu et al., 2021). This imbalance suggests that despite the framework's comprehensive design, researchers might prioritize certain aspects over others.

2.1.1. Objectives

This scoping review aims

- to examine how the Levesque Framework has been applied to assess access to mental health and care services,

- to explore how different dimensions of access have been conceptualized and measured,
- to develop operational definitions of the dimensions of Levesque Framework and
- to identify indicators that can inform the development of the draft assessment framework tailored to mental health contexts.

2.1.2. Research Questions

The research questions listed below were formulated to correspond with the specific objectives of the study:

1. How have the supply and demand side dimensions of the Levesque Framework been conceptualized in these studies?
2. How has access to mental health and care services been measured in studies based on the Levesque Framework?
3. Which specific variables or indicators represent the dimensions of Levesque Framework of access to health care?

2.2. Methodology

2.2.1. Study Design

This study was conducted as scoping review in accordance with the Joanna Briggs Institute (JBI) methodology for scoping reviews (Peters et al., 2024) and reported following the PRISMA-ScR guidelines (Tricco et al., 2018).

2.2.2. Inclusion Criteria

The inclusion and exclusion criteria were structured according to the domains of Participants, Concept, Context, and Types of Evidence Sources.

2.2.2.1. Participants:

This review did not focus on individual-level participants. Instead, it included sources that assess or propose approaches to evaluating access to mental health and care services. Therefore, studies discussing access at the population, system, or policy level were considered as eligible, regardless of the specific characteristics of individuals.

2.2.2.2. Concept:

The central concept of interest was access to mental health and care services, as conceptualized and assessed through the Levesque Framework. Therefore, the studies listed below were included:

- Studies that applied the Levesque Framework in whole or in part, including adapted or extended versions.
- Studies that utilized the Levesque Framework to evaluate or structure discussions around accessibility, either conceptually, empirically, or methodologically.

2.2.2.3. Context:

No restrictions were applied regarding the cultural, institutional, or political context.

2.2.2.4. Types of Evidence Sources:

The following types of sources were included:

- Peer-reviewed primary research studies, including quantitative, qualitative, and mixed-methods designs
- Peer-reviewed systematic reviews or scoping reviews that apply or examine the Levesque Framework in the context of mental health and care service access

The following sources were excluded:

- Studies that did not apply the Levesque Framework
- Studies that were not focused on access to mental health and care service

2.2.3. Search String

The search terms were selected to identify literature related to mental health and care services. In addition, a focused set of keywords was included to capture studies applying or discussing the Levesque Framework, which conceptually and empirically addresses access to care.

Terms related to “access” were not included in the search string, as the Levesque Framework itself is an established model for evaluating access. Therefore, studies that apply or reference this framework were considered inherently relevant to the topic of access to mental health and care service.

The search was conducted in PubMed, Scopus, Web of Science, and the Cochrane Library, using the keywords listed in Table 1. Searches were performed in the title and abstract fields and were limited to studies published in English from 2015 onward. An initial search was conducted on 6 May 2025, followed by a second search using the same strategy on 20 May 2026, restricted to studies published from 2025 onward, to identify any studies published in the intervening period.

Table 1. Search String and Databases

Keyword for Mental Health Care		Keywords for Levesque Framework	Databases
(mental OR psychiat* OR psycho*) AND	(care OR health* OR medica* OR preven* OR promot* OR rehab* OR service OR support OR therap* OR treat*) AND	(Levesque AND (model OR framework))	PubMed Cochrane Library Web of Science Scopus

2.2.4. Source of Evidence

All identified sources were assessed for eligibility based on the inclusion criteria, using a structured and transparent selection process. The selection of sources of evidence followed a two-stage process: (i) title and abstract screening, and (ii) full-text screening. Predefined inclusion and exclusion criteria were applied consistently throughout both stages.

All records retrieved from database searches were imported into Covidence (*Covidence*, n.d.), a web-based platform designed to streamline and manage the workflows of systematic reviews and other evidence synthesis projects. Automatic deduplication was applied, then two reviewers independently screened titles and abstracts against predefined eligibility criteria;

conflicts were resolved by discussion. Full texts of potentially eligible records were likewise assessed in Covidence, with exclusion reasons recorded. Covidence tracked screening counts at each stage, which were used to populate the PRISMA flow diagram.

The entire selection process was reported using a PRISMA-ScR flow diagram, which summarized the number of records retrieved, screened, included, and excluded, along with justifications for full-text exclusions.

2.2.5. Data Extraction

The patient-centred conceptual framework for access to healthcare services developed by Levesque et al (2013) illustrates access as the dynamic interface between characteristics of healthcare systems and the abilities of individuals. Specifically, it defines five dimensions of service accessibility Approachability, Acceptability, Availability and Accommodation, Affordability, and Appropriateness. These dimensions reflect structural, cultural, and systemic characteristics that determine whether services can be identified, reached, and appropriately utilised by the population.

In parallel, five corresponding individual abilities that influence access from the demand side: Ability to perceive, Ability to seek, Ability to reach, Ability to pay, and Ability to engage. These abilities capture the personal, social, and contextual capacities individuals need in order to interact with the healthcare system effectively.

The framework conceptualises access as a process occurring across several stages from the recognition of healthcare needs to the consequences of service use making it particularly suitable for analysing multi-level and person-centred barriers and facilitators to care. Based on this model, we systematically searched for components in the literature that correspond to each of these dimensions. The framework was used to generate the data extraction tool and informed the presentation of results.

Data extraction was carried out to derive conceptual definitions, pinpoint key Components, and outline characteristics for each dimension of the framework. Indicators previously extracted from HSPA documents were mapped onto the key Components identified in the scoping review.

2.3. Results

A total of 153 records were retrieved through the initial search conducted on 6 May 2025. After removing 84 duplicates, 69 unique records remained. Title and abstract screening excluded 39 records because they were either unrelated to mental healthcare access or did not apply the Levesque Framework. The 30 remaining articles underwent full-text review, where 3 were excluded because they did not address mental healthcare utilization sufficiently to be included in the scoping review, resulting in 27 studies included in the scoping review.

A second search was conducted on 20 May 2026 using the same search strategy, restricted to studies published from 2025 onward, to identify studies published after the initial search. This yielded 90 records, of which 51 remained after duplicate removal. All 51 records underwent title and abstract screening. Thirteen were included, while 38 were excluded: 4 had already been included in the initial scoping review, 15 did not apply the Levesque Framework and did not measure mental healthcare access, and 20 applied the Levesque Framework but did not measure mental healthcare access. The 13 remaining articles underwent a full-text review, where 2 were excluded because they did not address mental healthcare utilization sufficiently to be included in the scoping review. In total, 38 studies were included across both searches (Figure 2).

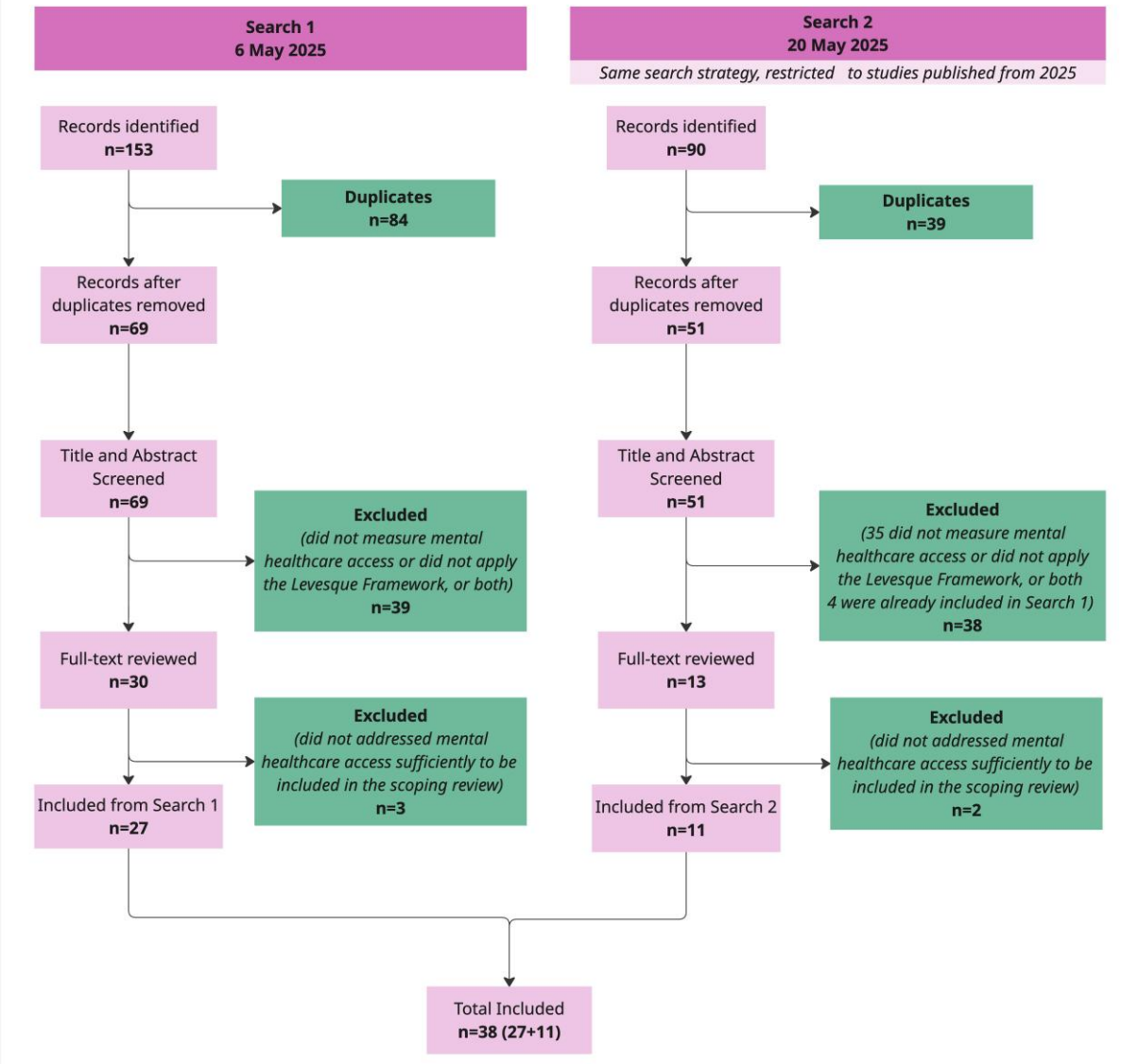

Figure 2. Study Flow Diagram

A total of 38 studies published between 2019 and 2026 were included in the scoping review, with the majority published between 2022 and 2026. The included literature was methodologically diverse. Reviews constituted the largest group (n=16), encompassing scoping reviews, systematic reviews, a narrative review, a mixed-method systematised review, a meta-ethnography, and an umbrella review. Primary qualitative studies formed an equally substantial group (n=15), drawing on approaches including thematic analysis, phenomenology, content analysis, ethnography, and codesign methodology. Three studies employed quantitative designs, two used mixed methods, and two were study protocols.

Geographically, the evidence base was heavily concentrated in high-income, English-speaking countries, most frequently the United Kingdom, Canada, the United States, and Australia. Studies from low- and middle-income country settings were markedly

underrepresented, with only five exceptions: Bangladesh, Mexico, India, Turkey, and one multi-country scoping review spanning low- and middle-income settings.

The study populations were heterogeneous. Migrants, refugees, and asylum seekers constituted the largest group (n=10), followed by LGBTQ+ individuals (n=3) and people experiencing homelessness (n=2). Other populations included children and adolescents, law enforcement officers, people with dementia, individuals with substance use disorders, people with serious mental illness, and those affected by domestic violence or sexual assault. Several studies incorporated both service users and healthcare providers as participant groups. Most studies addressed mental health broadly without restricting focus to a single diagnostic category; depression, anxiety, PTSD, and severe mental illness were the most commonly referenced conditions. A subset focused on specific conditions including perinatal mental health disorders, ADHD, and eating disorders. Several studies were not primarily mental health-focused but addressed mental health as a prominent secondary concern within broader healthcare access research. Studies were conducted across a range of settings, with primary and secondary care most frequently represented, alongside community-based and NGO-based care. Tertiary care, virtual and digital services, workplace-based care, school-based care, and forensic or rehabilitation settings also featured, reflecting the diverse contexts in which access to mental healthcare is negotiated.

All 38 studies employed the Levesque Framework as either a primary or secondary analytical tool. Twelve studies applied the framework a priori, using it to structure data collection and analysis from the outset; twelve applied it a posteriori, mapping findings retrospectively onto the framework's dimensions; and the remaining fourteen used a combined or adapted approach. A recurring pattern across studies was the tendency to address supply-side and demand-side dimensions together rather than as distinct analytical categories, and several studies reported findings under emergent thematic headings without explicit dimension-by-dimension reporting. Only a small number of studies operationalised all ten dimensions systematically and separately. Regarding measurement instrument availability, review studies were recorded as not applicable. Among primary qualitative studies and study protocols, eight made their interview or focus group guides publicly available as supplementary materials Berger et al. (2020), Brehon et al. (2025), Clifton and Hancock (2025), Hollingdrake et al. (2023), Lowther-Payne et al. (2026), Naheed et al. (2022), Salameh et al. (2025), Schwarz et al. (2022), Shah et al. (2025), and Williams-Ridgway et al. (2026)) while the majority did not. Two studies reported thematic categories of questions in the manuscript without providing the full instrument (Kourgiantakis et al. (2023) and Woodgate et al. (2023). Among the three quantitative primary studies, approaches varied considerably: Leclair et al. (2022) used no

survey instrument, operationalising framework dimensions through administrative records with all variables reported in full; Clifton and Hancock (2025) employed validated scales alongside author-developed Likert items targeting demand-side dimensions; and Martínez-Jaime et al. (2024) used the purpose-built AAcceDa survey developed a priori from the framework. The latter instrument was not publicly available, pointing to a broader gap in the transparency and replicability of access measurement in this literature. (Annex 1. Characteristics and Summary of the Studies Included in the Scoping Review)

2.3.1. Conceptual Definitions of Levesque Framework's Dimensions

2.3.1.1. Approachability

The scoping review findings highlight that approachability extends well beyond the physical or structural presence of services. For a service to be genuinely approachable, it must first be visible, but visibility itself is multidimensional. It encompasses not only the active promotion of services through accessible information channels, but also the capacity of the system to identify individuals with unmet mental health needs and to facilitate their awareness of relevant care options. In this sense, approachability is not a passive property of services but an active function of how systems reach out, detect, and connect. Equally important is the recognition that individuals rarely encounter mental health services in isolation: contacts with primary care, social services, educational settings, or community organisations all represent potential entry points that, when well-coordinated, can transform an unrelated encounter into a pathway to mental health care. The reviewed evidence suggests that approachability is shaped by the interplay of service visibility, system-level integration, provider knowledge and responsiveness, and the proactive strategies such as screening programs, outreach, and awareness initiatives through which services extend their reach to those who need them most.

Approachability Assessment Overview:

- Mental health prevention and screening programs
- Transparency
- Integration across health and non-health services
- Providers' awareness and knowledge
- Provider workload and patient contact time
- Cultural responsiveness of care and providers
- Community-based outreach
- Frontline actors
- Mental health awareness programs

- Visibility of services and accessible information channels

Mental health prevention and screening programs:

A fundamental dimension of approachability is the extent to which a service or system enables individuals to recognise that they have a mental health need in the first place. For a service to be truly approachable, it must not only be visible and non-stigmatising, but also actively facilitate the identification of those who need care yet remain unaware of it. Prevention and screening programs are central to this function: they create structured opportunities to detect unmet mental health needs at the population level, before distress escalates and help-seeking becomes urgent.

Among unaccompanied refugee children, the absence of systematic screening within detention settings and temporary accommodations represents a critical structural gap. These children frequently lack access to any form of mental health screening, with the absence of family or guardian support further hindering identification of unmet needs (Yılmaz et al., 2025). For minoritised ethnic young people with eating disorders, identification of need frequently occurred incidentally during routine medical appointments or emergency department visits rather than through proactive screening, reflecting a systemic failure to create structured opportunities for early detection within primary care (Williams-Ridgway et al., 2026). However, the reach of such programs is shaped by the assumptions embedded in how care is delivered. Among sexually and gender diverse populations, assumptions about heterosexuality consistently result in missed opportunities for preventive care and screening, contributing to lower rates of access to routine health services (Maria et al., 2025). Similar gaps emerge in perinatal mental health contexts: Syrian refugee women, for instance, reported that providers focused exclusively on their physical health without enquiring about their mental state, leading to missed opportunities to detect postpartum depression (Salameh et al., 2025).

The absence of routine mental health screening in heart failure care meant that clinicians relied on verbal and non-verbal cues during appointments to detect potential mental health concerns, creating significant gaps in systematic identification (Shah et al., 2025). In telemonitoring contexts, nurses developed indirect detection strategies using digital indicators such as changes in the frequency of readings or physical health data as proxies for mental health deterioration, illustrating how the absence of structured screening prompts informal and inconsistent substitutes (Shah et al., 2025). Clinicians identified acute health events following diagnosis as the most appropriate moments for screening, as these periods offered opportunities for individuals to reflect on the mental health impacts of their condition and could facilitate earlier help-seeking (Shah et al., 2025).

Targeted screening programs such as those designed for pregnant and postpartum women can serve as a strategy to improve approachability by creating structured entry points into care (Ash et al., 2025; Viveiros & Darling, 2019). Yet inconsistent implementation and low screening rates continue to hinder systematic detection (Viveiros & Darling, 2019). Beyond coverage, the design and delivery of screening programs are equally critical. When implemented without clear communication about their purpose or the implications of a positive result, screening can inadvertently erode trust rather than build it. Uncertainty about follow-up, compounded by prior experiences of racism and medical mistreatment, fosters fear and scepticism. Doubts about providers' capacity to deliver appropriate and culturally sensitive care further reinforce the perception of screening as superficial. Thus, while screening programs hold genuine potential to improve approachability, their effectiveness is contingent on transparent communication, culturally responsive delivery, and robust follow-up pathways (Ash et al., 2025).

Smartphone applications and wearable devices could be used as screening tools for ongoing mental health need identification, supporting continuous symptom monitoring outside formal clinical settings. Technology-mediated communication with friends and family served a parallel function, with informal check-ins operating as iterative mechanisms for need recognition. Such tools transform screening from a one-time clinical event into an active and ongoing process, creating opportunities to detect emerging or changing mental health needs before distress reaches crisis point (Stone & Veinot, 2026)

Transparency:

Transparency in service communication constitutes a distinct determinant of approachability. When individuals are uncertain about what follows a positive screening result whether they will be referred, monitored, or face institutional consequences disclosure becomes a calculated risk rather than a step toward care. Referral conversations were often inadequately transparent, failing to provide sufficient information about the purpose of a referral or to engage the individual's needs and preferences (Shah et al., 2025). Well-intentioned efforts to normalise mental health services by framing them as universal supports sometimes came at the cost of accuracy, with individuals receiving misleading information about why they specifically were being referred a dynamic that, when recognised, further eroded trust and reduced receptivity to care (Shah et al., 2025). Among postpartum women, limited information about post-screening pathways reduced willingness to report symptoms, as uncertainty

translated directly into fear and avoidance (Ash et al., 2025). A service that fails to provide this clarity may remain effectively inapproachable regardless of its physical or structural availability.

Integration across health and non-health services:

A further determinant of approachability is the degree to which mental health services are integrated within broader health and non-health service systems. When individuals access other services whether primary care, social support, or community-based organisations integrated systems create opportunities for mental health needs to be identified, communicated, and addressed that would otherwise not exist. Integration effectively expands the surface area through which a service becomes visible: a person who would never seek mental health care directly may encounter it through a service they already trust and use.

This mechanism is particularly significant for populations with low mental health literacy or high institutional mistrust. Among refugee newcomers, accessing a single integrated service increased awareness of available mental health supports and opened pathways to appropriate care (Hynie et al., 2022). For crack cocaine users, services that functioned as connected hubs ensured that even when individuals entered through the "wrong" access point, they could be redirected efficiently eliminating dead ends and reducing the burden of navigation (Duopah et al., 2024). Similarly, parents of children with mental health needs emphasised that stronger inter-service linkages would simplify navigation and prevent families from experiencing fragmentation across agencies (Woodgate et al., 2023).

Service integration as a determinant of approachability operates across multiple service contexts. Integration between mental healthcare and OB/GYN services enhances approachability by embedding mental health professionals within routine reproductive health settings, making support more visible and reducing the threshold for disclosure (Ash et al., 2025). Similarly, integration between mental healthcare and infant care services is critical for postpartum populations: while health visitors routinely address infant wellbeing, maternal psychological needs frequently go unscreened, as documented among Syrian refugee women (Salameh et al., 2025).

For individuals managing long-term conditions, integration of mental health care into chronic condition management is essential to ensure that psychological needs are recognised alongside physical ones. In conditions such as cystic fibrosis, integrated mental health and social support improves visibility and enables earlier identification of need (Brehon et al., 2025). In stigmatising, chronic, and often incurable skin and systemic diseases (SSSDs),

where mental health burden is high, integration remains limited and is further weakened by poor referral mechanisms (McCollum et al., 2022).

For marginalised and high-risk populations, integration into non-health services is particularly decisive. Crack cocaine users primarily learned about available services through outreach workers, prison services, and harm reduction programs, underscoring the importance of connecting substance use and mental health services through these channels (Duopah et al., 2024). For women experiencing domestic violence, integration with courts and trusted primary care providers, particularly GPs, created effective referral pathways and made services more visible and accessible (Hollingdrake et al., 2023).

Underpinning all of these, clear communication channels between providers and across sectors are a prerequisite for functional integration. Unclear governmental guidelines and poor inter-agency collaboration produce fragmented care, particularly for refugees and asylum seekers (Dumke et al., 2024).

Providers' awareness and knowledge:

A critical yet often overlooked determinant of approachability lies within the system itself: the knowledge and awareness of the providers who serve as first points of contact. When an individual engages with a health or social care provider regardless of the reason for that contact the provider's familiarity with mental health conditions, available services, and referral mechanisms determines whether that encounter becomes an opportunity for identification and support, or a missed one. Even when a person is physically present within the system, insufficient provider knowledge can render mental health care effectively invisible, leaving needs undetected and pathways unopened.

A recurring barrier to approachability is providers' limited awareness of what services exist and how to connect individuals to them. Across multiple population groups and care contexts, this gap translates into delayed, informal, or absent referrals. Health and social care providers working with people living with dementia frequently lacked awareness of available social farms, resulting in referrals made through informal routes such as word of mouth or local advertisements rather than established pathways (Bartlett et al., 2025). Similarly, limited knowledge of available services and referral processes made it difficult for providers to direct

refugee newcomers to specialised mental healthcare (Hynie et al., 2022; Dumke et al., 2024), while practitioners working with young people often failed to refer families to youth mental health services or provide meaningful guidance (Kourgiantakis et al., 2023; Woodgate et al., 2023). In perinatal care, midwives' insufficient familiarity with referral pathways limited the timely identification and support of women's mental health needs (Viveiros & Darling, 2019). For problematic alcohol use, providers' failure to share referral information or schedule initial appointments further constrained access at the point of first contact (Wolfe et al., 2023). Specialist eating disorder services frequently operated with limited visibility not only to the general public but also to referring clinicians within the wider health system, compounding existing barriers for minoritised ethnic communities who were already less likely to be informed about available services and appropriate help-seeking pathways (Williams-Ridgway et al., 2026).

Beyond knowledge of services, providers' understanding of mental health conditions themselves is equally decisive. When providers lack the clinical literacy to recognise mental health needs, identification fails before referral even becomes possible. Midwives with limited perinatal mental health literacy consistently underestimated the prevalence of perinatal mental health concerns, a gap compounded by the absence of adequate training and antenatal education content (Viveiros & Darling, 2019). In Limerick, service providers encountered crack cocaine use as a new and unfamiliar phenomenon, and reported having to rapidly self-educate often relying on information provided by service users themselves (Duopah et al., 2024). For LGBTQI+ populations, the predominance of heteronormative approaches and the absence of gender-affirmative care prevented providers from adequately identifying mental health needs (Maria et al., 2025). Insufficient knowledge of refugees' mental health conditions and entitlements led to delays and inadequate referrals (Dumke et al., 2024). while limited provider knowledge of treatment options for problematic alcohol use undermined patients' initial access to care (Wolfe et al., 2023). Healthcare professionals noted that GPs often failed to recognise eating disorder symptoms in minoritised ethnic patients, partly due to insensitivity to ethnic differences in presentation and misconceptions about which populations eating disorders affect resulting in missed screening opportunities at the first point of contact (Williams-Ridgway et al., 2026). Among refugee children and youth, first points of contact including general practitioners, nurse practitioners, social workers, and general paediatricians play a pivotal role in identifying mental health needs, yet their effectiveness depends on sufficient knowledge of refugee populations' distinct needs, including the interplay of medical and mental health conditions common in this group (Yılmaz et al., 2025). Reviews emphasise the importance of trauma-informed approaches at these early contact points to enable identification of at-risk groups, including unaccompanied children with high exposure to violence (Yılmaz et al., 2025).

Conversely, where practitioners recognised symptoms, prescribed treatment, and made timely referrals, approachability was significantly enhanced though parents frequently described having to actively convince providers of the seriousness of their child's condition before any action was taken (Woodgate et al., 2023).

Another barrier emerges when providers hold negative or restrictive perceptions about which patients are suitable candidates for particular services. These perceptions operate as informal gatekeeping mechanisms that constrain referral and limit individuals' awareness of available options. Among individuals with dementia, negative views held by some GPs and specialists regarding the effectiveness of rehabilitation contributed to reduced referrals, leaving patients unaware that such services existed and were relevant to their needs (Layton et al., 2024).

Provider workload and patient contact time:

Structural constraints on provider capacity represent an often overlooked barrier to approachability. Heavy workloads among midwives limited their ability to address perinatal mental health during routine appointments, reducing the likelihood that needs would be identified or raised (Viveiros & Darling, 2019). Insufficient consultation time was among the most consistently reported barriers in this context, as limited contact time restricted meaningful discussion of mental health concerns particularly for individuals who had not yet recognised or articulated their own needs (Viveiros & Darling, 2019).The bidirectional and clinically complex relationship between mental and physical health symptoms in heart failure made detection particularly difficult within the time constraints of routine appointments, compounding the absence of standardised screening tools and contributing to a medicalised care approach that frequently neglected social and psychological dimensions of health (Shah et al., 2025).

Cultural responsiveness of care and providers:

The cultural responsiveness of providers shapes whether individuals from diverse backgrounds feel understood and appropriately directed within the system. Where providers lack the cultural competence to recognise how mental health concerns are framed and expressed across communities, potential entry points into care become barriers instead. Gaps in understanding refugees' specific needs and cultural idioms of distress frequently led to delays and inadequate referrals (Dumke et al., 2024), and refugees, asylum seekers, and

migrants presenting to primary care with psychological needs were less likely than other patients to receive mental health referrals in the UK (Lowther-Payne et al., 2023). Cultural responsiveness also shapes provider behaviour more indirectly: childcare workers in migrant communities avoided suggesting support for children with neurodevelopmental differences out of fear of offending families, disrupting referral pathways (Place et al., 2021), while midwives reported low confidence in raising perinatal mental health concerns in cross-cultural contexts, leaving needs unaddressed (Viveiros & Darling, 2019).

Community-based outreach:

Community-based outreach represents an active strategy to extend the reach of mental health services beyond formal care settings, supporting individuals and caregivers in identifying appropriate services for their needs (Hollingdrake et al., 2023; Kourgiantakis et al., 2023). For refugee children and youth, NGO services, school-based programs, and community partnerships are essential for extending approachability to underserved populations. Implementing screenings within community settings is highlighted as an effective mechanism for reaching refugee children who would otherwise remain outside formal service pathways, particularly unaccompanied minors in detention for whom existing structures are systematically inadequate (Yılmaz et al., 2025). Where outreach is inadequate, it functions as a significant barrier: limited outreach to young people and their families was identified as a major obstacle to accessing youth mental health and addiction services (Kourgiantakis et al., 2023). For problematic alcohol use, outreach services were perceived as directly overcoming referral barriers, improving the approachability of care for those who would otherwise remain outside the system (Wolfe et al., 2023). Outreach and community-based interventions constitute a primary strategy for extending approachability to people experiencing homelessness, bringing care directly into familiar spaces including drop-in centres, soup kitchens, hostels, and shelters where individuals can access professionals informally and without prior appointments. Mobile health clinics operating in areas frequented by people experiencing homelessness similarly enhanced approachability by physically relocating services to where individuals live and socialise, overcoming the informational and relational distance between services and users (Meda et al., 2025).

Frontline actors:

Beyond formal healthcare providers, frontline actors in non-clinical settings play an important role in enhancing approachability by identifying mental health needs and facilitating pathways to care. Teachers, for instance, frequently serve as key figures in recognising ADHD symptoms in children and raising parental awareness (Martínez-Jaime et al., 2024), while

healthcare and hostel staff working with people experiencing homelessness act as critical intermediaries by identifying emerging health needs and connecting individuals to appropriate services (McNeill et al., 2022). Teachers and school counsellors serve as important frontline actors in identifying mental health needs among displaced children, yet limited training in refugee-specific mental health awareness frequently constrains their effectiveness (Yılmaz et al., 2025).

Mental health awareness programs:

Mental health awareness programs support approachability by building the knowledge and confidence needed to recognise mental health needs and seek care. However, their reach is uneven. Such programs were frequently absent in migrant communities or delivered in culturally irrelevant ways, limiting their effectiveness, while school curricula tended to focus on physical health at the expense of mental health and emotional wellbeing (Place et al., 2021). Parents emphasised the importance of education and awareness around anxiety and mood disorders as a means of supporting early recognition and increasing families' confidence in seeking services (Woodgate et al., 2023). For people experiencing homelessness, educational activities integrated into outreach and community-based interventions supported approachability by building health literacy and enabling individuals to recognise and articulate their own care needs functions that complement and extend the reach of more formal awareness programs (Meda et al., 2025).

Visibility of services and accessible information channels:

Limited visibility of available mental health services and inadequate information channels consistently emerge as barriers across diverse population groups. Crack cocaine users demonstrated relatively good awareness of general harm reduction and community services, yet their knowledge of treatment-specific options remained limited and the information they did have was obtained primarily through informal channels such as outreach workers, prison staff, and peers rather than through structured communication from treatment services themselves (Duopah et al., 2024). Similar patterns were documented among refugees, for whom both informal networks such as friends, family, and peers and formal providers served as primary information sources, meaning that the accuracy and completeness of the knowledge held by these intermediaries directly shaped individuals' awareness of and access to care (Hynie et al., 2022).

Where information is absent, unclear, or inaccessible, misinformation fills the gap. Parents of young people with mental health needs frequently encountered fragmented and contradictory

guidance on where to seek help, with misinformation about available services identified as a common and consequential barrier (Woodgate et al., 2023; Kourgiantakis et al., 2023). Language further compounds invisibility: migrant parents and youth reported that information about child and youth mental health services was often unavailable in their language or of poor quality, rendering services effectively incomprehensible (Place et al., 2021). Poor promotion of services was also documented among Australian Indigenous women and in UK alcohol services, while in the US military, inadequate communication about confidential treatment programs meant that many personnel only learned of their existence after using non-confidential care, a pathway that carried significant career risks (Wolfe et al., 2023). Many asylum seekers were unaware of free services or sliding scale payment options, and reported not having been informed of available resources upon arrival, illustrating how systemic failures in outreach and communication leave individuals without the knowledge needed to identify and access care (Wehbe et al., 2026). For transgender and gender-diverse individuals in Kerala, specialised clinics operated only on select days with limited publicly available information about their schedules, creating a fundamental visibility gap; even hospital staff at the facilities where these clinics were located were sometimes unaware of their existence or operating hours (Fernandez & Gaitonde, 2026).

2.3.1.2. Acceptability

The scoping review findings indicate that the acceptability of mental health care is shaped by the interplay of multiple, mutually reinforcing factors. At its core, acceptability reflects the degree to which care aligns with individuals' expectations, values, and preferences encompassing not only what is offered, but how, by whom, and in what environment it is delivered. The reviewed evidence suggests that acceptability is determined by whether individuals anticipate or experience care as respectful, culturally congruent, and responsive to their needs; by the availability of pathways that enable preference-concordant care, such as the ability to choose a provider or service format; and by the extent to which the care environment itself from institutional structures and policies through to the quality of interpersonal encounters is experienced as welcoming, safe, and free from stigma and discrimination.

Acceptability Assessment Overview

- Stigma and discrimination against people in vulnerable situations
- Confidentiality and privacy regulations
- Interpersonal quality of care
- Cultural inclusivity and sensitivity

- Ability to choose provider and preferences regarding provider characteristics
- Availability of different types of service provision
- Shared decision-making practices
- Compulsory treatment and coercive practices

Stigma and discrimination against people in vulnerable situations

Stigma and discrimination constitute some of the most pervasive barriers to the acceptability of mental health care, operating at both structural and interpersonal levels. For ethnic and sexual minorities, racism and homophobia rooted in structural discrimination undermine the ability to seek care, with similar dynamics affecting people with disabilities, individuals with lower educational levels, and those in contact with the criminal justice system (Lowther-Payne et al., 2023). LGBTQ+ individuals experienced a "double stigma" arising from the intersection of stigma associated with their sexual or gender identity and stigma associated with mental health conditions, with this compounding effect representing a distinct and particularly powerful deterrent to help-seeking. Feelings of low self-worth, shame, and fear of being judged rooted in exposure to discrimination and prejudice further reinforced reluctance to seek care, with some participants delaying help-seeking until crisis point out of fear of rejection by professionals (Lowther-Payne et al., 2026). For transgender and gender-diverse individuals in Kerala, discrimination within healthcare settings was pervasive, with 42 percent of survey respondents reporting experiencing discrimination at a health centre within the past year (Fernandez & Gaitonde, 2026). Refugees and asylum seekers reported being treated differently from host-country patients, experiencing disrespect, unfair treatment, and racially charged interactions with Syrian refugee women describing their refugee status itself as the primary obstacle to accessing psychological treatment (Dumke et al., 2024; Salameh et al., 2025). Asylum seekers in the US described feeling unheard by healthcare providers and characterised clinical encounters as rushed or dismissive, attributing these experiences to their asylum status and documentation constraints (Wehbe et al., 2026). Providers simultaneously failed to recognise discrimination as a barrier to care, attributing mistrust to individual provider fit rather than systemic dynamics, reflecting a pattern in which institutional discrimination remained unnamed and unaddressed (Wehbe et al., 2026).Migrants perceived discrimination along intersecting axes of ethnicity, migration status, and gender, fostering a pervasive sense of exclusion and inequity (Dumke et al., 2024). Such experiences created hostile environments that deterred help-seeking and negatively affected mental health outcomes, while also generating fears that sensitive information could be misused with potential consequences for residence status or child custody further discouraging engagement (Dumke et al., 2024; Place et al., 2021; Salameh et al., 2025). Migrants from Arabian countries and those who identified as Black reported discriminatory and racist encounters in medical

settings, which led them to avoid accessible providers in favour of those sharing their cultural background or ethnicity (Baierl et al., 2026).

Discrimination was not limited to attitudes but extended to concrete exclusionary practices. Crack cocaine users reported being turned away or treated with hostility by general practitioners and emergency departments, leading to persistently low service utilisation (Duopah et al., 2024). For LGBTQI+ individuals, discrimination undermined cultural safety and reduced acceptability across multiple dimensions: sexual minorities experienced stigma not only from heterosexual communities but also from within their own communities, with internalised biphobia and minority stress compounding barriers to care (Broadway-Horner, 2024). Anticipated stigma including fear of disclosing one's sexual or gender identity, expectations of bullying, or the risk of discrimination was itself sufficient to deter help-seeking, with some individuals relocating from rural to urban areas in search of greater acceptance (Maria et al., 2025). Stigma and discrimination targeting LGBTQI+ individuals, racialised groups, and other marginalised populations were similarly identified as significant barriers to the acceptability of youth mental health and addiction services (Kourgiantakis et al., 2023).

Confidentiality and privacy regulations:

Confidentiality and privacy are foundational to the acceptability of mental health care, particularly for populations where stigma is pronounced and the consequences of disclosure extend beyond social judgment to material harm. Breaches of confidentiality such as instances where information shared in supposedly confidential settings was disclosed to family members resulted in loss of trust and discontinuation of care among crack cocaine users (Duopah et al., 2024). For migrant communities, fear of disclosure frequently prevented care-seeking altogether (Place et al., 2021). In problematic alcohol use treatment, the need for anonymity and confidentiality was strongly linked to fears of deportation, loss of employment, custody of children, or damage to military careers and was greatest at the point of initiating therapy, particularly in small communities, military contexts, and peer- or online-based settings (Wolfe et al., 2023). For some minoritised ethnic young people, particularly those from South Asian communities, concerns about confidentiality between GPs and family members constituted a specific barrier to engaging with primary care, reflecting tight-knit community and family networks in which patients may share healthcare providers with relatives (Williams-Ridgway et al., 2026).

The use of interpreters introduced a specific confidentiality concern for refugee and migrant populations. The involvement of interpreters raised fears about the handling of sensitive information, with some migrants avoiding services altogether upon learning that a known

interpreter would be present (Place et al., 2021). Syrian refugee women described avoiding psychiatric consultations specifically because interpreter involvement risked exposing their situation to gossip within their community (Salameh et al., 2025; Dumke et al., 2024; Hynie et al., 2022).

Anonymity and confidentiality in virtual services presented a dual dynamic. Refugees frequently preferred online services precisely because anonymity reduced stigma and enhanced confidentiality (Hynie et al., 2023). However, concerns about how personal data were handled in virtual environments tempered this preference, introducing a new axis of privacy anxiety (Hynie et al., 2022). Remote mental healthcare delivery during COVID-19 introduced a distinct confidentiality threat for individuals living in unsupportive home environments, where fear of being overheard discussing their LGBTQ+ identity or mental health difficulties during telephone or video sessions significantly constrained what could be safely disclosed (Lowther-Payne et al., 2026).

Service location shaped confidentiality in equally significant ways. When services were situated within migrant communities, the visibility of attending them risked exposing individuals to stigma (Place et al., 2021). Migrant students held divergent views on school-based services: some valued their location outside the immediate community as a source of privacy, while others feared that sensitive information might reach teachers, peers, or parents (Place et al., 2021). For people with problematic alcohol use, services co-located with drug or HIV treatment facilities felt stigmatising, whereas hospital outpatient settings were more acceptable as attendance could be attributed to other reasons (Wolfe et al., 2023). Service location may introduce a paradox, while some services were considered inaccessible due to distance, others were perceived as located too close to home, increasing fears of being recognised while attending treatment a concern heightened for young people from communities with pronounced mental health stigma (Williams-Ridgway et al., 2026).

Service hours constituted a further dimension of privacy, particularly in military contexts. Appointments scheduled outside duty hours allowed personnel to attend in civilian clothes, avoid requesting time off from superiors, and keep treatment off official records reducing workplace stigma at a critical early stage of care-seeking (Wolfe et al., 2023).

Medical record sharing through referral pathways constituted a distinct confidentiality concern for LGBTQ+ participants. GP-mediated referral routes were perceived as threatening because they required the sharing of sensitive identity information including sexual orientation and gender identity through formal records and inter-provider communication over which individuals had limited control, whereas self-referral pathways were valued precisely because

they enabled disclosure on the individual's own terms, bypassing this mechanism (Lowther-Payne et al., 2026)

Interpersonal quality of care:

Negative encounters characterised by hostility, disrespect, judgment, or stereotyping not only deter immediate engagement but carry lasting consequences: poor interpersonal experiences, whether with the same service or across different services, erode trust and reduce the acceptability of future care-seeking. In this way, a single negative encounter can shape an individual's willingness to seek care long after it has occurred. Crack cocaine users reported being treated with hostility and having their self-reported substance use doubted by providers, fostering feelings of invalidation and reducing openness about their needs (Duopah et al., 2024). For LGBTQI+ individuals, provider biases, negative attitudes, and discriminatory insensitivity undermined acceptability and deterred help-seeking (Maria et al., 2025; Fernandez & Gaitonde, 2026), while negative past interactions with healthcare staff similarly eroded future care acceptability for people experiencing homelessness (McNeill et al., 2022). Conversely, providers who demonstrated active listening, took concerns seriously, and engaged without judgment enhanced trust and strengthened the therapeutic relationship (Woodgate et al., 2023). Providers themselves acknowledged that respectful, non-judgmental care is essential for individuals to feel accepted, and identified experiential training such as hands-on internships in addiction services as a means of fostering empathy and cultural competence among future professionals (Duopah et al., 2024).

Cultural inclusivity and sensitivity

Cultural inclusivity and sensitivity are central determinants of acceptability. When services fail to reflect the cultural contexts, values, and identities of the populations they serve, individuals feel misunderstood, judged, or stereotyped and are less likely to seek and engage with care. Migrant families frequently perceived services as culturally inappropriate, reporting that providers were unable to relate to their concerns or take them seriously (Place et al., 2021). A lack of cultural awareness led families to feel judged or misunderstood, and anticipation of such experiences was itself sufficient to deter help-seeking (Place et al., 2021). Inadequate cultural competence among clinicians reduces the perceived quality and acceptability of care, contributing directly to underutilisation of services among refugee children and youth (Yılmaz et al., 2025). Similar dynamics were documented in perinatal care, where services lacking cultural competence were viewed as unacceptable (Viveiros & Darling, 2019), and in alcohol use services, where cultural and language disconnects made providers appear unable to fully understand users' experiences (Wolfe et al., 2023). Addressing these barriers requires

culturally sensitive and inclusive approaches across all dimensions of service design and delivery, including for LGBTQI+ individuals, racialised groups, and other marginalised populations (Kourgiantakis et al., 2023). Where systemic inclusivity is limited, the ability to choose a culturally concordant provider can serve as a partial compensatory mechanism enabling individuals to seek care within a relationship of greater cultural safety even when the broader service environment falls short.

Cultural inclusivity operates through several interconnected dimensions:

Language inclusion and support constitutes a foundational barrier for migrants, refugees, and ethno-cultural minorities. Language barriers were among the most consistently reported obstacles to accessing mental health care across these populations (Dumke et al., 2024; Hynie et al., 2022; Place et al., 2021; Salameh et al., 2025). The scarcity of providers fluent in refugees' native languages and the absence of paraprofessionals from the same cultural background further diminish acceptability, with pairing healthcare providers with ethnic paraprofessionals identified as an effective bridging strategy (Yılmaz et al., 2025). For people living with dementia from South Asian communities, the unavailability of dementia social farm services in their preferred languages created significant communication barriers (Bartlett et al., 2025), while the absence of alcohol use treatment services in Indigenous and minority languages further compounded exclusion (Wolfe et al., 2023). Virtual mental health services have shown potential to partially address this gap by enabling individuals to access providers from the same cultural and linguistic background when such providers are not locally available (Hynie et al., 2022).

Religious sensitivity is an equally important dimension of cultural acceptability. Religious practices were not consistently respected or accommodated in dementia social farms, creating barriers to engagement for participants from South Asian communities whose religious observance formed an integral part of daily life (Bartlett et al., 2025).

Dietary inclusivity represents a further, often overlooked dimension. Unmet dietary requirements including cultural and health-related food restrictions limited the acceptability of dementia social farm services for participants and their families from South Asian backgrounds (Bartlett et al., 2025).

Sensitivity and respect for cultural health perspectives is critical where biomedical and non-biomedical understandings of mental health diverge. Refugees reported that providers displayed insensitivity, judgment, and stereotyping toward their cultural understandings of mental health, and felt pressured to abandon personal beliefs in favour of biomedical

frameworks, an experience that fundamentally undermined the acceptability of care (Dumke et al., 2024).

Diversity and representation in the workforce shapes whether services are perceived as designed for and inclusive of all communities. Participants from minoritised backgrounds in UK dementia social farms highlighted the lack of staff diversity, reinforcing the perception that services were predominantly designed for white users (Bartlett et al., 2025). For LGBTQ communities, the presence of sexual minority therapists was considered particularly valuable in fostering trust and safety, as providers who shared their experiences were seen as better equipped to offer non-discriminatory care (Broadway-Horner, 2024). For minoritised ethnic young people with eating disorders, workforce diversity was identified as essential for delivering culturally sensitive care, with a diverse team providing patients with the choice of working with someone who shares aspects of their background and creating an initial impression of inclusion and safety (Williams-Ridgway et al., 2026).

Visible signs of inclusion extend acceptability beyond the mere absence of discrimination. For LGBTQ+ communities, tangible signals such as rainbow flags, inclusive posters, staff wearing rainbow badges, and introducing themselves with their pronouns communicate safety and recognition, enhancing the perceived acceptability of services before any direct contact with a provider (Broadway-Horner, 2024; Lowther-Payne et al., 2026).

Gender-affirming care is a distinct and essential component of cultural acceptability for sexually and gender diverse populations. Mental health services designed and delivered within a cis-heteronormative framework failed to reflect the identities and needs of LGBTQ+ service users, with staff perceived as lacking the knowledge, awareness, and competencies necessary to deliver inclusive and affirming care (Lowther-Payne et al., 2026). Healthcare professionals' awareness and understanding of sexual and gender diversity, combined with care practices that affirm rather than pathologise diverse identities, were identified as fundamental to ensuring that services are experienced as acceptable and aligned with individuals' values and lived experiences (Maria et al., 2025).

Ability to choose provider and preferences regarding provider characteristics

Acceptability of care is shaped not only by the nature of the service itself, but also by the degree to which individuals can access providers whose characteristics align with their personal, cultural, and social preferences. The ability to choose a provider or at least to know that such a choice is possible functions as an important bridge between acceptability and the ability to seek care: when individuals anticipate a concordant and culturally safe encounter,

they are more likely to engage with services. These preferences are diverse and context-dependent, rooted in cultural norms, gender roles, lived experience, and prior encounters with care.

Racial and ethnic concordance was consistently identified as a significant factor. Black women expressed a preference for Black mental health providers, anticipating greater empathy, respect, and understanding of their lived experiences particularly in the context of trauma (Ash et al., 2025). Migrant families similarly preferred providers from the same cultural background, both for cultural understanding and to overcome language barriers (Place et al., 2021; Hynie et al., 2022; Baierl et al., 2026). In group-based therapies, ethnic composition mattered alongside individual provider identity: ethnic minority individuals often felt singled out in mixed-cultural groups and reported greater comfort in culturally homogeneous settings (Wolfe et al., 2023). Shared identity between providers and young people also increased comfort and enhanced acceptability in child and adolescent mental health care (Woodgate et al., 2023).

Gender concordance emerged as particularly consequential for women from communities with strong gender norms. Female refugee patients reported greater openness and willingness to disclose sensitive issues when seen by female providers (Baierl et al., 2026), while the presence of male interpreters in therapy was identified as a significant barrier to communication (Dumke et al., 2024; Salameh et al., 2025). In some cases, husbands' rejection of male providers led women to forgo care altogether unless a female provider was available (Salameh et al., 2025). Gender dynamics within refugee families play a crucial role in shaping access, with many refugee girls and women facing significant constraints on their capacity to seek care independently, often requiring accompaniment by male family members (Yılmaz et al., 2025). Men from patriarchal cultural backgrounds tended to question the competence of female providers (Baierl et al., 2026). Gender preferences were also evident in group therapy contexts, where women experiencing problematic alcohol use preferred women-only groups due to communication style, safety concerns, and the risk of triggering underlying mental health conditions in mixed-gender settings (Wolfe et al., 2023). Some children similarly expressed preferences for same-sex providers, citing increased comfort and trust (Woodgate et al., 2023). LGBTQ+ individuals expressed a preference for mental health professionals who also identified as LGBTQ+, describing greater anticipated empathy, relatability, and understanding of their lived experience as reasons for this preference. However, this preference might become less necessary if therapeutic alliance were effectively achieved through consistently affirming and inclusive care practices, suggesting that concordance in identity functions partly as a proxy for the cultural safety that services should provide by default (Lowther-Payne et al., 2026).

Age concordance was noted among crack cocaine users, who frequently expressed a preference for older providers (Duopah et al., 2024).

Preference for professional expertise represented a further dimension of acceptability in youth mental health care. Being assigned to trainees or interns was frequently perceived as dismissive and reduced the acceptability of care, while access to experienced professionals was highly valued by young people and their families (Woodgate et al., 2023).

Availability of different types of service provision:

Acceptability is also shaped by the extent to which services are available in formats that align with individuals' preferences and circumstances. When preferred modalities of care are unavailable, acceptability is inherently constrained regardless of the quality of the service itself (Wolfe et al., 2023).

Individual, group-based or peer-led care delivery preferences varied considerably across populations. Peer-led group interventions demonstrated particular promise for LGBTQI+ communities, where peer-to-peer support fostered trust, normalised experiences, and created a sense of shared understanding that enhanced both acceptability and appropriateness (Broadway-Horner, 2024). Among individuals with problematic alcohol use, some valued group therapy for the sense of solidarity and shared experience it offered, while others found its acceptability reduced by concerns around limited individualised attention, confidentiality, social anxiety, or the presence of participants who were still drinking (Wolfe et al., 2023). For people experiencing homelessness, peer navigators with lived experience of homelessness enhanced acceptability by using shared experience to build empathy and mutual understanding, reducing feelings of judgement and exclusion that commonly characterise encounters with mainstream healthcare (Meda et al., 2025). The value of peer support workers from minoritised ethnic backgrounds was specifically highlighted as a source of hope and motivation, offering young people visible evidence that recovery is possible for someone who looks like them (Williams-Ridgway et al., 2026). The involvement of peer coaches with lived experience of severe mental illness (SMI) was identified as an approach to improving access to annual health checks, enabling individuals to set their own physical and mental health goals and supporting a sense of agency and ownership over the care process (Owens et al., 2025).

Telehealth and virtual mental health care introduced both opportunities and limitations. For migrant populations, virtual services offered a meaningful means of overcoming cultural and language barriers by enabling access to providers with relevant linguistic and cultural competencies not available locally (Hynie et al., 2022; 2023). However, reliance on text-based

communication and discomfort with camera use reduced acceptability for some users, and many still expressed a preference for in-person care despite valuing the availability of virtual options (Hynie et al., 2022). Similar ambivalence was documented in problematic alcohol use treatment, where telephone- and internet-based interventions were preferred by some, while others found in-person care more genuine and conducive to deeper therapeutic relationships (Wolfe et al., 2023). Remote delivery during COVID-19 presented a dual dynamic for LGBTQ+ participants. For some, telephone-based and video consultations offered meaningful anonymity that reduced stigma-related barriers and enabled greater openness, particularly for those concerned about being judged on their appearance or presentation. For others, remote delivery was incompatible with safe engagement, as living in unsupportive home environments including households where family members were unaware of their LGBTQ+ identity made it impossible to participate in sessions without fear of being overheard (Lowther-Payne et al., 2026).

Levels of service provision constituted a further dimension of preference. For problematic alcohol use, primary care was favoured by many for its therapeutic continuity, convenience, lower cost, and reduced stigma, while specialist services were valued by others for their perceived expertise. Inpatient programs were appreciated for formally acknowledging the severity of problematic alcohol use, though many participants regarded hospitalisation as a last resort and preferred outpatient care. Fear of hospitalisation was notably stronger among bisexual individuals compared to heterosexual participants, reflecting the compounding effect of stigma on acceptability (Wolfe et al., 2023).

For people experiencing homelessness, acceptability was strongly shaped by the relational climate of care encounters. Low-threshold, on-site services delivered in non-clinical environments through community-based service provision were perceived as safer and more welcoming than mainstream settings, fostering trust and open communication. Providing care in familiar, stigma-free spaces helped rebuild trust relationships with healthcare professionals and supported person-centred engagement that mainstream services frequently failed to offer (Meda et al., 2025).

Shared decision-making practices:

The degree to which individuals are involved in decisions about their own care shapes the acceptability of services in fundamental ways. Involving individuals in treatment decisions and offering flexibility such as the choice between in-person and telehealth formats fostered a sense of empowerment, responsibility, and independence, enhancing the acceptability of problematic alcohol use care (Wolfe et al., 2023). Conversely, paternalistic approaches,

traditional punitive intervention models, and overly controlling strategies undermined acceptability by positioning individuals as passive recipients rather than active participants in their own care (Wolfe et al., 2023).

Compulsory treatment and coercive practices:

Coercive practices within mental health systems represent a significant threat to acceptability, with consequences that extend well beyond the immediate encounter. Experiences of involuntary or forceful interventions such as physical restraint can be deeply traumatic, fostering lasting distrust in mental health and substance use services. Even the perceived threat of coercion may lead individuals to withhold information or disengage from care preemptively, while indirect exposure to such practices can be profoundly distressing for parents, generating feelings of helplessness, guilt, and anger (Kourgiantakis et al., 2023). Compulsory treatment is not distributed equally across the population: detention under the Mental Health Act was disproportionately common among unemployed individuals, those living alone or in supported housing, ethnic minorities particularly Black individuals and people from deprived or disadvantaged areas, reflecting the intersection of coercive practice with structural inequality (Lowther-Payne et al., 2023).

2.3.1.3. Availability and Accommodation

The scoping review findings indicate that availability and accommodation are shaped by a complex interplay of structural, organisational, and practical factors that extend well beyond the mere existence of services. While service availability, workforce capacity, and geographic distribution constitute foundational determinants, the reviewed evidence demonstrates that the presence of a service does not in itself guarantee access to it. Referral mechanisms, eligibility criteria, and gatekeeping practices can restrict entry even where services are formally available, creating a gap between provision and accessibility. Waiting times, themselves a product of service distribution, capacity constraints, and workforce shortfalls, further erode availability, and where delays are prolonged, they risk undermining the timeliness of care in ways that diminish its appropriateness and responsiveness to need. A recurring consequence of insufficient public sector capacity is the displacement of individuals toward private services, converting an availability problem into an affordability burden. Accommodation, in turn, extends beyond geographic reach to encompass the degree to which services fit within the realities of individuals' everyday lives: caregiving responsibilities, work obligations, and transportation constraints all shape whether a service that is available in principle can be accessed in practice, making alternative delivery models an important facilitating mechanism. Finally, the physical accessibility of service environments including their suitability for

individuals with mobility limitations or disabilities constitutes a further dimension of accommodation that determines whether services are genuinely reachable for all.

Availability and Accommodation Assessment Overview

- Service availability and capacity
- Proximity of services
- Workforce availability and distribution
- Waiting times
- Referral and coordination mechanisms
- Eligibility criteria for services
- Bureaucratic barriers to utilising care
- Alternative care delivery models
- Physical accessibility of health facilities

Service availability and capacity:

A foundational determinant of availability and accommodation is whether sufficient services exist to meet population need, and whether existing services have the capacity to absorb demand. The two dimensions are closely linked: even where services formally exist, inadequate capacity can render them functionally inaccessible.

Shortfalls in availability of mental health services were pervasive across the reviewed literature. Specialised mental health services for refugees and asylum seekers were reported as critically insufficient, resulting in long waiting times and scheduling difficulties, compounded by chronic underfunding even within high-income countries (Dumke et al., 2024). For trans-gender and gender diverse (TGD) individuals in Kerala, access to mental health counselling services remained severely limited. Government hospitals were perceived as too crowded to allow adequate counselling time, while private facilities were prohibitively expensive (Fernandez & Gaitonde, 2026) The scarcity of specialist child and youth mental health services was similarly widespread, with culturally adapted provision even more limited, contributing to prolonged waits and unmet need (Kourgiantakis et al., 2023; Woodgate et al., 2023). The absence of dedicated perinatal mental health services further constrained availability for postpartum populations (Viveiros & Darling, 2019), while gaps in problematic alcohol use treatment were particularly acute in rural areas and for individuals with comorbidities requiring specialised care (Wolfe et al., 2023).

Even where services existed, insufficient service capacity frequently undermined their accessibility. As crack cocaine use increased in some settings, demand outpaced supply, rendering previously accessible services progressively harder to reach (Duopah et al., 2024). COVID-19 restrictions further reduced capacity through unexpected closures and extended waiting times across different population groups (Kourgiantakis et al., 2023; Lowther-Payne et al., 2026). NHS mental health services, already under-resourced and under-funded prior to the pandemic, were substantially worsened by temporary service closures, delayed restarts, and shifts to remote delivery formats, all of which compounded existing capacity limitations (Lowther-Payne et al., 2026). Where public capacity was exhausted for youth mental health and addiction services in Ontario, families were pushed toward private services, converting an availability problem into an affordability burden (Kourgiantakis et al., 2023). Systemic capacity shortfall was experienced as a fundamental barrier for all patients in Germany, but posed disproportionately greater challenges for migrants due to the limited availability of services in languages other than German and the excessive demand placed on specialised refugee-focused services (Baierl et al., 2026).

A further concern regarding availability and accommodation relates to the treatment availability within existing services. Even where services exist and maintain sufficient capacity, shortages in treatment availability can render them inaccessible to specific populations. While methadone treatment was readily accessible for heroin use, no equivalent pharmacological or structured treatment existed for crack cocaine use, leaving a distinct population without a viable treatment pathway despite the presence of broader addiction services (Duopah et al., 2024).

Proximity of services:

The geographic proximity of services to the populations they serve is a critical determinant of availability and accommodation and is directly shaped by how services are distributed across communities. Uneven geographic distribution not only limits overall service availability but reduces physical proximity for those who are already most disadvantaged, compounding existing barriers to access.

Evidence from the reviewed literature consistently highlighted proximity as a practical obstacle across diverse population groups. Social farms in England were disproportionately located in less deprived areas, and with the majority of attendees traveling by car, people in vulnerable situations facing transportation barriers were effectively excluded (Bartlett et al., 2025). In rural areas, distance and uneven service distribution emerged as major barriers to mental healthcare access for LGBTQI+ populations (Maria et al., 2025), while service location posed

additional challenges for people experiencing homelessness (McNeill et al., 2022). A disparity in therapy provision between urban and rural areas left migrants housed in remote refugee shelters with limited access to suitable care, with long distances and inadequate transportation options compounding geographic isolation for this group (Baierl et al., 2026). Syrian refugee women described avoiding clinic attendance because of the distance involved and the difficulty of navigating multiple bus connections (Salameh et al., 2025). For individuals with problematic alcohol use, service location was a consistently reported barrier, particularly for those in rural or peripheral areas and for individuals with physical disabilities or co-occurring mental health conditions (Wolfe et al., 2023).

Workforce availability and distribution:

Workforce availability and distribution shapes the extent to which services that formally exist can be practically accessed. Shortfalls in staffing levels, uneven geographic distribution of providers, and gaps in specialist and interpreter capacity all constrain the system's ability to translate service provision into genuine access, particularly for marginalised and geographically isolated populations.

Shortages in the availability and distribution of service providers were documented across multiple care contexts. Staffing deficits in social farms limited access for people in vulnerable situations (Bartlett et al., 2025), while long-term underfunding of addiction services left staffing levels inadequate to respond to growing and increasingly complex needs, including dual diagnoses, as crack cocaine use became more widespread (Duopah et al., 2024). Geographic distribution compounded these shortfalls: in rural areas of Australia, dementia rehabilitation was constrained by a scarcity of providers with adequate training (Layton et al., 2024), and in rural settings more broadly, shortages of qualified professionals limited LGBTQI+ populations' access to mental health care (Maria et al., 2025). Staff shortages in problematic alcohol use services similarly contributed to prolonged waiting times (Wolfe et al., 2023). For specialist eating disorder services, staff shortages and capacity constraints compounded by funding limitations and high clinical workloads restricted the ability to provide early intervention, family support, and culturally adapted care, with some services already operating beyond capacity and concerned about their ability to manage increased referral numbers if access barriers were reduced (Williams-Ridgway et al., 2026).

Interpreter or language-concordant provider availability constituted a distinct but related workforce gap. Shortages of trained interpreters and limited funding for translation services

reduced refugees' ability to reach appropriate mental health care (Dumke et al., 2024; Salameh et al., 2025), and in public mental health services, interpreter shortages sometimes left Syrian refugee women bearing the cost of interpretation themselves (Salameh et al., 2025). Beyond interpreters, the scarcity of psychotherapists able to deliver care in languages other than German or English, particularly in languages such as Farsi, meant that the few available language-concordant providers were rapidly overwhelmed, generating extended waiting times for migrant populations whose linguistic needs could not be met through mainstream services (Baierl et al., 2026).

Underlying many of these shortfalls is the chronic underinvestment in mental health services: as crack cocaine use increased, funding failed to keep pace with demand, leaving providers expected to manage complex caseloads without additional resources (Duopah et al., 2024), while funding cuts were directly linked to staff shortages and prolonged waiting times in problematic alcohol use services (Wolfe et al., 2023). In low- and middle-income countries, which host the majority of the world's forcibly displaced children, underfunded systems with mental health provider rates far below those of high-income countries represent a foundational structural barrier to availability (Yılmaz et al., 2025).

Waiting times:

Prolonged waiting times represent a critical barrier to availability and accommodation, frequently functioning as a point of disengagement before care has even begun. Across the reviewed literature, extended waits were consistently linked to staff shortages, insufficient funding, and limited service capacity, and their consequences extended beyond inconvenience: long waiting periods discouraged continued engagement, led to loss of motivation, and in some cases resulted in worsening of the very conditions for which care was sought. Long waiting lists and months-long delays for specialist appointments, with services operating only once or twice per week in some settings, represented significant availability constraints that led to disengagement and resignation among asylum seekers awaiting care (Wehbe et al., 2026). Staff shortages and limited specialised service availability contributed to prolonged waiting periods for refugees and asylum seekers (Dumke et al., 2024), while insufficient funding, low capacity, and inadequate staffing in crack cocaine treatment services meant that long waits and under-resourced facilities often discouraged individuals from continuing treatment (Duopah et al., 2024). Youth requiring specialised or culturally adapted services faced particularly extended wait lists, with delays described as discouraging and frequently leading to disengagement (Kourgiantakis et al., 2023; Place et al., 2021). For families, the consequences were equally tangible: parents reported that delays in specialist

assessments often meant services were accessed only after their child's difficulties had already subsided (Woodgate et al., 2023). Where public sector waiting times were excessive, individuals were pushed toward private services, converting an availability problem into an affordability burden (Schwarz et al., 2022). Prolonged waiting times in problematic alcohol use services, linked to overburdened systems, staff shortages, and funding cuts, were similarly cited as a consistent barrier to accessibility (Wolfe et al., 2023). Prolonged waiting times during COVID-19 had a deteriorating effect on participants' mental health, with the period of waiting itself representing a significant gap in care during which conditions worsened (Lowther-Payne et al., 2026). The absence of interim or bridging mental health interventions during waiting periods further compounded the impact of delays, leaving individuals without any support during periods of acute need (Wehbe et al., 2026).

Referral and coordination mechanisms:

Effective referral and coordination mechanisms are essential to ensuring that individuals can move through the system without facing unnecessary barriers, delays, or the burden of navigating fragmented care on their own. Where such mechanisms are absent or poorly functioning, access is undermined even when services formally exist. Multi-layered gatekeeping systems in which social workers and general practitioners served as sequential gatekeepers to specialised mental health care were associated with low referral rates, driven by uncertainty about referral pathways, the absence of clear formal guidelines for asylum seeker populations (Wehbe et al., 2026). Unclear government policies and poor collaboration among providers fragmented mental health care for refugees and asylum seekers (Dumke et al., 2024), while siloed service delivery in domestic violence support placed the burden of coordination on individuals themselves, creating isolation and overwhelm (Hollingdrake et al., 2023). Similarly fragmented service structures across health and social care sectors complicated access pathways for asylum seekers, with the separation of authority gatekeeping functions from clinical gatekeeping creating multiple sequential barriers that individuals had to navigate before reaching specialised mental health care (Wehbe et al., 2026). Pathways to mental health services were highly variable, siloed from heart failure care, and inconsistently applied, with access depending in part on place of residence and the quality of the relationship with a primary care physician (Shah et al., 2025). For survivors of sexual assault, sexual assault referral centres (SARCs) represent a critical potential entry point into mental health care; however, inadequate referral mechanisms out of SARCs into mental health services undermine this integrative function (Rogers et al., 2026) .Some individuals experienced rapid connections to psychiatric services while others faced significant difficulties booking appointments and long waiting lists, illustrating a structural inequity in which the

access journey was shaped by circumstance rather than need (Shah et al., 2025). Fragmented services and unclear referral pathways were similarly identified as barriers in youth mental health, addiction, and perinatal care (Kourgiantakis et al., 2023; Viveiros & Darling, 2019). In gatekeeping systems, short consultations and inconsistent provider contact hindered access to dementia rehabilitation, with patients frequently relying on an assertive and knowledgeable care partner to navigate and advocate on their behalf (Layton et al., 2024). For minoritised ethnic young people with eating disorders, the requirement for a GP referral to access specialist services functioned as a critical bottleneck, with eligibility for referral shaped by diagnosis type, symptom visibility, and weight-based thresholds that disproportionately excluded those with presentations less consistent with the dominant clinical stereotype (Williams-Ridgway et al., 2026). The absence of structured referral and counter-referral systems contributed to delays in ADHD diagnosis (Martínez-Jaime et al., 2024), while referrals to specialist mental health care for SSSD patients were weakened by staff reluctance, stigma, and limited resources (McCollum et al., 2022). For people experiencing homelessness, poor inter-provider communication and unclear responsibilities further complicated already complex referral pathways (McNeill et al., 2022). Migrant families frequently found referral processes unfamiliar, intimidating, and discouraging (Place et al., 2021), and in the Canadian context, securing a referral from a primary care physician a prerequisite for specialist mental health care was described by parents as neither easy nor straightforward (Woodgate et al., 2023). In problematic alcohol use services, fragmented and time-consuming referral pathways resulting from poor inter-provider coordination reduced accessibility for service users (Wolfe et al., 2023).

Beyond referral pathways, the practical mechanics of appointment systems and contact modalities constitute an equally important dimension of coordination. Inflexible systems characterised by reliance on phone calls with long hold times, the absence of alternative communication channels, and expectations that unwell individuals return calls promptly created barriers to reaching care for young people (Kourgiantakis et al., 2023). Older adults with dementia found online booking systems and automated phone menus difficult to navigate without assistance (Layton et al., 2024). For people experiencing homelessness, rigid appointment times were incompatible with unpredictable schedules and transport difficulties, with flexible time-block scheduling identified as a more realistic alternative (McNeill et al., 2022). Migrant families balancing multiple competing demands similarly reported inflexible scheduling as a barrier (Place et al., 2021). Inconvenient service hours limited access for employed individuals, and for those with problematic alcohol use and concurrent mental health conditions, rigid hours further reduced access during crisis periods (Wolfe et al., 2023). At the first point of contact, systemic barriers such as unanswered calls and automated messages

indicating two-to-three-month waiting periods discouraged engagement before it had begun (Wolfe et al., 2023).

For people experiencing homelessness, case management professionals and health navigators played a critical role in orienting individuals across and towards care services, coordinating appointments, connecting individuals to social services, and facilitating continuity across fragmented care pathways (Meda et al., 2025).

Integrated and co-located services including one-stop models embedding health, social, and housing support within shared spaces reduced navigational burden and promoted continuity, treatment adherence, and follow-up (Meda et al., 2025). However, integrated care initiatives introduced implementation challenges including coordination costs, difficulties sharing information across organisations, and conflicting responsibilities among partners (Meda et al., 2025).

Eligibility criteria for services

Eligibility criteria function as gatekeeping mechanisms that can exclude individuals from care despite the formal availability of services. Across the reviewed literature, overly restrictive criteria consistently prevented some of the most vulnerable populations from accessing the services they needed. Strict requirements imposed on crack cocaine users including demands to reduce or cease other substances such as methadone or Xanax, or to be drug-free prior to entry excluded polydrug users and created impractical conditions that generated long delays before care could begin (Duopah et al., 2024). Abstinence-based eligibility requirements similarly limited the availability of mental health services for people experiencing homelessness (McNeill et al., 2022). Strict age-based criteria risked excluding migrant youth who could otherwise benefit from available services (Place et al., 2021), while restrictive criteria prevented some women from accessing perinatal mental health services (Viveiros & Darling, 2019). A particularly acute form of exclusion emerged for individuals with co-occurring conditions: requirements for abstinence from substance use as a precondition for mental health therapy, or for stable mental health as a precondition for problematic alcohol use treatment, effectively barred those whose complex needs were greatest (Wolfe et al., 2023). For minoritised ethnic individuals, referral likelihood varied by diagnosis and clinical presentation, with those presenting with binge-type eating disorders or ARFID less likely to be referred than those with anorexia nervosa, partly reflecting weight-based referral thresholds and commissioning arrangements that limited some services to particular diagnoses. Healthcare professionals advocated for more comprehensive services accepting wider

presentations and engaging in earlier intervention, as well as increased flexibility in referral routes including the acceptance of self-referrals (Williams-Ridgway et al., 2026).

Bureaucratic barriers to utilising care:

Legal and administrative requirements can create concrete barriers to reaching care even where services are formally available. Syrian refugee women who had been relocated found that service entitlement tied to province-specific identification cards prevented them from accessing care, illustrating how administrative eligibility conditions can sever the link between service availability and actual access (Salameh et al., 2025). Asylum seekers in Bavaria were required to obtain a treatment certificate from asylum authorities before each medical appointment, a bureaucratic prerequisite that created significant practical barriers to accessing care particularly for individuals experiencing mental health difficulties that already impaired their capacity to manage administrative processes independently (Baierl et al., 2026). Legal status and administrative restrictions tied to the asylum application process directly constrained the ability to reach care, with some countries requiring explicit governmental approval before asylum seekers could access or receive coverage for mental health services, creating a bureaucratic gate between acknowledged need and actual service use (Wehbe et al., 2026).

Alternative care delivery models:

A further dimension of availability and accommodation concerns the extent to which services can be delivered in ways that fit within the realities of individuals' everyday lives. Caregiving responsibilities, work obligations, transportation barriers, and geographic distance all constrain individuals' ability to attend conventional in-person services and where alternative delivery models are unavailable, these practical demands effectively exclude those who cannot reorganise their lives around fixed service arrangements. Virtual and telehealth models have demonstrated particular potential in this regard. Women frequently preferred virtual mental health care precisely because it allowed them to engage with services without having to navigate distance, transportation, or competing caregiving and work obligations (Ash et al., 2025). The flexibility afforded by virtual services also enabled more frequent check-ins and allowed staff to accompany clients to appointments when needed, proving especially beneficial for women with childcare responsibilities (Hynie et al., 2022). For people experiencing homelessness, digital healthcare interventions including telehealth visits, text messaging, and mobile applications offered a means of delivering care that reduced inappropriate emergency department admissions and provided real-time health information and service navigation support (Meda et al., 2025). Similar benefits were documented in

problematic alcohol use treatment, where telehealth and internet-based services were preferred for overcoming geographic and transportation barriers, saving time, and removing childcare challenges during treatment participation (Wolfe et al., 2023). Housing instability and employment pressures frequently require refugee youth to assume financial responsibilities for their families, directly reducing capacity to attend conventionally delivered services. Reviews highlight the need for flexible delivery approaches including childcare provision, transportation services, home visits, tele-mental health, e-counselling, and mobile applications as strategies to extend reach and reduce practical barriers to attendance (Yılmaz et al., 2025). For low-SES individuals with severe mental health conditions, telehealth reduced transportation costs and increased scheduling flexibility, yet preparing for technology-mediated care including acquiring devices, learning platform-specific procedures, and securing private spaces added complexity that counteracted these benefits for those with limited digital resources (Stone & Veinot, 2026). Reasonable adjustments including telephone contact until individuals felt able to attend in person, home visits by physician associates, flexible appointment lengths tailored to the individual's tolerance, afternoon appointments, and set times and days for repeated attendance were identified as mechanisms for improving accommodation for people living with SMI (Owens et al., 2025).

Physical accessibility of health facilities:

The physical accessibility of healthcare environments constitutes a distinct dimension of availability and accommodation that is frequently overlooked in service design. Where facilities lack adaptations for individuals with mobility limitations or physical disabilities such as wheelchair-accessible entrances, lifts, or platforms in-person care becomes physically unreachable regardless of geographic proximity or service availability. Older adults with comorbidities and mobility needs faced limited access to mental health facilities due to insufficient physical adaptations (Schwarz et al., 2022), while the absence of wheelchair-accessible infrastructure similarly constrained in-person treatment access for individuals with problematic alcohol use and physical disabilities (Wolfe et al., 2023).

2.3.1.4. Affordability

The scoping review findings highlight that affordability operates across multiple and interconnected layers, extending well beyond the visible cost of a service at the point of use. At its most immediate, affordability is shaped by the direct costs individuals incur when accessing care determined by the structure of health financing systems, the breadth and depth

of insurance coverage, and the degree to which public provision absorbs costs that would otherwise fall on individuals. Yet direct costs represent only part of the financial burden: indirect costs including transportation, childcare, technology-related expenses, and interpreter fees add further layers of expenditure that can render nominally affordable services practically out of reach. Opportunity costs compound this picture, as time taken away from paid work to attend appointments carries economic consequences that are particularly acute for those with precarious employment or caregiving responsibilities. Where financial protection mechanisms are absent or inadequate, these cumulative costs intersect with vulnerability in ways that produce deeply inequitable patterns of access. Affordability is also closely tied to the dimensions of availability and accommodation: insufficient public sector capacity pushes individuals toward private providers, converting a supply-side shortfall into a financial burden. Poor geographic distribution of services generates transportation costs that add a further indirect financial layer, disproportionately affecting those in rural or peripheral areas. Similarly, workforce gaps in interpreter provision translate directly into out-of-pocket interpreter fees, illustrating how barriers do not operate in isolation but accumulate across the access journey, with shortfalls in one dimension generating costs in another.

Affordability Assessment Overview:

- Direct cost of care
- Indirect cost of care
- Opportunity costs of care
- Financial protection mechanisms

Direct cost of care:

Direct costs constitute a primary affordability barrier across the reviewed literature, shaped by the structure of health financing systems, the scope of insurance coverage, and the extent to which public provision meets population need. A recurring and consequential dynamic is the relationship between public sector capacity and private care utilisation: where public services are unavailable, under-resourced, or subject to prolonged waiting times, individuals are effectively pushed toward private providers incurring substantial out-of-pocket costs that fall disproportionately on those least able to bear them (Kourgiantakis et al., 2023; Schwarz et al., 2022; Woodgate et al., 2023). Virtual mental health care has shown potential to partially offset

these direct cost burdens, with mutual aid groups offering online care for problematic alcohol use reported to lower direct costs of care (Wolfe et al., 2023).

Use of private care emerged as a key driver of direct costs: in some contexts, private provision was not a matter of preference but the only available option, as dementia social farms and allied health services in Australia were largely absent from the public sector (Bartlett et al., 2025; Layton et al., 2024). In problematic alcohol use services, those who could pay privately accessed more timely and specialised care, while Indigenous people were left choosing between inadequate public treatment and unaffordable private costs, and Hispanic men perceived effective care as reserved for those who could pay (Wolfe et al., 2023). Even where free or low-cost public options existed, concerns about quality and continuity sometimes led individuals to prefer private providers, further increasing out-of-pocket expenditure (Ash et al., 2025).

The public or private provision of care thus shaped affordability at a structural level: exclusion of problematic alcohol use services from public coverage, combined with low insurance benefits, led to higher out-of-pocket costs (Wolfe et al., 2023), while publicly funded and community-based primary care services were identified as more affordable, reducing both direct and indirect costs (Wolfe et al., 2023). Where external funding was available, it offered meaningful relief: grant support made social farm services free of charge for 24% of people with dementia (Bartlett et al., 2025), and services funded through mechanisms such as the U.S. Health Resources and Services Administration were reported to reduce financial barriers and improve access (Wolfe et al., 2023).

The breadth of insurance coverage was equally determinative. Direct costs arose most acutely in its absence, compounded by the chronic nature of many mental health conditions requiring long-term specialist care (Place et al., 2021). For transgender and gender-diverse (TGD) individuals in Kerala, 84 percent of survey respondents lacked any form of insurance, leaving them without financial protection against healthcare costs. Despite health insurance being formally included in the Kerala Transgender Policy, its implementation remained pending at the time of the study illustrating a critical gap between policy commitment and practical financial protection that disproportionately burdened an already economically marginalised population (Fernandez & Gaitonde, 2026). Legal entitlement further shaped coverage access: legal status and administrative restrictions limited insurance entitlement for migrants, refugees and asylum seekers, particularly during asylum application processes (Dumke et al., 2024; Salameh et al., 2025; Baierl et al., 2026; Wehbe et al., 2026). Where insurance existed, the depth of insurance coverage frequently fell short of actual need: Medicare rebates for

psychology services were capped at ten sessions in Australia, leaving ongoing needs unmet for women experiencing domestic violence (Hollingdrake et al., 2023), while public funding structures built around short-term interventions failed to align with the progressive and long-term needs of people with dementia (Layton et al., 2024). The underinsurance of mental healthcare in Canada, which relies primarily on publicly funded psychiatric services, left people living with heart failure dependent on third-party insurance or out-of-pocket expenditure to access psychological services (Shah et al., 2025). Limited insurance coverage similarly constrained affordability in perinatal mental health care (Viveiros & Darling, 2019) and youth mental health services, where both public and private health care coverage offered inadequate protection against out-of-pocket costs (Woodgate et al., 2023; Kourgiantakis et al., 2023). In contrast, the universal healthcare system in the UK ensured that affordability was rarely a limiting factor even for vulnerable populations (Lowther-Payne et al., 2023).

Indirect cost of care:

Beyond direct service fees, indirect costs constitute a significant and often overlooked dimension of affordability, encompassing the financial burdens associated with accessing care rather than receiving it. Indirect costs including transportation and childcare, accumulated alongside direct service costs to produce financial burdens that exceeded many asylum seekers' capacity to pay, reinforcing the barrier created by formal insurance gaps (Wehbe et al., 2026). Virtual mental health care has emerged as a meaningful strategy for reducing these indirect costs: women frequently preferred virtual delivery precisely because it eliminated transportation and childcare expenses (Ash et al., 2025), refugee newcomers similarly valued online services as a way to avoid travel costs (Hynie et al., 2022), and mutual aid groups offering online care for problematic alcohol use were reported to lower both direct and indirect costs of care (Wolfe et al., 2023). The inflexibility of service delivery including the absence of childcare provision, transportation support, and home visiting generates additional hidden costs that function as indirect financial barriers for refugee families (Yılmaz et al., 2025). Limited availability of telehealth and online mental health options similarly increases indirect costs by requiring in-person attendance, with associated travel and missed-work costs falling disproportionately on economically constrained families (Yılmaz et al., 2025).

Transportation costs represented a consistently reported indirect barrier: long distances between residences and mental health providers generated additional travel expenses for refugees and asylum seekers (Dumke et al., 2024; Hynie et al., 2022; Salameh et al., 2025), while for LGBTQI+ individuals in rural areas, the need to travel to more inclusive, lower-stigma regions in search of gender-affirming care imposed a further financial burden (Maria et al.,

2025). Transportation costs were similarly identified as a barrier to the affordability of problematic alcohol use treatment (Wolfe et al., 2023).

Childcare expenses constituted a related indirect barrier: for women with caregiving responsibilities, attending in-person appointments required arranging and financing childcare, adding a further financial layer to the cost of seeking care (Ash et al., 2025).

Technology-related costs emerged as an indirect barrier specific to virtual care modalities: expenses associated with devices, data plans, and reliable internet access limited the feasibility of telehealth for low-income refugee newcomers (Hynie et al., 2022; 2023) and for LGBTQI+ individuals in rural areas, for whom the cost of required devices undermined the affordability of what might otherwise represent an accessible alternative (Maria et al., 2025). For low-SES individuals with severe mental health conditions, financial constraints limited access to the devices, data plans, and internet connectivity required for technology-mediated care, effectively introducing a new indirect cost layer that reduced the affordability of telehealth for those who lacked adequate technological infrastructure (Stone & Veinot, 2026).

Interpreter fees constituted a further indirect cost, particularly where public interpretation services were insufficient or insurance coverage for interpretation services were inconsistent: Refugees and asylum seekers who required interpretation were sometimes left bearing the cost themselves, directly hindering access to mental health care (Salameh et al., 2025).

Opportunity costs of care:

A further dimension of indirect affordability is the opportunity cost associated with attending mental health care. For many individuals, seeking care requires taking time away from paid work, generating an economic trade-off that can render care effectively unaffordable even when service fees are low or absent (Ash et al., 2025; Place et al., 2021). For many women, this tension was particularly acute, manifesting as a direct choice between attending an appointment and working a shift to support their families a constraint that positioned care-seeking itself as a financial sacrifice (Ash et al., 2025) For asylum seekers working long hours in precarious employment to cover basic living costs, the opportunity cost of attending appointments represented a concrete and consequential barrier to care-seeking (Wehbe et al., 2026).

Financial protection mechanisms:

The availability of financial protection mechanisms plays an important role in determining whether individuals can afford to access care. Where such mechanisms are absent or inadequate including limited financial aid for out-of-pocket payments the affordability of mental health care is substantially reduced, as documented among Syrian refugee women who faced direct costs without sufficient support to offset them (Salameh et al., 2025). Complex eligibility criteria and burdensome application procedures for government assistance programs limit access to financial support, while fear of deportation deters refugee families from seeking publicly provided services even where available at low cost (Yılmaz et al., 2025).

2.3.1.5. Appropriateness

The scoping review findings indicate that appropriateness extends well beyond the clinical match between a diagnosis and a treatment protocol. For mental health care to be truly appropriate, it must be responsive not only to individuals' mental health needs but to the full complexity of their lives encompassing their social circumstances, cultural identities, linguistic needs, caregiving responsibilities, and personal goals. This breadth of responsiveness requires both individual-level mechanisms, such as patient-centred care, shared decision-making, and meaningful caregiver involvement, and systemic conditions, including clinical quality, service integration, and care continuity, that together enable services to address need in a holistic and sustained manner.

Timeliness and continuity emerge as particularly critical dimensions of appropriateness, directly linked to the availability and accommodation of services: delays rooted in capacity constraints and fragmented referral systems do not merely inconvenience individuals but actively compromise the appropriateness of care by the time it is received. Similarly, the absence of integrated pathways across mental health, substance use, physical health, and social care produces fragmented responses that fail to reflect the intersecting nature of many individuals' needs.

A further layer of complexity arises from the cross-cutting nature of certain determinants. Stigma and discrimination, interpersonal quality of care, and cultural responsiveness each operate across multiple dimensions of the access journey: they undermine acceptability by deterring initial and continued help-seeking, and simultaneously compromise appropriateness by obstructing the therapeutic relationship and reducing engagement. The same encounter that feels unacceptable to an individual also renders care less appropriate not because the treatment itself is clinically wrong, but because the relational and cultural conditions necessary for it to be effective are absent. In this sense, appropriateness cannot be evaluated in isolation

from the dimensions that precede it; it is both shaped by and feeds back into the broader access trajectory.

Appropriateness Assessment Overview:

- Need responsiveness of care
- Clinical quality of care
- Provider workload and patient contact time
- Continuity of care
- Integration across services
- Consent, privacy, and confidentiality regulations
- Care setting and service environment
- Stigma and discrimination against people in vulnerable situations
- Interpersonal quality of care
- Cultural responsiveness of care
- Caregiver involvement and support
- Peer-led services and peer support groups
- Collecting patient-reported experiences

Need responsiveness of care:

Need responsiveness captures the degree to which care is designed and delivered in ways that genuinely address the actual needs of those seeking it. Across the reviewed literature, gaps in responsiveness emerged as a pervasive barrier to appropriateness, operating at multiple levels from the interpersonal quality of individual encounters to the structural design of care pathways and service systems.

At the interpersonal level, dismissive attitudes, failure to take symptoms seriously, and lack of respect undermined women's sense that care was tailored to their needs, at times resulting in inappropriate or poor outcomes (Ash et al., 2025). Limited provider knowledge about refugee populations' needs and entitlements, combined with a tendency to regard refugees as difficult patients, produced care that was poorly attuned to their actual circumstances (Dumke et al., 2024). Services operating within heteronormative frameworks that medicalise sexual minority identities while overlooking intersectional dimensions of identity in what has been described as "intersectional washing" similarly failed to recognise and respond to the real needs of service users (Broadway-Horner, 2024). Appropriate care for people experiencing homelessness was found to extend beyond traditional biomedical models, requiring bio-psychological approaches and trauma-informed service design that respond to the

intersecting medical, social, psychological, and housing needs of this population. Services that tailored care to the complexity of each individual's situation including intensive case management integrating medical, social, and psychological support achieved a higher degree of person-centred appropriateness than standardised clinical models (Meda et al., 2025).More broadly, limited responsiveness to the specific needs of diverse population groups resulted in lower appropriateness of mental health services across a wide range of vulnerable populations, including individuals with disabilities, gender-diverse people, pregnant or postpartum women, ethnic minorities, and those in contact with the criminal justice system (Lowther-Payne et al., 2023).

Trauma-related expertise constituted a specific gap in responsiveness for refugee populations. Uncertainty in identifying and treating trauma-related disorders led some providers to feel overwhelmed when confronted with patients' traumatic experiences, reducing their engagement and limiting the appropriateness of care delivered (Dumke et al., 2024). The absence of trauma-informed and culturally responsive models of care was identified as a fundamental gap in appropriateness, with providers' limited training in these approaches directly reducing the clinical responsiveness and therapeutic effectiveness of encounters (Wehbe et al., 2026). Existing trauma research disproportionately focuses on singular traumatic events, failing to address the diverse and chronic challenges experienced by refugee children, while individually focused pathology models overlook the socio-economic and ecological factors shaping their mental health (Yılmaz et al., 2025)

Responsiveness to comorbid conditions represented a further structural deficit. Crack cocaine treatment services failed to account for polydrug use patterns, requiring users to address each substance separately despite overlapping use (Duopah et al., 2024). Dual diagnosis, the co-occurrence of mental health and substance use conditions, was similarly poorly accommodated: treatment services frequently failed to integrate responses to both conditions, producing fragmented care pathways and leaving many without meaningful options (Duopah et al., 2024). For young people, the separation of mental health and substance use services was particularly problematic, contributing to inadequate and incomplete care for those with co-occurring disorders (Kourgiantakis et al., 2023).

Treatment availability gaps further constrained responsiveness: while methadone treatment was readily accessible for heroin use, no equivalent services existed for crack cocaine, highlighting the system's failure to keep pace with emerging and shifting patterns of need (Duopah et al., 2024).

Timeliness of care emerged as a critical dimension of responsiveness across multiple population groups. Limited facility capacity led to prolonged waiting times, delaying urgent and specialised care for young people with substance use disorders and contributing to disengagement (Kourgiantakis et al., 2023). In gatekeeping-based systems, inconsistent provider contact and brief consultations delayed timely referral to dementia rehabilitation particularly consequential for a progressive condition where delays compound harm (Layton et al., 2024). Weak referral systems extended diagnostic wait times for children with ADHD, with girls and children with siblings less likely to receive timely diagnoses (Martínez-Jaime et al., 2024). Delays in accessing mental health services frequently meant that care was received only after acute deteriorations in health had already resolved, representing a missed opportunity for clinicians to recognise the connection between mental health status and heart failure and for individuals to receive timely support during periods of greatest need (Shah et al., 2025). In perinatal care, long waits and the practice of requiring continuity of carer as a prerequisite for raising mental health concerns delayed timely discussion and support (Viveiros & Darling, 2019). For families of children with mental health needs, delays frequently meant that services were accessed only after conditions had either deteriorated or subsided, with parents emphasising the need for interim supports such as school-based peer groups, mental health education, and family services to bridge the gap during waits for specialist care (Woodgate et al., 2023).

Gender-affirming care was identified as essential to appropriateness for sexually and gender diverse populations. Inadequate provider training in caring for lesbian, bisexual, gay, and gender-diverse individuals, combined with heteronormative assumptions, created missed opportunities and reduced engagement with care (Maria et al., 2025; Lowther-Payne et al., 2026). A related concern was the pathologisation of sexual identity: some LGBTQ+ individuals were offered sex therapy in response to disclosed asexuality rather than treatment for the mental health condition they had presented with, illustrating a form of need non-responsiveness in which provider assumptions about what requires fixing override attention to the individual's actual presenting need (Lowther-Payne et al., 2026).

Patient-centredness was consistently identified as lacking in service design and delivery. Youth mental health and addiction services frequently relied on standardised, scripted approaches rather than individualised care, diminishing trust and perceived responsiveness (Kourgiantakis et al., 2023). The absence of mid-intensity options such as day programs and intensive outpatient care produced a binary system in which young people were either hospitalised or offered minimal support, with both frequently deemed inappropriate (Kourgiantakis et al., 2023). Dementia rehabilitation models often failed to accommodate

cognitive diversity or respond to patients' complex and evolving needs (Layton et al., 2024), while older adults with multimorbidity faced limited provider expertise in managing complex drug regimens, risking premature treatment discontinuation (Schwarz et al., 2022). In problematic alcohol use treatment, responsiveness was shaped by the alignment between program goals and individuals' personal goals: rigid or mismatched objectives reduced engagement, whereas flexible programs supporting multiple pathways including both abstinence and moderation were more acceptable and sustaining (Wolfe et al., 2023). For underhoused individuals, inpatient treatment that addressed broader social needs including stability and relief from daily hardship reflected a more holistic form of responsiveness (Wolfe et al., 2023)

Shared decision-making emerged as a facilitating mechanism for responsiveness. Involving individuals in care decisions and offering flexibility in treatment pathways promoted empowerment and independence, improving the alignment between care and individual needs (Wolfe et al., 2023). For minoritised ethnic young people with eating disorders, person-centred treatment in which individuals take an active role in developing their care plan and treatment is tailored to their narrative, cultural background, and understanding of their condition was identified by healthcare professionals as essential for ensuring patients feel understood and for enhancing engagement (Williams-Ridgway et al., 2026). People living with heart failure expressed a desire for choice across dimensions of care including provider type, delivery mode, and method, as well as the ability to disengage from treatment if desired (Shah et al., 2025).

Community involvement in service design emerged as a another facilitating mechanisms for cultural and contextual responsiveness. Traditional top-down approaches in which professionals and policymakers dictate service structures frequently fail to meet the cultural and contextual needs of refugee populations. Reviews emphasise the meaningful involvement of refugee communities in service design and evaluation as a prerequisite for building care that is genuinely responsive to the lived experiences of those it serves, with co-produced services more likely to be experienced as trustworthy and appropriate (Yılmaz et al., 2025).

Responsiveness to intersecting needs constituted a further dimension of need non-responsiveness, often rooted in limited cultural responsiveness and the absence of gender-concordant care. Some female migrants and gender nonconforming participants reported being misdiagnosed or not taken seriously by providers, reflecting limited provider familiarity with the specific clinical presentations and intersecting vulnerabilities of migrant populations (Baierl et al., 2026).

Clinical quality of care:

Clinical quality constitutes a distinct dimension of appropriateness, shaped by the competence, evidence base, and accountability of care delivery. For LGBTQI+ populations, clinical quality is undermined by the absence of a robust evidence base for effective psychological therapies: sexual minority participants are frequently excluded from studies or drop out early for instance during disclosure of monitoring data resulting in insufficient evidence from randomised controlled trials and quantitative research to guide appropriate care (Broadway-Horner, 2024). In child and adolescent mental health care, psychologists sometimes retained children with suspected ADHD in therapy without facilitating referrals to specialist services, preventing timely diagnosis and appropriate treatment (Martínez-Jaime et al., 2024). For people experiencing homelessness, unmanaged medication side effects reduced engagement and lowered the quality of care, with lasting consequences for future care acceptability (McNeill et al., 2022). In perinatal care, midwives frequently ranked suicide risk assessment and psychiatric evaluation among the least important clinical skills, while the referral of women with mild concerns to higher levels of care reflected inappropriate resource allocation and limited clinical quality (Viveiros & Darling, 2019). Parents of children with mental health needs questioned the appropriateness and quality of care when they observed little or no improvement, noting that providers sometimes overstated progress without real change raising concerns about clinical accountability (Woodgate et al., 2023)

Provider workload and patient contact time:

The amount of time available for patient appointments was identified as a critical determinant of appropriateness, particularly for migrants whose specific needs including managing bureaucratic processes and communication challenges required longer consultations than the standard quarter-hour allocated in general practice (Baierl et al., 2026). Specialised psychosocial treatment centres, by contrast, were able to offer extended appointment times that enabled providers to engage in depth with patients' perspectives, illustrating how structural differences in consultation time directly shape the quality and responsiveness of care (Baierl et al., 2026).

Continuity of care:

Continuity of care is a critical determinant of appropriateness, particularly in mental health contexts where the therapeutic relationship itself constitutes a core component of effective treatment. Disruptions to continuity whether through provider changes, poor service transitions, or fragmented care pathways undermine trust, reduce engagement, and

compromise the quality and appropriateness of care over time. Free and low-cost services often struggled to maintain therapist continuity, preventing patients from seeing the same provider consistently (Ash et al., 2025), while frequent practitioner changes among older patients disrupted therapeutic relationships and weakened trust (Schwarz et al., 2022). In crack cocaine treatment, short detox programs without direct transition into sustained treatment were viewed as inappropriate: the absence of integrated detox units within treatment centres disrupted continuity and increased relapse risk (Duopah et al., 2024). The transition from child to adult mental health services represented a particularly vulnerable juncture, with insufficient supports during this period identified as a significant barrier to continuity though navigation services were reported to help by facilitating connections and securing faster responses than families could achieve independently (Kourgiantakis et al., 2023). For people experiencing homelessness, poor discharge planning and weak service transitions characterised by poor communication and complex paperwork created gaps that disrupted care continuity (McNeill et al., 2022). In perinatal care, lack of continuity forced women to repeatedly recount their concerns, undermining care quality, timeliness, and appropriateness (Viveiros & Darling, 2019). Staff turnover and provider inconsistency across different phases of problematic alcohol use treatment similarly hindered continuity and disrupted therapeutic relationships, reducing individuals' ability to sustain engagement (Wolfe et al., 2023). For unaccompanied refugee children, who frequently face sudden relocations between temporary accommodations, maintaining continuity of care presents particular structural challenges. Reviews recommend patient-held healthcare plans shared with general practitioners and relevant providers, with follow-up appointments arranged prior to discharge as a mechanism for preserving continuity across transitions (Yılmaz et al., 2025). Disrupted continuity of care during COVID-19 was identified as a significant barrier to appropriate and effective treatment for LGBTQ+ participants. Having to repeatedly disclose both their mental health difficulties and their LGBTQ+ identity to different professionals across fragmented service contacts caused distress and eroded willingness to continue engaging with services (Lowther-Payne et al., 2026). For people experiencing homelessness, hospital-to-community transition models and case management programs explicitly designed to bridge discharge and ongoing community care improved appropriateness by aligning services with patient trajectories and ensuring consistent follow-up. Co-located one-stop models further supported continuity by concentrating multiple service contacts within a single setting, reducing the risk of disengagement between care episodes (Meda et al., 2025).

Integration across services:

The appropriateness of mental health care is significantly shaped by the degree to which services are integrated across different sectors and care domains. Integration operates as a cross-cutting mechanism within the access journey: it enhances approachability by making mental health services visible through other points of contact, supports continuity of care by enabling smooth transitions between services and care levels, and strengthens need responsiveness by ensuring that the full complexity of individuals' needs spanning mental health, physical health, substance use, and social circumstances can be addressed within a coherent rather than fragmented system. Where integration is absent, individuals with complex and intersecting needs fall through the gaps between services that each address only part of their situation, with the burden of bridging those gaps frequently left to the individuals themselves. Fragmented systems that address mental health, substance use, physical health, and social care in isolation consistently failed to respond to the complex and intersecting needs of vulnerable populations.

Integration of mental health care into addiction services was identified as a critical gap across multiple contexts. Crack cocaine use frequently co-occurred with serious mental health conditions, yet substance use services focused narrowly on drug use while mental health services excluded those actively using substances leaving individuals with dual diagnoses without appropriate treatment options (Duopah et al., 2024). Similar fragmentation was documented in youth services, where mental health and substance use care were delivered in isolation, producing inadequate and incomplete responses to co-occurring disorders (Kourgiantakis et al., 2023). For people experiencing homelessness, the integration of mental health with substance use and problematic alcohol services was identified as essential given the high prevalence of these co-occurring conditions (McNeill et al., 2022). In problematic alcohol use treatment, siloed systems requiring abstinence as a precondition for mental health therapy, or stable mental health as a precondition for alcohol use treatment effectively excluded those with concurrent conditions from both, and even where combined services existed, many felt their needs remained unmet (Wolfe et al., 2023).

Integration of mental health care into general health services was equally important for populations with complex physical and mental health needs. People experiencing homelessness presented with higher rates of comorbidities, conditions such as Hepatitis C and sexually transmitted infections, and more advanced illness trajectories, necessitating integrated mental and physical health responses (McNeill et al., 2022). For older adults with multimorbidity, insufficient coordination between somatic and psychiatric care left patients and families bridging communication gaps themselves, producing fragmented services and diminished responsiveness (Schwarz et al., 2022).

Integration between mental health care and social care represented a further dimension of appropriateness, particularly for people experiencing homelessness. Holistic responsiveness to need required connecting healthcare with practical social support including addressing basic needs such as food and shelter recognising that mental health care delivered in the absence of social stabilisation is unlikely to be effective or appropriate (McNeill et al., 2022). Appropriate care for refugee children requires coordination across interpreters, legal teams, voluntary organisations, social services, and schools, as mental health needs cannot be meaningfully addressed in isolation from the broader conditions of displacement (Yılmaz et al., 2025). For low-SES individuals with severe mental health conditions, simultaneous engagement with therapy, psychiatric care, social services, and housing support was required, yet these were delivered through separate, poorly coordinated systems. Individuals could be at entirely different stages of the access journey for different services concurrently, with the burden of coordination falling on those already managing chronic and complex conditions (Stone & Veinot, 2026). For people experiencing homelessness, service integration across health, social care, housing, and voluntary sector organisations was identified as essential for addressing complex and evolving needs that no single service could meet in isolation (Meda et al., 2025). Integration took multiple forms including joint casework and multi-agency meetings, co-location of services within shelters and community centres, and multidisciplinary teams combining clinical and social expertise each contributing to more coherent and responsive care pathways (Meda et al., 2025).

Consent, privacy, and confidentiality regulations:

Regulatory frameworks governing consent, privacy, and confidentiality, while essential to protecting individual autonomy, can introduce unintended barriers to the appropriateness and timeliness of care. In youth mental health services, consent regulations that come into effect when young people reach the legal age of consent restricted family involvement and limited provider-family communication, making timely collaboration more difficult (Kourgiantakis et al., 2023). Some parents felt that allowing young people to make all treatment decisions even where insight into their own needs was limited created barriers to accessing appropriate and timely care (Woodgate et al., 2023).

Care setting and service environment:

The physical and virtual environments in which care is delivered constitute an important dimension of appropriateness, shaping whether the setting itself supports or undermines the therapeutic process. In virtual mental health care, privacy was frequently compromised by unsuitable settings: providers and clients without access to private spaces resorted to cars,

parks, or public places, while women experiencing domestic violence faced particular risks when sessions took place at home in the presence of the perpetrator circumstances that fundamentally undermined the appropriateness of care (Hynie et al., 2022). Virtual delivery was also identified as unsuitable for certain clinical presentations, including autism and psychosis in young people, where the modality itself was incompatible with effective treatment (Kourgiantakis et al., 2023). In problematic alcohol use treatment, telehealth sometimes restricted access to the full range of in-person therapies, and remote interventions via email, phone, or videoconference were frequently perceived as difficult to engage with and insufficient compared to face-to-face interaction though they also reduced appointment cancellations, increased flexibility, and lowered anxiety when initiating group therapy (Wolfe et al., 2023). Within group therapy settings, heterogeneity in treatment goals such as abstinence versus reduction, and participant motivations including court-mandated attendance reduced cohesion and engagement, further affecting the appropriateness of the group environment for individual participants (Wolfe et al., 2023). Alignment between refugee children's preferences and treatment modalities is a critical determinant of sustained engagement. Unaccompanied children tend to prefer activity-based, less emotionally evocative interventions in initial stages, while non-verbal methods such as drawings and creative therapies including play, art, music, and storytelling have demonstrated effectiveness in facilitating engagement among traumatised children who struggle to articulate distress verbally (Yılmaz et al., 2025).

Stigma and discrimination against people in vulnerable situations:

Stigma and discrimination within care settings directly undermine the appropriateness of mental health services, operating both through their impact on the quality of individual encounters and through their broader effect on sustained engagement. Importantly, stigma and discrimination do not operate solely as barriers to acceptability as documented in earlier dimensions of the access journey but extend into the appropriateness of care itself: by deterring continued engagement, they prevent individuals from receiving the sustained and responsive treatment their needs require, ultimately compromising care quality and outcomes. Refugees and asylum seekers reported being subjected to unfair treatment, negative sentiments, and racially charged questioning by service providers experiences that compromised the appropriateness of care at the point of delivery (Dumke et al., 2024). For sexual minority groups, discrimination functioned as a structural barrier, lowering the overall quality of care and deterring continued engagement (Broadway-Horner, 2024). Service providers' stigmatisation of young people with substance use disorders and their families led to discriminatory interactions that eroded trust and created additional barriers to engagement

(Kourgiantakis et al., 2023). For LGBTQI+ individuals, stigma and discrimination shaped both the perceived and actual appropriateness of care, affecting not only how services were experienced but whether they were deemed worth returning to (Maria et al., 2025).

Interpersonal quality of care:

Within the dimension of appropriateness, the interpersonal quality of care shapes whether treatment encounters are experienced as responsive, respectful, and genuinely tailored to individual needs. As with stigma and discrimination, interpersonal quality operates across multiple dimensions of the access journey: poor interpersonal encounters undermine acceptability by deterring future help-seeking and simultaneously compromise appropriateness by preventing care from being genuinely responsive to individual needs. Where interpersonal quality is poor, care may be formally delivered yet remain substantively inappropriate failing to address the actual needs of those receiving it and generating outcomes that reflect the quality of the relationship as much as the content of the intervention. The quality of the therapeutic relationship was identified as central to sustained engagement, with LGBTQ+ migrants and refugees describing positive experiences with providers who demonstrated genuine understanding of their circumstances as a foundation for a trusting and effective therapeutic relationship (Baierl et al., 2026). Women reported that their concerns were frequently dismissed or not taken seriously, with such experiences perceived as disrespectful and generating feelings of unsafety and invalidation; the resulting lack of trust in providers contributed, at times, to inappropriate treatment and poor outcomes (Ash et al., 2025). For LGBTQI+ individuals, clinician qualities such as empathy, inclusivity, and non-judgment were identified as essential to ensuring that care was both appropriate and conducive to sustained engagement (Maria et al., 2025). Service providers' mistrust toward people who use crack cocaine including the dismissal of self-reported substance use as unrealistic left users feeling invalidated and less willing to disclose their needs openly, directly undermining the responsiveness of care (Duopah et al., 2024). Parents similarly reported that their concerns were dismissed and their knowledge of their child's symptoms undervalued, with some feeling labelled as overprotective or blamed rather than recognised as experts on their own children a dynamic that eroded trust and reduced engagement in care (Woodgate et al., 2023).

Cultural responsiveness of care:

Cultural responsiveness is a critical determinant of appropriateness, shaping whether care is experienced as relevant, trustworthy, and genuinely aligned with the needs of individuals from diverse backgrounds. As with acceptability, cultural responsiveness influences

appropriateness not only through its impact on the quality of individual encounters but through its effect on long-term engagement and treatment outcomes. Care that fails to reflect the cultural, linguistic, and gender-specific dimensions of individuals' experiences may be formally delivered yet remain substantively inappropriate.

Ethnically and racially responsive care was identified as essential across multiple contexts. Within Black communities, persistent medical mistrust rooted in historical experiences of racism and medical mistreatment underscored the necessity of culturally responsive service provision (Ash et al., 2025). Among migrant families, providers' lack of cross-cultural responsiveness reduced the perceived value of care for children and young people, while judgmental attitudes and misinterpretation of cultural parenting practices damaged the therapeutic process (Place et al., 2021). For minoritised ethnic young people with eating disorders, culturally responsive care required integrating Western clinical practices with culturally relevant frameworks including assessment terminology with cultural resonance, treatment approaches adapted to religious observances such as fasting and Ramadan, and collaboration with religious leaders where appropriate (Williams-Ridgway et al., 2026).

Language-concordant care emerged as a foundational dimension of appropriateness for migrants, refugees, and asylum seekers. Language shaped not only clinical communication but also diagnosis, treatment, and administrative processes such as referrals and continuity of care (Dumke et al., 2024; Hynie et al., 2022; Place et al., 2021; Salameh et al., 2025). Language barriers substantially impaired the appropriateness of mental health services for asylum seekers by limiting effective communication, accurate diagnosis, and meaningful therapeutic engagement, with providers identifying language as a factor that highly interfered with their ability to deliver appropriate care (Wehbe et al., 2026). Care that failed to respect linguistic needs reduced perceived quality, undermined trust, and discouraged long-term engagement (Place et al., 2021; Salameh et al., 2025). The use of interpreters was central to addressing language barriers, yet shortages of trained interpreters and inadequate funding for translation services frequently compromised communication quality (Dumke et al., 2024; Wehbe et al., 2026). Providers sometimes avoided using interpreters altogether, and those available were often inexperienced (Place et al., 2021). Reliance on family members or community interpreters raised further concerns about confidentiality, accuracy, and cultural sensitivity, leading to inaccurate communication, strained family-provider relationships, and diminished trust and appropriateness of care (Dumke et al., 2024; Place et al., 2021). Where linguistic barriers were overcome, youth engagement improved and families from diverse backgrounds were better able to participate in the care process (Kourgiantakis et al., 2023).

Gender-responsive care represented a further dimension of cultural appropriateness. Female patients reported that the presence of male interpreters created barriers to disclosing sensitive issues, underscoring the importance of gender concordance not only in direct care delivery but in interpretation arrangements (Dumke et al., 2024). A lack of LGBTQ+ affirmative practice encompassing provider knowledge of sexual and gender diversity, challenge of cis-heteronormative assumptions, and proactive integration of identity-related issues into therapeutic work was identified as a fundamental gap in the appropriateness of care. LGBTQ+ individuals proposed staff training and the development of learning communities as mechanisms to embed affirmative competencies within the mental health workforce, framing this not as optional enhancement but as a prerequisite for effective and appropriate care for LGBTQ+ service users (Lowther-Payne et al., 2026).

Cultural sensitivity and competence among providers shaped the appropriateness of care in equally significant ways. Limited knowledge of refugees' mental health needs and entitlements frequently resulted in delays and inadequate referrals, while refugees were at times perceived as "difficult patients" because of their specific cultural needs and explanatory models of illness a framing that further compromised the appropriateness of treatment rather than prompting adaptation (Dumke et al., 2024). Health professionals emphasised that treatment of mental disorders is shaped by how those disorders are defined, and that understandings of mental illness vary substantially across cultural contexts. Where providers were unprepared to engage with patients' explanatory models including frameworks invoking external causes of illness, spiritual dimensions of suffering, or a more passive role in recovery therapeutic approaches risked clashing with patients' expectations, reducing the appropriateness and effectiveness of care (Baierl et al., 2026).

Caregiver involvement and support:

The involvement of families and caregivers in mental health care constitutes an important dimension of appropriateness, particularly where social support is integral to sustained engagement and recovery. Involving families can reduce intra-family tensions and strengthen the social foundation that supports young people's engagement in care (Kourgiantakis et al., 2023). Yet in youth mental health and substance use services, family involvement was frequently peripheral or structurally unsupported: individually focused service models and design flaws left limited room for proactive family participation, and participants emphasised the need for more intentional and integrated family-centred approaches, particularly in therapeutic and psychiatric settings (Kourgiantakis et al., 2023). In problematic alcohol use treatment, involving family members or caregivers was similarly perceived as enhancing

understanding of the condition, supporting abstinence, and strengthening overall engagement in care (Wolfe et al., 2023). Within refugee communities, family involvement and collectivist values are central to wellbeing, and involving families in treatment has demonstrated benefits for both children's and parents' engagement in care. The process of family reunification, particularly for children reuniting with parents after years of separation, introduces additional emotional complexity that appropriate services must be equipped to address (Yılmaz et al., 2025).

Peer-led services and peer support groups:

Peer-led services and support groups represent a distinct mechanism for enhancing the appropriateness of care by grounding service design in the lived realities of those it serves. Drawing on shared experiences, peer networks reduced the disconnect between standardised service models and the everyday challenges faced by service users, ensuring greater responsiveness to actual needs. For sexual minority groups in particular, peer-led services improved appropriateness by aligning care with the specific experiences and identities of LGBTQI+ individuals in ways that professionally led services frequently failed to achieve (Broadway-Horner, 2024). The limited availability of peer support through heart failure care was identified as a specific gap, as peer-based support was perceived by people living with heart failure as offering a distinct source of hope and shared understanding not achievable through professional services alone (Shah et al., 2025).

Collecting patient-reported experiences:

The systematic collection of patient-reported experiences constitutes a mechanism for enhancing both the appropriateness and trustworthiness of care. Where client assessments were routinely gathered and shared, users expressed greater trust in services as documented in the context of virtual mental health programs for refugee newcomers, where the systematic collection of client assessments contributed to building confidence in the intervention and its responsiveness to individual needs (Hynie et al., 2023).

2.3.1.6. Ability to Perceive

The ability to perceive constitutes the first step on the demand side of the access journey, capturing the degree to which individuals recognise that they have a mental health need and

are aware that appropriate care exists to address it. Without this foundational awareness, the subsequent steps of seeking, reaching, and engaging with care cannot be initiated. The scoping review findings highlight that this perceptual capacity is shaped by a complex interplay of individual, cultural, social, and systemic factors.

Symptom recognition is not a neutral cognitive process: it is mediated by cultural frameworks that shape how distress is interpreted and by the degree to which individuals possess the mental health literacy to identify their experiences as requiring professional care. Social networks are bidirectional in their influence: the same networks that help some individuals identify their needs or reinforce normalisation and discourage disclosure. Stigma surrounding can silence the social conversations that might otherwise prompt recognition. For migrants and refugees, language barriers and limited familiarity with host-country health systems make both need recognition and service identification substantially more difficult, while for children and young people, the ability to perceive is largely mediated through caregiver recognition and response.

Underpinning all of these dynamics are individuals' perceptions of the system itself: beliefs about whether services exist, whether they are effective, whether providers are capable, and whether care is likely to be responsive to their specific needs all shape the threshold at which a mental health concern is perceived as something worth acting upon. Some determinants of the ability to perceive such as stigma, cultural attributions, and social network dynamics lie largely beyond the direct reach of health systems. Others, however, are more amenable to system-level intervention: perceptions of treatability, provider capability, and service availability, as well as mental health literacy more broadly, are shaped in part by how visible, communicative, and outward-facing services are. This is where approachability becomes critical, a system that actively promotes awareness of mental health needs, communicates clearly about available services, and fosters confidence that appropriate, good quality, and trustworthy care is available and accessible can meaningfully expand individuals' ability to perceive and act on their needs.

Ability to Perceive Assessment Overview:

- Symptom interpretation and awareness about mental health
- Perceived responsiveness of care
- Knowledge of available services
- Awareness of legal entitlements
- Language-related challenges
- Social network and support

- Stigma around mental health

Symptom interpretation and awareness about mental health:

The ability to perceive a mental health need is a foundational prerequisite for help-seeking, yet it is shaped by a complex interplay of individual, cultural, and social factors that vary considerably across population groups. Difficulties in recognising mental health symptoms constituted a pervasive barrier to the ability to perceive across diverse subgroups (Lowther-Payne et al., 2023), with limited awareness of mental health and its manifestations identified as a key obstacle preventing refugees and other vulnerable populations from recognising their need for care (Hynie et al., 2022; Dumke et al., 2024). People living with heart failure reported difficulties recognising when their mental health deteriorated (Shah et al., 2025). For minoritised ethnic young people limited knowledge of eating disorders within communities reduced the ability to recognise symptoms as requiring professional care, with some families not viewing eating disorders as valid illnesses and others attributing symptoms to physical causes such as thyroid disorders rather than psychological distress (Williams-Ridgway et al., 2026).

Somatic attribution represented a particularly consistent pattern: psychological distress was frequently interpreted and described in physical or bodily terms, with mental health symptoms perceived as physical illness rather than psychological problems a tendency documented across migrants, refugee and asylum seeker populations (Dumke et al., 2024; Yılmaz et al., 2025; (Baierl et al., 2026). Especially older migrants and female refugees tended to define health exclusively in terms of physical well-being, with mental health remaining largely unaddressed as a distinct concept (Baierl et al., 2026). Individuals living with heart failure who interpreted their mental health symptoms as physical manifestations of heart failure experienced delayed recognition of the psychological dimension of their distress, with some taking a considerable period of time to distinguish panic attacks from cardiac events (Shah et al., 2025). Religious and supernatural attributions further shaped perception, with mental health problems often understood through frameworks invoking curses, witchcraft, or evil spirits (Dumke et al., 2024; Place et al., 2021). These attributions were consistently identified as barriers to perceiving the need for professional care, and Western providers regarded them as among the most significant challenges in delivering mental health care to refugee populations (Dumke et al., 2024). More broadly, cultural framing of mental health led individuals to interpret their experiences through frameworks that diverged from biomedical models: some refugees did not relate to Western-defined categories of mental illness and therefore did not perceive their difficulties as requiring professional treatment (Dumke et al., 2024; Wehbe et al., 2026), while some migrant families attributed mental health problems to

poor family relations, parenting deficits, or cultural over-protection beliefs that strongly influenced perceived need, attitudes toward formal treatment, and treatment experiences (Place et al., 2021).

Normalisation of symptoms constituted a further barrier across multiple population groups. Crack cocaine users who did not experience their substance use as clearly disruptive normalised their experiences and did not perceive a need for healthcare (Duopah et al., 2024). Young migrants frequently framed their difficulties as a normal part of life rather than a health concern (Place et al., 2021). Syrian refugee women with depressive symptoms often attributed their distress to the cumulative effects of displacement, loss, and war-related hardship, relying on personal coping strategies rather than seeking professional support (Salameh et al., 2025). In perinatal contexts, emotional distress was commonly attributed to normal pregnancy-related experiences, preventing women from identifying their mental health concerns as requiring care (Viveiros & Darling, 2019). Older adults with a history of mental health problems similarly showed denial or distorted illness perceptions that delayed recognition and help-seeking (Schwarz et al., 2022).

Severity of symptoms shaped the threshold at which individuals perceived a need for care. Crack cocaine users tended to seek help only when symptoms became severe, particularly when experiencing significant emotional instability or dependency (Duopah et al., 2024) while people experiencing homelessness often acknowledged health needs only at crisis point (McNeill et al., 2022).

Caregivers' ability to recognise mental health needs was equally critical, particularly for young people who rely on families to identify problems and initiate care. In ADHD, formal diagnosis was frequently delayed by approximately one year, largely due to low symptom awareness among primary caregivers; teachers often became the main drivers of referral, though their recognition tended to favour externalised symptoms more common in boys, contributing to gender disparities in timely identification (Martínez-Jaime et al., 2024). Parental emphasis on academic performance over emotional wellbeing created further barriers among migrant families, with young people internalising these priorities and avoiding disclosure (Place et al., 2021). Some parents recognised their child's need only after months of persistent difficulties, while those with personal experience of anxiety identified symptoms earlier and sought care more readily (Woodgate et al., 2023).

Perceiving mental health problems as a personal burden discouraged both recognition and disclosure. Young migrants and their parents viewed mental health difficulties as burdens that should not be placed on others, reinforcing avoidance of professional support (Place et al.,

2021). Relatedly, de-prioritisation of mental health in collectivist cultural contexts where individuals are expected to subordinate personal needs to family or community responsibilities further suppressed the ability to perceive and act on mental health needs, as documented among Latinx young people who were expected to place family responsibilities above their own wellbeing (Place et al., 2021). For unaccompanied children, the prioritisation of immediate survival needs and the prolonged uncertainty of legal status determination make need recognition especially difficult (Yılmaz et al., 2025).

Mental health literacy constitutes the overarching capacity that underlies many of the perceptual barriers documented across the reviewed literature. While it was explicitly named as a barrier only among people experiencing homelessness and refugee children and youth where lower levels of health literacy were identified as hindering the ability to perceive and articulate health needs (McNeill et al., 2022; Yılmaz et al., 2025) the patterns documented across other population groups, including somatic attribution, normalisation of symptoms, cultural framing, and caregiver recognition gaps, all reflect, in different forms, the degree to which individuals possess the knowledge and frameworks necessary to interpret their experiences as mental health needs requiring professional care. Younger generations within minoritised ethnic families demonstrated greater awareness of eating disorders than older generations, partly through school education and social media exposure, suggesting that generational shifts in knowledge may progressively improve early recognition over time (Williams-Ridgway et al., 2026).

Stigma around mental health problems, shaped by cultural taboos and gender role expectations, further suppressed recognition and disclosure: men in particular reported concealing their difficulties and attempting to cope alone, reflecting the internalisation of norms equating help-seeking with weakness (Baierl et al., 2026).

Perceived responsiveness of care:

The ability to perceive a need for professional care is shaped not only by symptom awareness but by individuals' expectations of whether care will be effective, appropriate, and responsive to their specific circumstances. Where services are perceived as unlikely to help whether due to doubts about provider capability, beliefs about the treatability of conditions, or broader scepticism about the value of professional mental health care the perceived need for care is diminished even when distress is recognised.

Perceived provider capability influenced whether individuals believed that seeking care was worthwhile. Women questioned whether OB/GYN and primary care providers had the training

and resources to respond effectively to perinatal mental health needs, undermining confidence that care would address their concerns (Ash et al., 2025). Providers were sometimes perceived as dismissive, reinforcing the belief that help-seeking was futile, while school-based mental health providers were frequently regarded as not being "real" professionals (Place et al., 2021).

Perceptions regarding the treatability of conditions constituted a further barrier. Many postpartum women believed no meaningful treatment options for postpartum depression existed, rendering screening programs feel meaningless and burdensome in the absence of confidence that effective care would follow (Ash et al., 2025). Syrian refugee women with postpartum depression symptoms similarly lacked awareness that their condition was treatable through mental health care, limiting their ability to perceive it as a health problem requiring professional attention (Salameh et al., 2025). Some crack cocaine users perceived services as unable to help with withdrawal, leading them to turn to other substances instead (Duopah et al., 2024), while scepticism about treatment effectiveness was a common barrier among individuals with problematic alcohol use more broadly (Wolfe et al., 2023).

Perceived causes of mental health conditions shaped engagement with formal services in equally significant ways. Where somatic, religious, or supernatural attributions framed mental health symptoms as inconsistent with what professional services could address, individuals were discouraged from engaging with the mental health system and turned instead to family, social networks, and religious figures sources perceived as more culturally congruent and effective (Dumke et al., 2024; Place et al., 2021; Baierl et al., 2026). Notably, young people with the highest levels of mental health and substance use need, along with their parents, were often the least informed about available resources (Kourgiantakis et al., 2023).

Perceived effectiveness of mental health care reflected broader scepticism about the value of professional intervention. Some migrants viewed mental health services as offering little beyond what friends or family could provide (Place et al., 2021). Syrian refugee women with postpartum depression symptoms expressed beliefs that interventions including medication and psychotherapy would worsen their condition, while others doubted the value of psychiatric care, perceiving it as providing only temporary relief without addressing the root causes of their distress (Salameh et al., 2025).

Knowledge of available services:

The ability to perceive a need for care is closely linked to awareness of what services exist and what they offer. Even where individuals recognise a mental health concern, limited

knowledge of available services can prevent them from identifying appropriate care pathways or acting on their perceived need. This gap was documented across a wide range of population groups and service contexts.

People living with dementia and their carers frequently lacked awareness of social farming as a service option, a gap partly shaped by low provider awareness (Bartlett et al., 2025). Knowledge of available mental health treatment options and of the healthcare system more broadly was limited among migrants, particularly among the newly arrived (Baierl et al., 2026). Awareness of services was highly uneven and often dependent on the presence of a well-informed individual within a refugee shelter, meaning that access to information was effectively a matter of chance rather than systematic provision (Baierl et al., 2026). Refugees and asylum seekers often lacked knowledge of the existence of services, the roles of different health professionals, and available treatment types gaps that reduced their ability to navigate the system effectively and, in some cases, led to care-seeking through inappropriate entry points such as accident and emergency services (Dumke et al., 2024; Yılmaz et al., 2025). Syrian refugee women reported limited awareness of municipal and NGO-based psychological and social support services, with some unaware that support for postpartum depression existed at all (Salameh et al., 2025). Limited knowledge of low-cost mental health services within host-country health systems meant that low-income individuals were frequently not matched to affordable options and remained unaware of free or subsidised services even when these formally existed (Wehbe et al., 2026). Limited knowledge of insurance coverage and the cost of health services constituted additional barrier to accessibility among migrants. One LGBTQ+ migrant incorrectly believed that psychotherapy was unaffordable, being unaware that it was covered by statutory health insurance, illustrating how misinformation about cost can function as a perceived barrier independently of actual affordability (Baierl et al., 2026). Survivors attending sexual assault referral centres frequently had no prior knowledge of the service or of available mental health support options (Rogers et al., 2026) Limited knowledge of available dementia rehabilitation services similarly constrained care-seeking among people with dementia and their care partners (Layton et al., 2024). Among LGBTQI+ individuals, limited awareness of available mental health services was consistently documented, particularly outside metropolitan areas (Maria et al., 2025), while people experiencing homelessness often had limited understanding of how healthcare systems worked and what services were accessible to them (McNeill et al., 2022).

Misconceptions about service scope and eligibility further narrowed perceived options. Some young people believed school-based services were reserved for severe mental illness or academic concerns, and many migrant families were unfamiliar with different provider types

and unsure where to begin though second-generation migrants were better informed and more likely to identify accessible care pathways (Place et al., 2021). In problematic alcohol use, knowledge gaps were more pronounced among men, ethnic minority groups, and military populations, and some treatment seekers perceived services as intended only for those who had already lost employment, relationships, or housing a misperception that effectively raised the threshold at which care was considered relevant to their situation (Wolfe et al., 2023). Parents similarly lacked awareness of available services, though prior experience with mental health care improved their knowledge of options over time (Woodgate et al., 2023).

Awareness of legal entitlements:

Awareness of legal entitlements to healthcare constitutes a distinct dimension of the ability to perceive, bridging the recognition of a mental health need and the identification of a viable care pathway. Even where individuals acknowledged their distress, uncertainty about their rights including the scope and duration of specialist care coverage created a disconnect between recognising a need and knowing that appropriate care was accessible to them. This gap was particularly pronounced among refugees and asylum seekers, for whom limited awareness of legal entitlements further constrained an already fragmented ability to navigate the system (Dumke et al., 2024; Place et al., 2021).

Language-related challenges:

Language barriers constitute a cross-cutting determinant that operates across the entire care journey in interconnected ways. Within the dimension of ability to perceive, limited proficiency in the host-country language compounded difficulties in navigating an already complex and unfamiliar health system, making mental health services less recognisable as viable options and harder to approach particularly for those arriving unaccompanied or without prior familiarity with the local context (Dumke et al., 2024).

Social network and support:

Social networks play an important facilitative role in the ability to perceive mental health needs, particularly among populations with limited mental health literacy or unfamiliarity with available services. Friends and family members were key sources of information for refugees, helping them recognise mental health needs and identify available care options (Hynie et al., 2022; Wehbe et al., 2026). Some migrants receiving psychological treatment had found their therapist through another migrant's recommendation (Baierl et al., 2026). Among people experiencing homelessness, learning from peers about health behaviours and available

services similarly increased awareness of both personal health needs and accessible care pathways (McNeill et al., 2022).

However, social networks do not always function as facilitators. Cultural communication norms and stigma can prevent informal actors from raising concerns or recommending services, as such remarks may be perceived as offensive or disrespectful (Place et al., 2021). Limited or dismissive communication within families often shaped by cultural norms and parental difficulties in emotional expression hindered open discussion about mental health among young migrants, who frequently relied on family support to initiate help-seeking (Place et al., 2021). For Syrian refugee mothers, migration disrupted the cultural and familial practices that traditionally provided postpartum support including childcare assistance, rest, and emotional support from relatives increasing vulnerability to postpartum depression in the absence of these protective networks (Salameh et al., 2025). Emotional isolation and loneliness, particularly among refugee women, further undermined the ability to perceive mental health needs, as the absence of supportive relationships made it harder to recognise symptoms as requiring professional care (Viveiros & Darling, 2019).

Stigma around mental health:

Stigma surrounding mental health constitutes a cross-cutting barrier that, within the dimension of ability to perceive, operates through a distinct mechanism: rather than deterring engagement with services that have already been identified, it shapes whether individuals recognise and acknowledge their mental health needs in the first place. At the social network level, stigma can silence the very informal actors friends, family members, and community peers who might otherwise help individuals identify their needs and navigate care, as raising mental health concerns may be perceived as offensive or disrespectful within communities where psychological difficulties carry significant social shame (Place et al., 2021).

2.3.1.7. Ability to Seek

The ability to seek care captures the step at which an individual who has recognised a mental health need and identified available services must decide whether to act on that recognition. It is, in essence, the gap between knowing and doing, and at its core, this gap is shaped by perception: individuals' anticipation of what seeking care will involve, what it will cost them socially and practically, and what it is likely to produce. Whether or not they have previously encountered a service, individuals form expectations about the likely outcomes of seeking care, and it is these perceived benefits and risks, rather than objective realities alone, that determine whether help-seeking occurs.

At the centre of this dimension lies stigma: the fear that seeking care will make a mental health need visible, exposing individuals to judgment, labelling, or social and institutional consequences. Privacy concerns and trust in healthcare systems are deeply intertwined with this dynamic where individuals doubt that their information will be protected or that the system is safe for people in their position, stigma's deterrent effect is amplified. Conversely, when confidentiality is trusted and systems are perceived as non-punitive, the threshold for seeking care is meaningfully lowered. These perceptions are not formed in isolation: prior negative experiences with healthcare rooted in systemic shortfalls such as poor interpersonal quality, discrimination, and culturally inappropriate care become internalised as personal expectations that shape future willingness to seek care. The negative experiences of peers carry similar weight, extending the reach of system-level failures into social networks.

Social networks and support structures mediate the ability to seek in bidirectional ways: they can facilitate care-seeking by providing practical assistance, encouragement, and a buffer against anticipated difficulties, but they can equally reinforce stigma, discourage disclosure, or transmit negative perceptions of services. The ability to seek is thus not purely an individual decision but a socially embedded one, shaped by the interactions between personal experience, community norms, and the perceived trustworthiness and safety of the systems individuals are being asked to engage with.

Ability to Seek Assessment Overview:

- Stigma around mental health conditions and care seeking
- Privacy and confidentiality concerns
- Trust in mental healthcare services
- Prior negative experiences with healthcare
- Negative peer advice
- Social network and support
- Perception about the cost of mental healthcare
- Perceived language and communication barriers
- Fear of treatment consequences

Stigma around mental health conditions and care seeking:

Stigma surrounding mental health conditions and care-seeking constitutes one of the most pervasive barriers to the ability to seek care, operating across diverse population groups and cultural contexts. Unlike its role in the ability to perceive where stigma hinders recognition of need, in the ability to seek, stigma acts as a direct deterrent to acting on a recognised need.

Individuals may be fully aware of their difficulties, yet fear that seeking care will expose them to judgment, labelling, or social consequences, making visibility itself the barrier rather than awareness.

Stigma manifested in multiple, culturally specific forms. Women described community norms framing mental health challenges as weakness and reinforcing secrecy, while pressure to embody ideals such as the "Strong Black Woman" or the "good mother" discouraged disclosure, with some fearing punitive consequences including child removal (Ash et al., 2025; Viveiros & Darling, 2019). Among older adults, shame and fear of labelling intersected with ageism to produce a "double stigma" that further suppressed help-seeking (Schwarz et al., 2022). In migrant and refugee communities, mental health problems were associated with terms such as "crazy" or "abnormal," perceived as shameful, and linked to risks of discrimination and isolation from family or community (Dumke et al., 2024). Among refugee children and youth, cultural frameworks prioritising self-reliance and community-based emotional support over professional intervention reinforce stigma around help-seeking, with the traumatic nature of displacement strengthening norms of keeping emotional difficulties within the family. Reviews recommend engaging religious leaders and elder family members as cultural brokers to mitigate stigma prior to offering individual care (Yılmaz et al., 2025). Syrian refugee women feared ridicule or disapproval from relatives if seen visiting a psychiatrist (Salameh et al., 2025), while migrant families concealed mental health problems within the family to protect reputations and children's marriage prospects (Place et al., 2021). For minoritised ethnic young people with eating disorders, shame and stigma around both the condition and mental health more broadly were particularly pronounced, with the negative connotations of mental illness perceived as extending beyond the individual to the entire family. Collectivist cultural values emphasising family harmony, social acceptance, and the resolution of difficulties within family networks before seeking external support reinforced avoidance of professional help-seeking, with some individuals concealing their difficulties entirely rather than risk family or community judgment (Williams-Ridgway et al., 2026).In Asian migrant communities, fear of undermining the "model minority" stereotype deterred students from seeking care, while in others, enduring without complaint was culturally valued (Place et al., 2021). Explanatory models framing neurodevelopmental conditions as family faults similarly fuelled stigma and discouraged help-seeking (Place et al., 2021).

Stigma around addiction and substance use created additional barriers: crack cocaine users described stigmatising narratives within social networks that generated mistrust and delayed help-seeking until crisis point, with concerns about institutional or housing consequences leading users to conceal their drug use (Duopah et al., 2024). For individuals with problematic

alcohol use, fears of judgment, shame, and consequences such as deportation, loss of children, or employment made anonymity and confidentiality essential conditions for care-seeking (Wolfe et al., 2023). Police officers similarly expressed concerns that seeking mental health support might jeopardise their careers (Clifton & Hancock, 2025). For LGBTQI+ individuals, combined stigma related to both identity and mental health conditions added further social and structural barriers to seeking care (Maria et al., 2025; Lowther-Payne et al., 2026). Among young people and their families, mental health conditions were frequently perceived as signs of weakness, family dishonour, or personal failure, while therapy itself was sometimes viewed as "weird" or unfamiliar, reducing motivation to seek support (Kourgiantakis et al., 2023; Woodgate et al., 2023). Ensuring privacy and confidentiality in mental health services was identified as a key mechanism for mitigating the deterrent effect of stigma on care-seeking (Place et al., 2021).

Privacy and confidentiality concerns:

Privacy and confidentiality concerns constitute a significant barrier to the ability to seek care, particularly among populations in vulnerable legal or social positions. Even where mental health information is formally protected, fears that disclosure could be used against them, jeopardising residence status, child custody, housing, or social standing led individuals to avoid care altogether. These fears reflect a profound mistrust of institutions and a perception that the health system is not a safe space for those whose position is already precarious. Additionally, privacy and confidentiality concerns are closely linked to stigma around mental health: when individuals trust that privacy and confidentiality regulations genuinely protect them, the deterrent effect of stigma on care-seeking is correspondingly reduced (Place et al., 2021).

Privacy and confidentiality concerns constitute a significant barrier to the ability to seek care, particularly for populations whose legal status, family circumstances, or social position make disclosure a source of tangible risk. Refugees and asylum seekers expressed strong concerns about the confidentiality of sensitive information shared in mental health settings, frequently perceiving the health system as connected to legal and government authorities raising fears that disclosures could be misused, negatively affect residence status, or lead to loss of child custody (Dumke et al., 2024; Place et al., 2021). Undocumented migrants feared that accessing mental health services could expose them to deportation risk, with some minimising contact with government agencies altogether even when their children needed care, and others worrying that mental health records would harm future opportunities (Place et al., 2021). Among crack cocaine users, concerns about sensitive information being shared with family

members undermined trust and discouraged care-seeking (Duopah et al., 2024). For women experiencing domestic violence, privacy concerns were particularly acute in the context of child custody disputes: formal mental health records were perceived as liabilities that could be used against them, leading some to avoid subsidised services requiring documentation and opt instead for private care to retain control over their personal information (Hollingdrake et al., 2023).

Trust in mental healthcare services:

Trust in healthcare providers and systems constitutes a foundational condition for the ability to seek care. Where trust is absent, individuals may recognise their need and be aware of available services yet remain unwilling to engage. Lack of trust in healthcare providers was identified as a barrier to care-seeking across multiple subgroups (Lowther-Payne et al., 2023). For Black women, histories of medical mistreatment rooted in racism reinforced scepticism toward mental health services (Ash et al., 2025). Refugees and asylum seekers expressed deep mistrust toward authority figures and public institutions, including healthcare services, a mistrust rooted in past experiences of persecution and compounded by fears of being reported to authorities, shaping persistently negative attitudes toward formal support (Dumke et al., 2024). Experiences of discrimination, dismissive encounters, and perceived prioritisation of financial considerations over patient need generated lasting mistrust of health systems among asylum seekers, reducing future willingness to engage with services even when a recognised need existed (Wehbe et al., 2026). In some cases, high costs encountered during care-seeking without financial support reinforced distrust in providers, illustrating how affordability failures compounded the erosion of trust and further deterred help-seeking (Wehbe et al., 2026). For unaccompanied refugee children, experiences of scepticism and a lack of compassion during asylum hearings and interactions with host country systems actively discourage young refugees from seeking support. Rigid refugee determination procedures and detention environments create atmospheres of institutional hostility that undermine the perceived safety of formal systems, reducing the ability to seek of mental health services (Yılmaz et al., 2025) Migrant parents and young people similarly perceived health and school systems as unfamiliar and untrustworthy, viewing professionals as unwilling or unable to help (Place et al., 2021). Among crack cocaine users, willingness to disclose substance use was contingent on having established a trusted relationship with a provider, and the absence of such trust frequently led to disengagement from services altogether (Duopah et al., 2024). Where mental health services were perceived as punitive or emotionally harmful, families' trust in providers was further eroded, resulting in avoidance of future care (Kourgiantakis et al., 2023).

Prior negative experiences with healthcare:

Prior negative experiences with healthcare constitute a significant barrier to the ability to seek care, operating through the erosion of trust and the anticipation of repeated harm. Critically, these experiences are not random they are rooted in systemic failures of care design: poor interpersonal quality, culturally inappropriate care, discrimination, and adverse treatment effects are all system-level shortcomings that become internalised as personal experiences, shaping individuals' expectations of future encounters and reducing their willingness to seek care.

For people experiencing homelessness, negative experiences encompassed both social setbacks such as poor interactions with healthcare staff and physical setbacks, including adverse medication effects (McNeill et al., 2022). Older adults who had felt excluded following a poor first contact, or who had repeatedly been required to explain their needs from scratch, reported reduced willingness to seek care again (Schwarz et al., 2022). Among migrant parents and young people, poor experiences with culturally inappropriate care and perceptions of discrimination and disrespect compared to native-born populations reduced motivation to seek support (Place et al., 2021). Syrian refugee women who had encountered discrimination and disrespect in healthcare settings described these experiences as reinforcing feelings of exclusion and deterring future care-seeking (Salameh et al., 2025).

Negative peer advice:

Just as prior negative experiences with healthcare can deter individuals from seeking care, the negative experiences of peers can carry similar weight. Despite being aware of available services, some crack cocaine users avoided seeking care due to negative advice or discouragement from peers (Duopah et al., 2024).

Social network and support:

Social network and support constitutes an important facilitating mechanism for the ability to seek care. Social networks played a significant facilitative role in migrants' ability to seek care, with acquaintances and community members helping individuals navigate healthcare appointments, overcome communication difficulties, and identify appropriate services (Baierl et al., 2026). Syrian refugee women frequently relied on their husbands to navigate language barriers, with accompaniment to healthcare visits and translation support reducing anticipated

communication difficulties and increasing willingness to seek care (Salameh et al., 2025). Among law enforcement officers, greater trust in supervisors and stronger perceived leadership support were associated with higher likelihood of perceiving mental health services as accessible (Clifton & Hancock, 2025). Loss of social connectedness with the LGBTQ+ community during COVID-19 removed a critical buffer against isolation and stigma, falling disproportionately on individuals whose support systems rely more heavily on chosen family and community networks than on family of origin (Lowther-Payne et al., 2026). Where community networks were absent or where asylum seekers were unable to form connections with local populations due to geographic isolation, neighbourhood composition, or stigma associated with asylum seeker status, social support was unavailable, compounding other barriers to care-seeking (Wehbe et al., 2026).However, social support was unevenly available: most participating migrants reported receiving no such assistance, and support from social organisations within refugee shelters was frequently insufficient in both capacity and scope (Baierl et al., 2026).

In some cases, social support may be neither uniformly available nor unconditional:: stigma around mental health can erode family support structures removing a critical source of encouragement and creating additional barriers to care-seeking among young people (Kourgiantakis et al., 2023). For younger refugee children dependent on parental consent, parental hesitancy rooted in host-country language difficulties constitutes an additional barrier to seeking care. Unaccompanied children, lacking family advocacy, face substantially greater difficulty initiating help-seeking within unfamiliar systems (Yılmaz et al., 2025). For minoritised ethnic young people, family dynamics including intergenerational conflict, differences in understanding of eating disorders, and cultural expectations around food and body image shaped the social conditions for help-seeking in complex ways (Williams-Ridgway et al., 2026).

Perception about the cost of mental healthcare:

Perceived cost can deter care-seeking independently of actual cost. Migrants and refugees sometimes avoided seeking mental health care based on misperceptions about the cost of psychotherapy or assumptions formed in their countries of origin where specialist services were costly, leading them to perceive care as an unaffordable in contexts where it was available free of charge or at low cost (Place et al., 2021; Baierl et al., 2026). This dynamic illustrates how the ability to seek is shaped not only by real affordability barriers but by individuals' prior experiences and expectations, which may not reflect the actual financial conditions of the host-country system.

Perceived language and communication barriers:

Anticipated language and communication difficulties can deter care-seeking before any encounter with a service has taken place. Syrian refugee women described avoiding appointments when they would have to attend alone, relying on husbands to translate, and feeling unable to understand providers' explanations with the anticipation of these difficulties itself functioning as a barrier to seeking care (Salameh et al., 2025).

Fear of treatment consequences:

Fear of treatment consequences a distinct barrier to the ability to seek care, operating through the perceived threat to individual autonomy. Young migrants feared that disclosing their difficulties to parents might result in being forced into care, making problem-sharing itself a risk rather than a step toward support and deterring disclosure before formal help-seeking could even be considered (Place et al., 2021). Fear of deportation among asylum seekers with rejected or precarious legal status led some individuals to avoid the healthcare system entirely, illustrating how the threat of legal consequences can suppress engagement with care even among those who have already navigated earlier stages of the access journey (Wehbe et al., 2026).

2.3.1.8. Ability to Reach

The ability to reach care captures the point at which an individual who has recognised a need, decided to seek care, and identified an appropriate service must physically or virtually present themselves to receive it. Unlike earlier dimensions of the access journey, which are shaped primarily by perception, awareness, and decision-making, the ability to reach is grounded in the practical realities of everyday life: transportation, geography, time, competing responsibilities, and physical and cognitive capacity all determine whether the intention to access care can be translated into actual attendance.

Critically, in mental health care, reaching a service is rarely a one-time act. The chronic and often fluctuating nature of mental health conditions means that individuals must navigate these practical barriers repeatedly for every appointment, every referral, and every transition between services. Barriers that might be manageable on a single occasion can become prohibitive when sustained over months or years, making the cumulative burden of reaching care a significant determinant of continuity and engagement.

The reviewed evidence highlights a wide range of factors that shape the ability to reach, spanning individual-level constraints including mental and physical health status, mobility,

occupational commitments, caregiving responsibilities, and autonomy and structural conditions such as geographic proximity, transportation infrastructure, and digital access. Across these factors, social support emerges as a particularly important enabling mechanism: where individual capacity to navigate systems is limited by language, cognition, fear, or circumstance, the practical assistance of family members, peers, and advocates frequently makes the difference between reaching care and not.

Ability to Reach Assessment Overview:

- Mental health status and condition
- Mobility and physical health condition
- Occupational flexibility
- Caregiving responsibilities
- Autonomy
- Language-related barriers
- Digital access and literacy
- Transportation options
- Physical proximity to healthcare services
- Capacity and emotional resilience for navigating services
- Social network and support
- Safety and unsupportive living environments

Mental health status and condition:

An often overlooked yet fundamental barrier to the ability to reach care is the mental health condition itself. The very symptoms that generate a need for care can simultaneously impair the capacity to access it, creating a self-reinforcing dynamic in which those with the greatest need face the greatest difficulty reaching services. Past traumatic experiences, PTSD diagnoses, fear of travel, and fear of receiving distressing health news all limited individuals' ability to attend appointments (Aldadi et al., 2024). Exhaustion and other symptoms of perinatal mental health conditions similarly acted as barriers for women in attending scheduled care (Viveiros & Darling, 2019). For crack cocaine users, substance use itself frequently took precedence over appointment attendance, while agitation, withdrawal symptoms, and the urgency of obtaining drugs further reduced the capacity to wait for or sit through treatment sessions (Duopah et al., 2024). For individuals living with dementia, cognitive impairments constrained the ability to reach care through difficulties in scheduling appointments, navigating complex service systems, and travelling to facilities independently (Layton et al., 2024). For people experiencing homelessness, substance dependence similarly hindered the physical

ability to reach healthcare services when needed (McNeill et al., 2022). The compounding of pre-migration trauma, peri-migration stressors, and post-migration uncertainties created mental health burdens that could themselves impair the capacity to navigate complex healthcare systems, seek out appropriate services, and sustain attendance among asylum seekers (Wehbe et al., 2026).

Mobility and physical health condition:

Physical health conditions and mobility limitations constitute a distinct barrier to the ability to reach care, independent of mental health status. Age-related factors including poor vision or hearing, dizziness, forgetfulness, and multimorbidity reduced older adults' ability to reach services independently (Schwarz et al., 2022), while reduced physical mobility in individuals with dementia increased reliance on caregivers for transportation and navigation (Layton et al., 2024). For individuals with problematic alcohol use, physical mobility difficulties and wheelchair use similarly hindered the ability to reach services (Wolfe et al., 2023). In virtual care contexts, hearing difficulties among older refugees posed a specific barrier to participation in remote sessions (Hynie et al., 2023). People living with heart failure faced a particular paradox in the ability to reach care: acute deteriorations in their physical health represented the periods of greatest need for mental health support yet simultaneously generated the least capacity to travel to in-person services, meaning that those who needed care most were least able to access it (Shah et al., 2025).

Occupational flexibility:

Work commitments and the inflexibility of employment arrangements constituted a practical barrier to the ability to reach care. Women described difficulties scheduling mental health appointments around work obligations (Ash et al., 2025), while employed individuals seeking problematic alcohol use treatment faced the additional challenge that taking time off work was often discouraged and could require disclosing the reason for absence to employers a prospect that, given the stigma associated with alcohol use, further deterred attendance (Wolfe et al., 2023).

Caregiving responsibilities:

Caregiving responsibilities, particularly for those without adequate support networks, constituted a significant practical barrier to the ability to reach care. Women who were sole caregivers for their children described difficulties arranging mental health appointments, as attending required either securing childcare or bringing children along both of which posed

challenges (Ash et al., 2025; Salameh et al., 2025; Baierl et al., 2026; Wehbe et al., 2026). Syrian refugee women specifically described having to bring children to healthcare centres as an obstacle, noting that the absence of childcare support or assistance from husbands frequently resulted in missed appointments or an inability to attend altogether (Salameh et al., 2025). For refugee girls, caregiving roles combined with restricted mobility and limited access to supportive networks create compounding barriers to physically reaching care (Yılmaz et al., 2025). Childcare difficulties similarly hindered access to problematic alcohol use treatment, with this barrier reported more frequently in Nepal, Ethiopia, and among US veterans, Indigenous groups, women, and those with comorbid mental health conditions (Wolfe et al., 2023).

Autonomy:

Social structures and gender roles can directly constrain women's ability to reach care by limiting their freedom of independent movement, autonomy and their control over their own time. Some Syrian refugee women described rarely leaving the house alone, relying on their husbands for accompaniment, and lacking the confidence to use public transportation independently circumstances that prevented them from attending services (Salameh et al., 2025). Gender dynamics within refugee families play a crucial role in shaping access, with many refugee girls and women facing significant constraints on their capacity to seek care independently, often requiring accompaniment by male family members. Limited social support networks and the prevalence of intra-familial violence further compound these barriers, undermining autonomy in ways that standard service models fail to accommodate (Yılmaz et al., 2025). Others reported being unable to complete psychological support programs or attend sessions consistently, as household responsibilities including cooking, cleaning, and caring for their husbands, left no time for their own mental health needs. These constraints were reinforced by gender and social norms that positioned women's domestic roles as taking precedence over their individual wellbeing (Salameh et al., 2025).

Language-related barriers:

As a cross-cutting determinant, language barriers extend into the ability to reach care, compounding difficulties that begin at earlier stages of the access journey. Refugees and asylum seekers faced particular challenges in navigating complex health systems when arriving unaccompanied or without fluency in the local language, making the practical steps of locating, contacting, and attending services substantially more difficult (Dumke et al., 2024).

Digital access and literacy:

As virtual care becomes an increasingly prominent modality, digital access and literacy have emerged as distinct determinants of the ability to reach care. Access to devices and reliable internet varied considerably by gender, income, and education level, with lower access reported among women and those with lower socioeconomic status (Hynie et al., 2022; 2023). Lack of internet access prevented older adults from attending telehealth video appointments, while poor or unstable connectivity led some individuals with problematic alcohol use to reject telehealth in favour of in-person care (Wolfe et al., 2023). Beyond access, digital literacy constituted an equally important barrier: disparities in digital skills similarly followed gender, income, and education lines, with older adults, people with learning disabilities, those with lower education levels, and individuals in rural areas disproportionately affected (Wolfe et al., 2023; Hynie et al., 2022). Low digital literacy or discomfort with digital devices hindered engagement with technology-based treatment options more broadly (Wolfe et al., 2023). Online schooling for children and language classes were noted as incidental pathways through which digital literacy improved within some migrant families (Hynie et al., 2022). For low-SES individuals with severe mental health conditions, limited device ownership, variable platform requirements across providers, and insufficient digital skills constituted compounding barriers to reaching technology-mediated care (Stone & Veinot, 2026).

Transportation options:

Access to transportation constitutes a practical yet consequential determinant of the ability to reach care. Limited transportation options were identified as a common barrier to problematic alcohol use services, particularly for rural residents, people with disabilities, and those with concurrent mental health conditions (Wolfe et al., 2023). Private transport access played a particularly significant role in contexts where services were located in less accessible areas: social farms for people with dementia were disproportionately situated in less deprived areas of England, making car ownership effectively essential for reaching them (Bartlett et al., 2025). The absence of a private vehicle similarly constrained older adults in rural and remote areas from reaching health facilities (Schwarz et al., 2022). Where private transport was unavailable, the adequacy of public transportation became critical yet a lack of public transport options represented an equally significant barrier for older adults in remote areas, leaving those without personal vehicles effectively cut off from care (Schwarz et al., 2022).

Physical proximity to healthcare services:

The physical distance between individuals and healthcare services directly shapes the ability to reach care, with geographic proximity frequently determining whether attendance is feasible at all. Women often selected providers based on geographic convenience rather than perceived quality of care, reflecting the degree to which proximity functions as a primary access criterion (Ash et al., 2025). For refugees placed in remote or segregated accommodations such as camps, the combination of long distances to providers, limited and costly transportation options, and the absence of services within accommodations created compounding barriers to reaching care (Dumke et al., 2024). For older adults in rural and remote areas, geographic isolation similarly constrained access, with distance and limited transport options contributing to withdrawal from care and a progressive loss of confidence in the ability to reach services (Schwarz et al., 2022).

Capacity and emotional resilience for navigating services:

The practical effort required to navigate service systems can itself constitute a barrier to reaching care, particularly for individuals whose mental health condition already depletes their capacity for sustained engagement. The process of searching online, making lengthy calls, and managing waiting lists was described as emotionally exhausting, discouraging engagement and exacerbating the very symptoms, including anxiety and depression that had prompted the search for care in the first place (Kourgiantakis et al., 2023). LGBTQ+ individuals described lacking sufficient personal resources including energy, motivation, and self-advocacy capacity to navigate a system requiring persistent effort, a burden that was substantially amplified during COVID-19 as mental health deteriorated and social support diminished (Lowther-Payne et al., 2026).

Social network and support:

Social support plays a significant facilitative role in the ability to reach care, and its mechanism here differs from its influence on earlier dimensions of the access journey. Whereas in the ability to perceive, social networks help individuals recognise their needs, and in the ability to seek, they provide encouragement and reduce stigma-related hesitancy, in the ability to reach, social support operates more directly, functioning as a practical navigator that bridges the gap between the intention to seek care and the physical act of reaching it. Refugees and asylum seekers relied on family members and friends as informal interpreters, enabling those with limited host-country language fluency to navigate health services (Dumke et al., 2024). Crack cocaine users often depended on trusted companions to advocate for them when reaching services, with this support not only reducing fear of rejection but also creating positive first experiences that sometimes enabled independent access in subsequent encounters (Duopah

et al., 2024). For people with dementia, reliance on care partners was similarly essential: in the absence of coordinated service pathways, caregivers navigated fragmented systems, arranged appointments, and provided transportation on behalf of those in their care (Layton et al., 2024). For people experiencing homelessness, having a peer advocate or chaperone to accompany them to appointments and ensure they reached the appropriate service was identified as a key facilitator of access (McNeill et al., 2022). Unaccompanied children, who lack the family accompaniment and language advocacy that facilitate reaching services, face substantially greater practical barriers to attending care than those with family support (Yılmaz et al., 2025). For low-SES individuals with severe mental health conditions, case managers and peer support specialists served as practical navigators for reaching technology-mediated care, providing temporary device access, demonstrating platform use, and accompanying individuals through digital appointment procedures (Stone & Veinot, 2026).

Safety and unsupportive living environments:

For LGBTQ+ individuals living in unsupportive home environments including households where family members were unaware of their sexual or gender identity, the shift to remote delivery during COVID-19 created a specific barrier to reaching care in any meaningful sense (Lowther-Payne et al., 2026). Even when services were nominally accessible via telephone or video, the absence of a private and safe space from which to engage made attendance functionally impossible for some participants, illustrating that the ability to reach care in virtual modalities is contingent not only on digital access but on the domestic safety of the individual's environment (Lowther-Payne et al., 2026). In the UK, hotel accommodation without adequate Wi-Fi connectivity prevented asylum seekers from accessing digital mental health appointments, while shared living spaces made honest disclosure in remote sessions impossible due to fears of being overheard (Wehbe et al., 2026).

2.3.1.9. Ability to Pay

The ability to pay captures the degree to which individuals possess the financial capacity to meet the costs associated with mental health care both direct and indirect. It is most immediately shaped by the financial resources available to individuals, which in turn reflect broader socioeconomic circumstances including employment stability, income level, and legal status. Vulnerable populations including migrants, refugees, Indigenous communities, and

those in precarious employment are disproportionately affected by financial constraints that limit their capacity to pay, and these constraints are further compounded when individuals are pushed toward private care due to insufficient public sector capacity or prolonged waiting times. Health insurance constitutes the primary mechanism through which financial protection against care costs is extended to individuals, and its presence or absence is therefore a critical determinant of the ability to pay.

Ability to Pay Assessment Overview:

- Financial resources
- Health insurance status

Financial resources:

The availability of sufficient financial resources constitutes a foundational determinant of the ability to pay for mental health care. Across the reviewed literature, financial constraints disproportionately affected populations already vulnerable in other dimensions of the access journey. Having adequate financial resources was essential for accessing social farms, which were not covered by insurance (Bartlett et al., 2025), while the potential cost of mental health services in the absence of insurance represented a significant concern for refugees and asylum seekers with low incomes (Dumke et al., 2024; Salameh et al., 2025). Unaccompanied children face particularly acute constraints, as detention, food insecurity, and prolonged legal processes severely limit their ability to secure resources for care (Yılmaz et al., 2025). Migrants' vulnerability to precarious employment directly affected their capacity to pay for health services (Place et al., 2021; Salameh et al., 2025; Yılmaz et al., 2025), and insufficient financial resources prevented some refugees from securing the technical and digital infrastructure required for virtual mental health care (Hynie et al., 2022). In youth mental health care, where services were predominantly available through the private sector, the ability to afford direct costs depended heavily on stable family income with families possessing sufficient resources able to pay out-of-pocket and access care more quickly (Kourgiantakis et al., 2023; Woodgate et al., 2023). For LGBTQI+ individuals, stable income and employment facilitated the ability to pay (Maria et al., 2025), while vulnerable groups including veterans, Indigenous people, Hispanic men, and those with comorbid mental health conditions reported financial barriers to problematic alcohol use services more frequently than the general population (Wolfe et al., 2023). Even within universal healthcare systems, financial barriers persisted: in the UK, higher mental health service costs disproportionately affected younger and older adults, individuals with long-term conditions, those living alone, ethnic minority groups, and people in more deprived areas (Lowther-Payne et al., 2023).

Health insurance status:

Health insurance status constitutes a critical determinant of the ability to pay, functioning as the primary mechanism through which financial protection against the costs of mental health care is or is not extended to individuals. Insufficient or absent insurance coverage was particularly prevalent among migrants and refugees (Place et al., 2021), with coverage for mental health care often further limited during asylum application processes (Dumke et al., 2024). For refugees and asylum seekers with low financial resources, insurance coverage was identified as a key facilitating factor, yet its absence left many without meaningful financial protection (Dumke et al., 2024). Where public sector waiting times pushed families toward private youth mental health and substance use care, the lack of insurance coverage for private services severely constrained the ability to pay (Kourgiantakis et al., 2023). For LGBTQI+ individuals, health insurance coverage similarly strengthened the ability to pay for mental health care (Maria et al., 2025). Among migrants, Indigenous, and Hispanic communities, insurance gaps were frequently linked to employment status and legal position, compounding financial vulnerability across multiple dimensions of the access journey (Wolfe et al., 2023).

2.3.1.10. Ability to Engage

The ability to engage captures the final and perhaps most sustained dimension of the access journey: the degree to which individuals can actively and meaningfully participate in care once it has been reached. It is shaped by a complex interplay of individual factors including mental and physical health status, motivation, trust, language proficiency, and living conditions alongside relational and structural conditions that either support or undermine sustained participation. Social support, as throughout the access journey, continues to play a facilitative role, though here its function is less about navigation and more about enabling active participation in the therapeutic process itself.

Crucially, the ability to engage is contingent on all preceding dimensions having been successfully negotiated. Where earlier stages of the journey have been disrupted by stigma, fragmented referrals, financial barriers, or practical obstacles to reaching care the therapeutic relationship that underpins meaningful engagement cannot be established. Disjointed or discontinuous care pathways are therefore not merely availability problems; they are engagement problems, as each rupture in continuity requires individuals to rebuild trust and re-establish the conditions for participation from the beginning.

Beyond sustained attendance, the ability to engage ultimately speaks to something deeper: personal empowerment within the care process. Having navigated every preceding barrier,

reached the right service, and received appropriate treatment, individuals must be able to actively participate in managing and directing their own care in accordance with their needs and goals. This requires not only that services are responsive and trustworthy, but that individuals feel sufficiently informed, confident, and supported to exercise agency within the therapeutic relationship transforming engagement from passive receipt of care into active partnership in recovery.

Ability to Engage Assessment Overview:

- Mental health status and condition
- Physical health condition
- Living conditions
- Language-related barriers
- Motivation and readiness to engage
- Trust
- Fear of treatment consequences
- Self-advocacy skills
- Social support

Mental health status and condition:

As with the ability to reach, the mental health condition itself can directly undermine the ability to engage with care once it has been accessed. Shame around disclosing psychological distress particularly in the context of trauma or abuse was identified as amplifying reluctance to engage with services, with providers recognising that the isolating nature of depression and trauma-related conditions could compound this effect (Wehbe et al., 2026).For crack cocaine users, substance use frequently took precedence over sustained participation in treatment: agitation, withdrawal symptoms, and the urgency of obtaining drugs made it difficult to sit through sessions or wait for care, while the isolating effects of crack cocaine further reduced willingness to engage (Duopah et al., 2024). Comorbid mental health conditions similarly posed barriers to engagement, particularly in telephone-based telehealth modalities for problematic alcohol use treatment (Wolfe et al., 2023). For traumatised refugee children and youth, PTSD-related avoidance of traumatic content constitutes a specific barrier to sustained therapeutic engagement (Yılmaz et al., 2025). For individuals with severe mental health conditions, cognitive and organisational difficulties associated with the condition including impaired time management and memory directly undermined the ability to sustain engagement, with missed appointments occurring even when attendance was legally mandated (Stone & Veinot, 2026; Owens et al., 2025).

Physical health condition:

Physical health conditions can directly impair the ability to engage with care, particularly in virtual or telephone-based modalities. Hearing difficulties among older refugees posed a barrier to participation in virtual mental health care sessions (Hynie et al., 2023), while older adults more broadly faced difficulties engaging with problematic alcohol use services delivered via telephone, with barriers particularly pronounced for those with memory problems, speech impairments, or hearing difficulties (Wolfe et al., 2023).

Living conditions:

Unstable living conditions can undermine the ability to engage with care in practical and consequential ways. For people experiencing homelessness, the inability to store prescribed medication safely in hostel environments disrupted treatment adherence, creating a structural barrier to sustained engagement that was rooted not in individual behaviour but in the conditions of daily life (McNeill et al., 2022). Unstable and overcrowded living conditions in hotel accommodation, refugee camps, and detention centres directly impaired the ability to engage meaningfully in mental health treatment by compromising the privacy, confidentiality, and continuity necessary for therapeutic participation (Wehbe et al., 2026).

Language-related barriers:

Language barriers extend their cross-cutting influence into the ability to engage, shaping the quality and depth of participation in care once it has been reached. Limited language fluency was consistently identified as a key obstacle to migrants', refugees', and asylum seekers' ability to engage meaningfully with mental health care (Dumke et al., 2024; Place et al., 2021; Salameh et al., 2025; Yılmaz et al., 2025). These barriers were compounded in virtual settings, where both newcomers and providers noted that the absence of non-verbal communication cues made self-expression even more difficult (Hynie et al., 2022). Syrian refugee women reported that limited language proficiency prevented them from fully understanding care instructions, undermining the therapeutic process (Salameh et al., 2025). For migrant families, the absence of appropriate terminology for mental health concepts in their language further hindered engagement: parents with poor language skills lacked confidence in interacting with institutions, while young people sometimes struggled to articulate their experiences in a new language (Place et al., 2021). Even with interpreter support, children may experience discomfort and difficulty expressing psychological distress, with interpreter consistency,

additional session time, and attention to seating arrangements identified as practical measures to improve engagement. In contexts of collective trauma, interpreters themselves may require psychological support to sustain effective participation in therapeutic work (Yılmaz et al., 2025).

Motivation and readiness to engage:

Motivation and readiness to engage constitute internal determinants of the ability to engage that operate independently of external barriers. Among crack cocaine users, motivation was identified as a critical factor: while some individuals initiated the process of accessing services, many withdrew during or shortly after first contact due to insufficient motivation to sustain engagement. Feelings of discomfort when being observed or interacted with in treatment settings further contributed to withdrawal (Duopah et al., 2024). For low-SES individuals with severe mental health conditions, repeated failures to navigate digital systems produced frustration, anger, self-blame, and lowered self-efficacy, consequences that extended beyond dissatisfaction to actively undermine the motivation and capacity for continued engagement with care (Stone & Veinot, 2026).

Trust:

Trust in providers and services is a prerequisite for meaningful engagement, and its absence or erosion directly compromises the quality and honesty of therapeutic interactions. Disrupted continuity of care undermined trust among older adults, damaging therapeutic relationships and leading to underreporting of symptoms a dynamic that not only reduced engagement but compromised the accuracy of treatment itself (Schwarz et al., 2022). For LGBTQ+ individuals, who are less likely to trust healthcare professionals due to prior experiences of discrimination and pathologisation, the absence of continuity had disproportionate consequences for the depth and honesty of therapeutic engagement (Lowther-Payne et al., 2026).

Fear of treatment consequences:

Fear of the consequences that may follow from full disclosure constitutes a distinct barrier to genuine engagement in care. Older adults reported underreporting or minimising symptoms due to fears of psychiatric hospitalisation, reducing openness and limiting the honesty of therapeutic interactions undermining active engagement and the effectiveness of care even when services had been successfully reached (Schwarz et al., 2022).

Self-advocacy skills:

The ability to engage effectively with care can depend, in part, on individuals' capacity to advocate for themselves within the system. Participants described a persistent need to assert their concerns in order to have them acknowledged, reflecting a dynamic in which the responsibility for securing adequate care was effectively transferred onto patients rather than absorbed by providers. This ongoing self-advocacy demanded considerable emotional strength and added stress, with women repeatedly describing the effort required to remain persistent and be taken seriously (Ash et al., 2025). For low-SES individuals with severe mental health conditions navigating technology-mediated care, sustained engagement required continuous individual effort to navigate varied and poorly integrated digital systems across multiple providers, with the burden of technological complexity frequently transferred to individuals rather than absorbed by the care system (Stone & Veinot, 2026).

Social support:

Social support continues to play a facilitative role in the ability to engage, though its function shifts once again: whereas in earlier dimensions it aided recognition, decision-making, and physical access, here it supports active and meaningful participation in care. Women emphasised the need for greater support during pregnancy to engage with mental health care and navigate available resources, with its absence leaving many feeling discouraged and uncertain (Ash et al., 2025). Where linguistically inclusive services and interpreter support were unavailable, refugees and asylum seekers relied on friends and family members to facilitate their participation in the care process (Dumke et al., 2024). For people experiencing homelessness, peer advocates and chaperones helped individuals understand information shared during consultations, enabling more active engagement in their own care (McNeill et al., 2022).

2.3.2. Towards an Equitable Access Journey

A central insight emerging from the scoping review is that access to mental health care cannot be read as a supply-side or demand-side phenomenon in isolation. The Levesque Framework's ten dimensions, five describing the characteristics of services, five describing the abilities of individuals are most meaningfully understood in relation to one another: each supply-side dimension has a corresponding demand-side ability it should, in a well-functioning system, actively support and strengthen. Approachability should facilitate the ability to perceive; acceptability should create the conditions under which seeking care feels safe; availability and accommodation should reduce the practical burden of reaching care; affordability should not compound the vulnerabilities of those with the fewest resources; and appropriateness should sustain the ability to engage meaningfully over time.

This relational reading matters because individuals do not arrive at services with equal knowledge, resources, or opportunities. Mental health literacy, financial stability, language proficiency, social support, and freedom of movement are not uniformly distributed and a system that leaves the burden of access primarily on individuals will inevitably exclude those whose circumstances make that burden heaviest. Equitable system design requires that supply-side dimensions be deliberately configured to reflect the characteristics and circumstances of the populations they serve, responsive to diversity, flexible in delivery, and capable of adapting to the varying needs, capacities, and contexts that individuals bring to the access journey.

With this framing in mind, the access journey can be traced from its earliest stage. It begins with perception, the recognition that a mental health need exists and that appropriate care is available. This is not a neutral cognitive act; it is shaped by cultural frameworks, mental health literacy, social network dynamics, and the degree to which services actively reach out to identify and inform those who need them. Where approachability is strong through screening programs, community outreach, integrated pathways, and visible, non-stigmatising communication, the system does part of the perceptual work that individuals cannot always do alone.

Should perception occur, the individual must then decide whether to seek care. Stigma is the dominant force at this stage, operating across cultural, social, and institutional dimensions to make the visibility of need feel dangerous. Privacy concerns, institutional mistrust, and prior negative experiences themselves products of system-level failures in interpersonal quality, cultural responsiveness, and discrimination compound this deterrence. An acceptable system, one that is genuinely trustworthy, confidential, and non-punitive, lowers the threshold at which seeking care feels possible.

Reaching care then requires navigating the practical realities of everyday life: geography, transportation, digital access, caregiving responsibilities, employment constraints, physical capacity, and legal entitlements. For those managing chronic or fluctuating conditions, these barriers must be overcome not once but repeatedly across every appointment, every referral, every transition. A system with adequate availability, flexible accommodation, and sufficient workforce distribution reduces this burden; one that is geographically concentrated, rigidly scheduled, and under-resourced transfers it back onto individuals.

Affordability intersects the journey at multiple points not only at the moment of payment, but wherever supply-side failures generate indirect costs; insufficient public capacity creates private sector dependency; poor geographic distribution generates transportation expenses;

interpreter shortfalls produce out-of-pocket fees. The ability to pay is therefore not a discrete gate but a cumulative pressure shaped by system design choices made at every preceding stage. Crucially, affordability operates on more than the ability to pay. Perceived cost can deter care-seeking independently of actual cost: where people believe they will be unable to afford care, an expectation shaped by prior experience rather than the real price seeking itself can come to feel impossible, and the available options appear narrower than they are (Place et al., 2021; Baierl et al., 2026). This cross-link, in which a supply-side dimension (affordability) acts on a demand-side ability it is not formally paired with, the ability to seek rather than the ability to pay, complicates the framework's one-to-one mapping of dimensions to abilities, and is one of the ways in which the present review extends, rather than simply reproduces, the structure of the Levesque framework.

Appropriateness determines whether care, once accessed, genuinely responds to need and whether individuals can sustain engagement over time. Cultural responsiveness, continuity of care, integration across services, and the quality of therapeutic relationships are all system-level conditions that shape not only the experience of care but its effectiveness. The same cross-cutting determinants that appeared as barriers at earlier stages such as stigma, discrimination, poor interpersonal quality reappear here, now as threats to sustained engagement rather than to initial access.

Throughout this journey, a cluster of cross-cutting determinants recurs across multiple dimensions: language barriers, stigma and discrimination, social network dynamics, and the availability of social support all shape perception, seeking, reaching, paying, and engaging in different but interconnected ways. Their cross-cutting nature is not incidental, it reflects the degree to which access is fundamentally a social phenomenon, embedded in relationships, communities, and institutional histories that no single service encounter can fully address.

The journey, however, is not linear. Individuals move through its stages in different sequences, at different speeds, and with interruptions that do not simply pause progress but reshape the conditions for future engagement. Each encounter with the system, positive or negative, generates perceptions that feed forward into subsequent help-seeking decisions. A poor experience does not merely end one episode of care; it raises the threshold for the next. A trustworthy, culturally safe, and responsive encounter can open pathways that years of prior barriers had closed. Equitable mental health systems must be designed with this circularity in mind not as one-time access points, but as ongoing relationships with the communities they serve, in which every interaction either builds or erodes the conditions for the next.

2.3.3. Measuring the Levesque Framework Dimensions: Methodological Approaches in the Reviewed Studies

This section examines how the dimensions of the Levesque framework have been measured in the empirical literature; that is, the research methods used to render each dimension into qualitative and quantitative measures. It is therefore a methodological synthesis of how access has been studied, rather than a guide to applying the framework in practice; practical application is developed in Part II. Of the 38 studies included in the scoping review, 22 generated original empirical data using the Levesque Framework as the basis for data collection instrument development, comprising 17 qualitative studies (including two study protocols), two mixed-method studies, and three quantitative studies.

Among the 17 qualitative studies and protocols, nine made their data collection instruments publicly available as supplementary materials (Berger et al., 2020; Brehon et al., 2025; Hollingdrake et al.,2023; Lowther-Payne et al., 2026; Naheed et al., 2022; Salameh et al., 2025; Schwarz et al., 2022; Shah et al., 2025; Williams-Ridgway et al., 2026), while two reported thematic categories of interview questions within the manuscript without providing the full instrument (Kourgiantakis et al., 2023; Woodgate et al., 2023). Among the three quantitative studies, approaches to operationalisation varied markedly: one made its instrument fully available within the manuscript (Clifton & Hancock, 2025); one used no survey or interview instrument, instead operationalising framework dimensions through administrative records with all variables reported in full (Leclair et al., 2022and one operationalised access as time-to-diagnosis across five sequential pathway stages derived directly from the Levesque Framework, using a purpose-built instrument developed a priori, which was not publicly available (Martínez-Jaime et al., 2024). The instruments used in both mixed-method studies were also not publicly available (Bartlett et al., 2025; Fernandez & Gaitonde, 2026). Given this variation in instrument availability and operationalisation approach, the following sections present the qualitative and quantitative evidence separately, examining how each Levesque dimension has been operationalised across these two methodological traditions Annex 2. Measurement of the Levesque Framework Dimensions in Studies Included in the Scoping Review).

2.3.3.1. Qualitative Approaches to Measuring Levesque's Framework Dimensions

Berger et al. (2020) present a study protocol for a qualitative exploratory study examining perinatal mental health care from both user and provider perspectives in Switzerland. The semi-structured interview guide for women comprises 13 main questions with optional probes,

covering the full care pathway from symptom recognition to service experience. The guide is stage-informed, progressing through recognition of illness, help-seeking, referral, and treatment experience, and in doing so addresses all access stages of the Levesque Framework. However, supply-side and demand-side dimensions are not distinguished within the questions; both systemic and individual factors are explored through the same items without differentiation, leaving the analytical separation of these dimensions to the interpretation of responses rather than to the instrument design itself.

A notable feature of the guide is the inclusion of a dedicated question on the patient-provider relationship, framed as: "Before feeling unwell or seeking help, how did healthcare professionals obtain information from you about your mental wellbeing?" With optional probes on trust, openness, perceived competence, and comfort in communication, this question generates data that cuts across multiple framework dimensions. While the content is most directly relevant to Acceptability and Appropriateness through its focus on interpersonal quality of care, it also carries implications for Approachability, as the proactive role of healthcare professionals in initiating conversations about mental wellbeing constitutes an important supply-side condition for whether services are perceived as accessible in the first place.

The focus group guide for healthcare and social care providers follows a different logic from the individual interview guide. Rather than tracing an individual care pathway, the questions centre on providers' clinical experiences and their perceptions of the challenges faced by women with perinatal mental disorders. The format is consistent with the nature of focus group methodology, which prioritises breadth and collective reflection over individual depth, resulting in questions that are broader and more crosscutting across framework dimensions rather than targeting specific access stages.

Several questions address provider-level barriers and facilitators in a crosscutting manner, generating data relevant to multiple supply-side dimensions simultaneously. Notably, the guide includes a dedicated section on interdisciplinary collaboration, referral systems, and integration of care across providers and disciplines, which speaks directly to Availability and Accommodation and Appropriateness at the system level. A further section on basic and ongoing education for healthcare professionals addresses a supply-side gap relevant to Approachability and Appropriateness, probing whether providers feel sufficiently equipped to identify and respond to perinatal mental health needs. Overall, the focus group guide complements the individual interview guide by capturing the supply-side perspective on access, though its crosscutting structure means that findings generated from it are likely to resist clean mapping onto individual Levesque dimensions (Berger et al., 2020).

Naheed et al. (2022) present a qualitative study protocol aimed at exploring the perceptions, beliefs, and experiences of NCD patients, their family members, healthcare providers, and community health workers regarding mental health problems and the feasibility and acceptability of integrating mental health services into primary healthcare settings in rural Bangladesh. The study employs four separate data collection instruments: individual interview guides for NCD patients, family members of NCD patients, and healthcare providers, and a focus group discussion guide for community health workers, all of which are publicly available as supplementary materials.

The interview guides for NCD patients and their family members follow a largely parallel structure. Under the Approachability heading, questions primarily address the Ability to Perceive dimension by exploring participants' awareness and understanding of the link between NCDs and mental health, their recognition of their own or their family member's mental health needs, and their beliefs about whether such needs warrant professional attention. Questions generated for healthcare providers under Approachability explore providers' awareness of the mental health needs of NCD patients in their community, their capacity to identify and understand mental health problems, and the functioning of referral systems within primary healthcare centres.

Under the Acceptability heading, the patient and family member guides explore whether participants would find mental health services acceptable if offered within primary healthcare centres, whether they believe such services should be provided in that setting, whether they would use them if available, and their preferred mode of service delivery for instance, face-to-face versus telephone. These questions are reasonably well-aligned with the Acceptability dimension, capturing acceptability of service design and willingness to use mental health services of patients and their caregivers if services would be offered in primary care. The questions posed to healthcare providers under the same Acceptability heading, however, diverge from this dimension in their content. Acceptability from a provider perspective could have explored providers' attitudes toward mental health conditions, stigmatising beliefs, or willingness to integrate mental health into their practice. Instead, the questions focus on providers' perceptions of the importance of mental health for NCD patients and the feasibility of service integration topics more closely aligned with Approachability and Availability and Accommodation.

Under the Availability and Accommodation heading, the patient and caregiver guides include a single question asking what treatments participants have received or are currently receiving for their mental health problems. Understanding current treatment uptake is relevant for

planning future service and treatment availability, as it reveals existing gaps in provision. However, this single question is insufficient to fully operationalise the dimension, addressing neither the broader reach and accessibility of services nor their fit with patients' daily lives and practical circumstances. The provider guide addresses this dimension more substantively, with questions exploring the availability of NCD and mental health treatments, existing screening systems, and clinical guidelines for detecting mental health problems. Accommodation, however, remains largely unaddressed across all participant groups.

The single Affordability question posed to patients and caregivers asking whether they would agree to pay for mental health services and if so how much measures willingness to pay rather than actual ability to pay. While this may capture the acceptability of cost as a condition of service use, it does not operationalise the Affordability dimension as conceptualised by Levesque's Framework. The ability to pay is instead approached indirectly through the provider guide, which asks whether providers think patients would be able to bear the cost of mental health services making it the only question in the instrument that gestures toward Ability to Pay as a demand-side capacity, albeit from a third-party perspective rather than from patients themselves.

Under the Appropriateness heading, only patients and caregivers are asked two questions. The first, asking what can be done for mental health problems, is broadly crosscutting and does not target Appropriateness specifically. The second, asking whether mental health problems should be treated, probes the perceived legitimacy and importance of mental health treatment a question more closely aligned with Ability to Perceive, as it concerns whether individuals recognise mental health problems as a legitimate health need warranting care, rather than with Appropriateness.

The instrument also includes a dedicated Barriers section across participant groups. Patients and caregivers are asked about the challenges they face in seeking mental health services at individual, familial, and societal levels, while providers and community health workers are asked about the challenges of integrating mental health into primary care. These crosscutting barrier questions generate data relevant to multiple dimensions simultaneously but resist clean mapping onto any single Levesque's Framework dimension (Naheed et al., 2022).

Brehon et al. (2025) conducted a qualitative study exploring patient and provider perspectives on the impact of the COVID-19 pandemic on cystic fibrosis healthcare access and service delivery in Canada. Mental health needs of patients emerge as a secondary concern within the findings rather than constituting a primary focus of the study. The semi-structured interview guide for cystic fibrosis patients and healthcare providers is publicly available as

supplementary material. However, examination of the instrument reveals that the questions are not structured around the Levesque Framework's dimensions; instead, they consist of broad, crosscutting questions exploring how the pandemic affected healthcare access and service delivery for cystic fibrosis patients. No questions specifically address mental health access, and the instrument does not attempt to operationalise individual Levesque's Framework dimensions.

Hollingdrake et al. (2023) conducted a qualitative study exploring the perceptions of women with lived experience of domestic and family violence on accessing healthcare in Australia, with a focus on identifying how nurses can facilitate and support access to care. Mental health needs including psychological support, trauma, and anxiety emerged as a secondary but prominent theme within the findings rather than constituting the primary focus of the study. The questions were structured directly around the Levesque's Framework, with supply-side and demand-side dimensions combined within each thematic area rather than treated as separate analytical categories. While this approach reflects a deliberate a priori application of the framework, examination of the instrument reveals that individual questions are broadly formulated in a way that is likely to generate responses spanning multiple dimensions simultaneously. As with several other studies in this review, the framework informed the structure of the instrument without translating into dimension-specific questions capable of isolating individual components of access. In addition to the dimension-informed questions, the guide includes broader crosscutting items asking what makes it easier or harder to access healthcare, and how participants would design the pathway between domestic violence and health services. These questions generate reflective and evaluative data that span multiple dimensions, complementing the framework-structured items with a more open-ended exploratory layer.

Lowther-Payne et al. (2026) conducted a qualitative study exploring LGBTQ+ people's experiences of accessing NHS mental health services during the COVID-19 pandemic in the UK, with a particular focus on how LGBTQ+ identity shaped these experiences. The interview guide is publicly available as supplementary material and is explicitly informed by the Levesque Framework, structured as a journey from initial recognition of mental health needs through to outcomes of service use. This sequential, pathway-based organisation gives the instrument a coherent narrative logic that maps well onto the framework's overall architecture.

The instrument is organised into five sequential sections that mirror the access journey. Under Perception of Mental Health Needs and Desire for Care, questions explore how participants recognised and understood their mental health needs during the pandemic and what types of

support they considered seeking, capturing content relevant to Ability to Perceive and the early stages of Approachability. Under Healthcare Seeking, questions address the decision-making process leading to help-seeking, how participants determined where to go, and whether their LGBTQ+ identity influenced their choice of service content that spans Ability to Seek and Acceptability. Under Healthcare Reaching, questions explore referral mechanisms, the services accessed, and experiences of those services. While this section primarily addresses Availability and Accommodation and Ability to Reach, it also incorporates Acceptability and Appropriateness-relevant content, notably through questions asking whether LGBTQ+ identity influenced what happened after seeking help and whether services asked about sexual orientation or gender identity. Under Healthcare Utilisation, questions focus on the quality and fit of services received, aligning most closely with Appropriateness and Ability to Engage. A final Healthcare Consequences section invites broader reflection on the overall access experience and recommendations for improvement. Affordability and Ability to Pay are absent across all sections, which may reflect the NHS context in which out-of-pocket costs are minimal; however, indirect costs such as time and transport remain relevant access barriers that are not explored.

Salameh et al. (2025) conducted a qualitative study describing Syrian refugee women's experiences of barriers to accessing mental health services for postpartum depression in Turkey. The semi-structured interview guide is informed by the Levesque's Framework, though questions are not organised under explicit dimension headings. The guide opens with questions addressing Ability to Perceive, exploring participants' knowledge and perceptions of postpartum depression, their awareness of available services and treatment options, and their mental health needs during and after pregnancy. Questions about whether healthcare providers discussed postpartum depression with them relate to Approachability, capturing the supply-side role of providers in initiating mental health conversations. Questions on participants' understanding of available mental health services and treatment options for postpartum depression in Turkey, while placed under Ability to Perceive, may also yield indirect information about service availability though only through the lens of patient awareness rather than through direct assessment of what services exist. Where participants had used services, their experiences are explored through questions that generate data relevant to Acceptability and Appropriateness. A notable feature of the instrument is its barrier and challenge section, which includes a crosscutting question supported by dimension-informed prompts. These prompts address each dimension pair in turn: health beliefs, trust, and expectations for Approachability and Ability to Perceive; culture, gender, and autonomy for Acceptability and Ability to Seek; living environment, transportation, time, and social support for Availability and Accommodation and Ability to Reach; income and health insurance

for Affordability and Ability to Pay; and caregiver support and engagement for Appropriateness and Ability to Engage.

Schwarz et al. (2022) conducted a qualitative study identifying barriers to accessing healthcare services for three distinct population groups in Austria's fragmented social health insurance system, including older people with pre-existing mental illness. The semi-structured interview guide is publicly available as supplementary material and is informed by the Levesque Framework, though questions are organised around access barriers, influencing factors, and recommendations rather than individual dimensions, resulting in a crosscutting rather than dimension-specific structure.

A distinctive feature of the instrument is that the Levesque Framework is explicitly introduced to participants prior to the barrier questions, orienting them to the conceptual model before they are asked to reflect on their experiences. This approach uses the framework not only as an analytical lens but as a participant-facing tool to structure the conversation, which may facilitate more theoretically grounded responses while also raising questions about the extent to which participants' answers are shaped by the framing provided.

Shah et al. (2025) conducted a qualitative study identifying factors affecting access to mental health services for people living with heart failure, drawing on perspectives from patients, clinicians, and researchers. Three separate interview guides were developed, with patient questions targeting demand-side dimensions and clinician and researcher questions targeting supply-side dimensions a structural choice that reflects a deliberate attempt to align participant groups with their respective positions within the Levesque Framework.

Examination of the instrument reveals, however, that the alignment between question content and the intended dimension is inconsistent across several sections. Under Approachability, clinicians are asked how they identify mental health needs in patients with heart failure, whether screening exists, and how they communicate about mental health questions that are well-aligned with the supply-side dimension. Researchers are similarly asked about best practices for identifying mental health impact. Under Ability to Perceive, patients are asked how heart failure affects their mental health and whether they are aware of available services, which is appropriate. However, questions placed under Acceptability for both clinicians and researchers addressing referral practices, approaches to managing mental health, and the role of clinicians in this process are more closely aligned with Approachability, as they concern the supply-side conditions that make services identifiable and reachable rather than their social or cultural acceptability. Some of these questions may also yield interpersonal quality of care data, but their primary content remains approachability related.

Under Ability to Seek, patients are asked how they manage their mental health, who they seek help from, and their awareness of available services. While labelled as Ability to Seek, these questions engage more with Ability to Perceive and Approachability, as they probe knowledge and awareness rather than the attitudinal and social factors such as stigma, autonomy, and social support that more precisely constitute barriers to help-seeking at the demand side. Under Availability and Accommodation, clinicians and researchers are asked about appointment mechanisms, waiting times, service location, format, and hours of operation, which is well-aligned with this dimension. The patient questions placed under Ability to Reach, largely replicate these supply-side concerns asking about travel, location, booking, and waiting times rather than probing the individual-level factors that prevent patients from navigating these conditions, such as physical capacity, competing responsibilities, or social support, yet responses may shed light on how these structural factors interact with individual-level barriers to reaching care.

Affordability is addressed through a single question to clinicians and researchers, while patients are asked how mental health costs affect their access, generating data relevant to both Affordability and Ability to Pay. Under Appropriateness, clinician questions explore contributors to care quality, examples of high and low quality care, and the extent to which available services meet patient needs all of which are core components of the Appropriateness dimension while researcher questions focus solely on determinants of quality. Finally, under Ability to Engage, patients are asked about the quality of services received and how well these met their needs content that aligns more closely with Appropriateness than with Ability to Engage, which concerns the sustained and active participation of individuals in care rather than their retrospective evaluation of service quality.

Williams-Ridgway et al. (2026) conducted a qualitative study exploring healthcare professionals' perspectives on minoritised ethnic young people's access to specialist eating disorder services in the UK, including barriers and facilitators to help-seeking and healthcare providers' experiences of working with this population and their families. The interview guide is organised into four thematic sections including Help-Seeking, Accessing Treatment, Treatment Experience, and Future Provision none of which maps directly onto individual Levesque's Framework dimensions. Questions are crosscutting in nature, exploring provider perceptions of barriers and facilitators to access, referral patterns, assessment experiences, treatment delivery, and cultural adaptation of care. The Help-Seeking and Accessing Treatment sections address barriers and facilitators spanning from Approachability to Affordability in a crosscutting design, with a consistent focus on the specific challenges faced by minoritised ethnic groups. The Treatment Experience section contains questions more

closely aligned with Acceptability and Appropriateness, exploring providers' experiences of delivering care to this population and their cultural sensitivity and competence in doing so. A distinctive feature of the instrument is its explicit focus on ethnicity as a vulnerability characteristic, with questions consistently probing whether and how ethnic background shapes access experiences, help-seeking patterns, and treatment engagement positioning equity as a central analytical lens throughout. All questions are posed from a supply-side perspective, with demand-side dimensions addressed only indirectly through providers' observations of patient and family experiences.

Kourgiantakis et al. (2023) conducted a qualitative study exploring access to mental health and addiction services for youth aged 16–24 in Ontario, Canada. The interview guide is not publicly available; however, the thematic categories of questions are reported within the manuscript. Questions were organised into six categories: experiences of youth, parents/caregivers, and service providers; mental health and addiction services used currently or in the past; concerns that prompted requests for navigation support; barriers and facilitators to accessing mental health and addiction services; the role of families and the impact of family involvement; and experiences of discrimination, racism, and stigma. The thematic categories suggest a crosscutting design, spanning multiple Levesque dimensions simultaneously rather than targeting individual dimensions in isolation. The inclusion of a dedicated category on the role of families and family involvement is noteworthy, as social support is a cross-dimensional enabler that can shape barriers and facilitators across multiple demand-side dimensions from Ability to Perceive through to Ability to Engage while also shedding light on the system-level factors that make such support possible or inaccessible. Similarly, the inclusion of a dedicated category on experiences of discrimination, racism, and stigma reflects an equity-oriented approach to access, capturing barriers related to Acceptability, Appropriateness, Ability to Seek, and Ability to Engage that are frequently under addressed in framework-informed instruments.

Woodgate et al. (2023) conducted a qualitative hermeneutic phenomenological study exploring factors that influence parents' perceptions of youth mental health service access in Canada. The interview guide is not publicly available; however, thematic categories of questions are reported within the manuscript. The study employs a two-session interview design. The first session was used to confirm that participants met the sampling criterion of having a child with a clinical diagnosis of anxiety. The second session used an open-ended interview guide organised around three thematic areas: what it is like for the child to live with anxiety, how living with anxiety shapes daily life, and what hinders and helps the child to live a satisfying and productive life. As the full instrument is not publicly available, it is not possible

to assess whether individual questions targeted specific Levesque dimensions or adopted a broader crosscutting approach. The thematic categories reported in the manuscript suggest a lived experience orientation consistent with the hermeneutic phenomenological approach. Notably, the study also incorporated arts-based methods as part of its broader approach to data collection, reflecting a commitment to amplifying participant voices beyond the constraints of conventional interview formats. Given that access is ultimately a deeply personal journey shaped by the interaction between individual circumstances and system-level characteristics, this study offers a valuable example of how methodological approaches beyond structured interviewing can capture the nuanced, lived dimensions of access that dimension-specific instruments may not reach (Annex 2. Measurement of the Levesque Framework Dimensions in Studies Included in the Scoping Review)

2.3.3.2. Quantitative Approaches to Measuring Levesque's Framework Dimensions

Clifton and Hancock (2025) conducted a quantitative cross-sectional study examining the applicability of the Levesque Framework to law enforcement officers' access to mental health care, with a particular focus on the role of police culture and stigma. Data were collected through an online survey administered to sworn officers in Kentucky and Virginia. The instrument combined items from the Mental Health Literacy Scale (MHLS; O'Connor & Casey, 2015), the Medical Mistrust Index (LaVeist et al., 2009), and author-developed Likert-scale items to operationalise each of the five demand-side dimensions of the Levesque Framework. All dimensions were addressed individually and analysed separately through structural equation modelling.

Ability to Perceive was operationalised through two distinct constructs. The first, Perceive as Illness, drew on five items from the MHLS measuring health beliefs about mental illness including whether it reflects personal weakness, constitutes a real medical condition, is a matter of willpower, or is contagious. This construct captures the intersection of symptom awareness and internalised stigma, targeting the cognitive and attitudinal dimensions of need recognition. The second construct, Associate, comprised seven MHLS items measuring willingness to engage socially and professionally with people living with mental illness including willingness to live next door to, make friends with, or employ someone with a mental health condition. This construct reflects externalised stigma directed toward others. While the authors positioned Associate under Ability to Perceive on the grounds that perceiving mental illness as real and legitimate underpins recognition of need, its conceptual reach extends beyond this dimension. Low willingness to associate with people with mental illness may signal an internalised reluctance to identify with the category of "mentally ill," potentially inhibiting

self-recognition of need; at the same time, the attitudinal content of this construct has strong implications for Ability to Seek, as fear of being perceived and treated the way one perceives others with mental illness may constitute a significant barrier to help-seeking.

Ability to Seek was operationalised through two constructs. The first, Not Seek Help, comprised a single MHLS item "If I had a mental illness, I would not seek help from a mental health professional" measuring general willingness to pursue professional mental health care. This construct captures a broad attitudinal disposition toward help-seeking, reflecting the individual's overall readiness to engage with the healthcare system. The second construct, Keep from Work, was primarily author-developed and included one additional MHLS item. It measured attitudes and willingness regarding the disclosure of a mental health diagnosis in the workplace, capturing beliefs that seeking mental health care would negatively affect one's career, that it should be concealed from coworkers, bosses, and supervisors, and that it may lead to mistreatment at work. While Not Seek Help reflects a generalised help-seeking attitude, Keep from Work targets the occupationally specific dimension of stigma, the fear of professional consequences and workplace judgement that is particularly salient in law enforcement culture. Together, these two constructs offer a nuanced operationalisation of Ability to Seek, distinguishing between individual-level reluctance to seek care and the structural and cultural barriers within the occupational environment that discourage disclosure and help-seeking.

Ability to Reach was operationalised through two constructs. The first, Knowledge of Treatment, drew on four items from the MHLS measuring confidence in knowing where to find information about mental illness, confidence in using digital or telephone resources for this purpose, confidence in attending face-to-face appointments to obtain such information, and perceived access to resources including primary care, the internet, and social networks that could be used to seek information about mental illness. Notably, all four items are framed around information-seeking confidence and self-efficacy rather than the ability to physically or logistically reach mental health services. This positions the construct closer to Ability to Perceive than to Ability to Reach. The second construct, Agency Trust, comprised four author-developed items measuring trust in and the quality of the relationship with one's immediate supervisor. While supervisor trust is relevant to the law enforcement context, its conceptual fit with Ability to Reach is also debatable. Trust in a supervisor may function more as a social support factor with crosscutting effects across multiple dimensions reducing stigma, facilitating disclosure, and enabling help-seeking rather than directly addressing the logistical and structural aspects of reaching care. Indeed, a more direct operationalisation of Ability to Reach

in this occupational context might have addressed whether officers can obtain leave to attend appointments or whether scheduling conflicts with shift work.

Ability to Pay was operationalised through a single author-developed item assessing whether seeing a mental health professional is perceived as affordable. However, perceived affordability is not entirely disconnected from actual financial capacity, if an individual perceives a service as affordable, this implicitly reflects a judgement that its cost falls within their means, rendering a direct measure of financial capacity potentially redundant.

Ability to Engage was operationalised using the Medical Mistrust Index, a seven-item validated scale measuring generalised distrust toward healthcare organisations. Items probe beliefs about deception, cover-ups, harmful practices, privacy breaches, and overall competence of healthcare organisations. While the authors positioned this construct under Ability to Engage, the Medical Mistrust Index captures a broad attitudinal orientation toward healthcare organisations rather than the experience of engagement with care itself. Ability to Engage as conceptualised by Levesque et al. (2013) concerns the individual's capacity and motivation to participate in and adhere to care once accessed, a process-level construct more directly shaped by actual service experiences. Generalised medical mistrust, by contrast, is likely to exert its strongest influence at earlier stages of the access pathway, shaping Ability to Perceive, and Ability to Seek before an individual ever enters into a care relationship. Its placement under Ability to Engage therefore underestimates its crosscutting role across the full framework. However, trust issues may also hinder information sharing during the care process itself, which may ultimately compromise the quality and appropriateness of care received.

Leclair et al. (2022) conducted a quantitative retrospective cohort study examining individual and contextual barriers and facilitators of access to mental health services among people found Not Criminally Responsible on account of a Mental Disorder (NCRMD) in Québec, Canada. Rather than employing a survey or interview instrument, the study operationalised Levesque Framework’s dimensions through governmental administrative health records a methodologically distinct approach that enables population-level analysis but constrains the constructs that can be measured to those captured by routine data.

The causal logic of the study is sequential and consistent with the Levesque Framework's access pathway: the authors conceptualised access as a stepwise process in which seeking care is a precondition for reaching it, and reaching it is a precondition for receiving it. Accordingly, three demand-side dimensions were operationalised as discrete dependent variables. Ability to Seek was defined as having had at least one contact with any mental

health service prior to the index offence a dichotomous variable that, while constrained by the nature of administrative data, is conceptually coherent given the assumption that all individuals in the sample had a mental health need. Ability to Reach was operationalised as having had at least one contact with a psychiatrist, reflecting successful navigation to specialist care. In the Canadian context, where psychiatric care is accessible almost exclusively through referral, this operationalisation also indirectly captures the absence of structural access barriers reaching a psychiatrist implies that referral pathways were successfully navigated. Ability to Engage was operationalised through two outcomes: volume of psychiatric visits as a proxy for intensity of care, and the Bice-Boxerman continuity of care index described by the authors as a proxy for quality of services reflecting the extent to which regular psychiatric care is provided by a single psychiatrist outside of hospitalization and emergency room visits. While these measures sit closer to Appropriateness in the Levesque Framework, they offer indirect evidence of engagement an individual who accumulates psychiatric visits and maintains a relationship with the same provider is, at minimum, physically present in the care system. However, administrative data cannot capture whether care was experienced as meaningful, participatory, or beneficial, leaving the deeper dimensions of Ability to Engage active participation, adherence, and therapeutic benefit beyond the reach of this operationalisation. Despite these limitations, Leclair et al. (2022) represent a methodologically distinctive and rigorous example of how administrative records can be leveraged to operationalise access framework dimensions at a population level, with all variables and their operationalisations reported in full.

Independent variables were organised into three blocks following the behavioural model of health services use (Andersen, 2008). The first block comprised contextual supply-side factors operationalising Availability and Accommodation at the meso-level: the number of physicians per 1,000 population in the regional health district, community resources within a 15-minute drive radius, hospital centres offering outreach services within a 30-minute drive radius, and hospital centres offering referral services within a 60-minute drive radius. These variables capture the structural availability and geographic accessibility of services at the system level. Residency outside of major urban centres was also included as a contextual factor, providing an indirect measure of geographic barriers relevant to Ability to Reach.

Ability to Pay was approached at the area level through two deprivation indices material and social disadvantage of the area of residency, represented as quintiles. While these are ecological rather than individual-level measures, they offer an indirect and contextually meaningful proxy for Ability to Pay in a dataset where individual financial data were unavailable.

The second block comprised individual predisposing and enabling factors with crosscutting relevance across multiple dimensions: age, gender, living with a partner, family or friends as a proxy for social support, having a criminal record, and having a significant connection to a primary care physician operationalised using the Usual Provider Care index. The third block comprised need-related clinical variables history of prior NCRMD verdict, primary diagnosis at verdict, concurrent personality disorder, and concurrent substance use disorder which, while primarily need indicators, may also carry implications for access across multiple dimensions.

The study employed a sequential block regression approach, entering independent variables into the model in three successive blocks to examine the contribution of each layer of factors contextual, individual, and need-related while controlling for those entered previously. This design was motivated by the recognition that contextual and individual factors operate at different levels of causality. This sequential structure mirrors the logic of the Levesque Framework itself, in which supply-side system-level characteristics shape the conditions under which services exist and are reachable, while demand-side individual-level factors determine whether and how those conditions are met by any given person. Access, in this sense, emerges from the intersection of what the system offers and what the individual is able and willing to do a fit between supply and demand that the block structure captures by first establishing the system-level context before examining individual-level responses to it.

Martínez-Jaime et al. (2024) conducted a quantitative retrospective cohort study evaluating accessibility of specialized mental health services for children and adolescents with ADHD in Mexico City, using the Levesque Framework as the basis for instrument development and data analysis. The study offers a methodologically distinctive approach to operationalising access dimensions: rather than measuring attitudes, perceptions, or service characteristics directly, the authors tracked the child's age at each of five sequential pathway stages perception of the problem, search for a mental health professional, first contact with a professional, arrival at the host hospital, and formal diagnosis treating the time elapsed between stages as an indirect measure of access barriers at each dimension.

Ability to Perceive was operationalised as the age at which the problem was first recognised, with caregiver education level examined as an independent variable reflecting the caregiver's capacity to identify and interpret symptoms as a mental health need. Ability to Seek was operationalised as the age at which caregivers began searching for a mental health professional. Ability to Reach was captured through two stages: the age of first contact with a mental health professional and the age of arrival at the host hospital, reflecting both initial access and navigation to specialised care. Ability to Pay was not operationalised as a

dependent variable but was approached indirectly through health insurance status and primary caregiver occupation as independent variables, reflecting the financial and structural conditions that shape timely access. Ability to Engage was operationalised as the age of formal diagnosis the endpoint of the pathway capturing the cumulative result of all preceding access stages. Several crosscutting independent variables were included across all models: child gender, number of siblings, and primary caregiver age. These factors were not mapped onto specific dimensions but were examined for their influence on diagnostic timing across the full pathway, reflecting the study's recognition that sociodemographic characteristics operate as crosscutting barriers and facilitators rather than dimension-specific determinants Annex 2. Measurement of the Levesque Framework Dimensions in Studies Included in the Scoping Review).

Across the qualitative and quantitative studies reviewed, two distinct but complementary approaches to operationalising the Levesque Framework emerge, each with characteristic strengths and limitations (summarised in Table 2).

Qualitative approaches offer rich potential for capturing the experiential, relational, and contextual dimensions of access that structured instruments cannot easily reach. Their open-ended nature is particularly well-suited to surfacing group-, condition-, and context-specific factors including those that are unlikely to be anticipated a priori by researchers. Studies in this review demonstrated that qualitative instruments can illuminate how Approachability is shaped by provider behaviour and health literacy (Berger et al., 2020; Naheed et al., 2022; Schwarz et al., 2022), how Acceptability is mediated by cultural identity, stigma, and trust (Salameh et al., 2025; Lowther-Payne et al., 2026; Williams-Ridgway et al., 2026), how Availability and Accommodation is experienced through waiting times, geographic distance, and service fragmentation (Hollingdrake et al., 2023; Shah et al., 2025), how Affordability intersects with indirect costs and socioeconomic disadvantage (Kourgiantakis et al., 2023), and how Appropriateness and Ability to Engage are shaped by interpersonal quality of care, cultural competence, and continuity (Shah et al., 2025; Lowther-Payne et al., 2026). However, a recurring limitation across the qualitative instruments reviewed is that data collection predominantly relied on broad experiential questions asking participants to narrate their experiences and then mapping responses onto framework dimensions post hoc rather than designing questions to target specific dimensions from the outset. This a posteriori mapping, while consistent with qualitative traditions, limits the comparability of findings across studies and makes it difficult to assess which dimensions are systematically under addressed versus simply less salient in a given context. Notable exceptions include Salameh et al. (2025), whose barrier section used dimension-informed prompts to systematically elicit data across all ten

Levesque dimensions, and Lowther-Payne et al. (2026), whose journey-based structure traced the full access pathway sequentially approaches that preserve qualitative depth while strengthening conceptual coverage.

Quantitative approaches, by contrast, offer greater precision in isolating specific constructs and testing relationships between them. The studies reviewed demonstrated three distinct strategies: the use of validated scales and author-developed items grouped by dimension (Clifton & Hancock, 2025), the extraction of access-relevant variables from administrative records (Leclair et al., 2022), and age-based pathway measurement as a proxy for access barriers at each sequential stage (Martínez-Jaime et al., 2024). Each of these approaches enabled dimension-specific operationalisation and formal statistical modelling. However, a shared limitation is the crosscutting nature of the constructs used. Stigma, medical mistrust, and social support do not map cleanly onto single dimensions they operate through multiple mechanisms across the full access pathway, and their placement within a single dimension risks both misclassification and underestimation of their broader influence. Clifton and Hancock (2025) partially addressed this through structural equation modelling, which allowed covariances between dimensions to be examined, but the theoretical rationale for which constructs belong to which dimension was not always made explicit or consistent with Levesque's original definitions.

This points to a fundamental challenge in operationalising access: access is a complex, multifactorial phenomenon in which any given barrier or facilitator may exert effects across multiple dimensions simultaneously and through different causal mechanisms. What is needed, across both qualitative and quantitative traditions, is a more explicit causal theory a conceptual map specifying not only which factors affect access, but through which dimension, at which stage of the pathway, and via which mechanism. For quantitative research in particular, the construction of directed acyclic graphs (DAGs) prior to analysis would enable researchers to make their causal assumptions explicit, identify potential confounders and mediators, and avoid the conflation of constructs that operate at different levels of the causal chain.

For qualitative research, a journey-focused approach offers particular promise. Rather than organising data collection around thematic domains or asking participants to reflect on their experiences in the abstract, a journey-focused instrument would accompany the participant through the sequential stages of the access pathway from the moment a problem is first noticed, through its interpretation and recognition as a mental health need, through help-seeking and first contact, to engagement with services and its outcomes. This requires the

researcher to walk alongside the participant through their access journey, using Levesque-informed prompts at each stage to gently orient the conversation without closing down the emergence of unanticipated barriers and facilitators. Schwarz et al.'s (2022) approach of introducing the framework to participants before posing barrier questions offers one model for this; Lowther-Payne et al.'s (2026) sequential section structure offers another. What both approaches share is a commitment to temporal and experiential coherence the recognition that access is not a single event but a process unfolding over time, and that its dimensions are most meaningfully captured when questions follow the logic of that process rather than the logic of an analytical taxonomy.

A further and more fundamental challenge that cuts across both qualitative and quantitative approaches is the conceptual boundary between supply-side and demand-side dimensions, a distinction that, while analytically useful, is frequently blurred in practice, both in how instruments are designed and in how findings are interpreted. Several studies in this review conflated the two, placing questions about system characteristics under demand-side headings or framing individual-level barriers as if they were fixed properties of the person rather than responses to system failures. This confusion is not merely terminological; it reflects a deeper epistemological question about what is being measured and from whose perspective.

The Levesque Framework positions supply-side dimensions as characteristics of the health system what services exist, how they are organised, and whether they are designed to be reachable, acceptable, and appropriate for the populations they serve. Demand-side dimensions, by contrast, capture the individual's capacity to respond to and interact with those system characteristics. Access, in this formulation, is not a property of either the system or the individual alone but emerges from their fit. This has important implications for instrument design: the same phenomenon can be measured from either side of the interface, and how a question is worded can determine which side it captures. Clifton and Hancock's (2025) single affordability item "Seeing a mental health professional is affordable" illustrates this well: an affirmative response implies a fit between cost and financial capacity, but it cannot distinguish between a system that has made services genuinely affordable and an individual who has adjusted their expectations downward. Whether affordability is addressed through pricing policy, insurance coverage, or indirect cost reduction is a supply-side question; whether an individual can and will pay is a demand-side one and the two require different measurement strategies.

This distinction carries broader implications for how access barriers are conceptualised. Living in a rural area, having a physical disability, or speaking a language other than the host

country's majority language are frequently operationalised as individual-level barriers to Ability to Reach or Ability to Seek. Yet these are not inherent properties of the person they become barriers only because the system has not organised itself to accommodate them. Outreach services, telehealth, accessible infrastructure, and interpreting services are supply-side responses to what would otherwise be framed as demand-side limitations. Rurality, disability, and language become access barriers not because of what the individual is, but because of what the system has failed to provide. Recognising this distinction is essential for instrument development: asking an individual whether they find it difficult to travel to services measures their experience of a supply-side gap, not a fixed characteristic of their demand-side capacity. A measurement framework that collapses this distinction risks attributing to individuals what is properly the responsibility of the system, and risks designing interventions at the wrong level of the causal chain.

This distinction also carries implications that extend beyond instrument design into the fundamental question of what an equitable access system looks like. If access barriers are properties of the system rather than the individual, then the system bears the responsibility of continuously reorganising itself to meet the needs of those it currently fails to reach. This is not a one-time design challenge but an ongoing adaptive process and it has direct consequences for how access is conceptualised and measured. A measurement framework that treats access as a stable construct risks missing the dynamic nature of the supply-demand fit: what constitutes a barrier for one group at one point in time may not constitute a barrier for another group, or for the same group at a different time.

People who face barriers to access are not a fixed or inherent category they are constituted by the intersection of individual circumstances and system limitations at any given moment. A sudden influx of refugees following conflict, earthquake displacing communities, or a pandemic restructuring care delivery can render previously underserved groups further marginalised, or bring entirely new groups into contact with systems that were not designed for them. A system that is genuinely equitable must therefore be resilient and responsive capable of identifying and accommodating new forms of unmet need as they emerge, rather than designing for a static population profile. If we are to measure access in a way that captures this adaptability, our instruments must be sensitive not only to whether services exist and are reachable, but to whether the system is organised in a way that can respond to shifting needs whether it can extend its reach, adjust its format, and reconfigure its pathways when the population it serves changes.

This has a further, perhaps counterintuitive implication: as systems become more equitable and previously excluded groups begin accessing services, new inequities may become visible that were previously hidden by non-use. Groups that never engaged with the system did not generate data about their barriers their absence was invisible. As outreach improves and uptake increases among historically marginalised populations, the barriers that remain become more apparent precisely because more people are now attempting to navigate them. Equity progress, in this sense, does not reduce the complexity of the access problem it illuminates it more fully A measurement framework adequate to this challenge must therefore be not only multidimensional and causal, but dynamic capable of tracking how the supply-demand fit shifts over time, across populations, and in response to system-level changes.

The evidence reviewed in this section suggests that no single methodological approach is sufficient to capture this complexity in full. Whether qualitative or quantitative, or a combination of both, a robust measurement framework for access must be

- Journey-informed, tracing the sequential stages through which individuals move from recognising a need to engaging with care
- Theory-driven, grounded in an explicit causal map that specifies which factors operate through which dimensions and via which mechanisms
- Equity-oriented, sensitive to the ways in which barriers are produced by system failures rather than individual deficits
- Adaptive, capable of responding to the shifting composition of populations and the evolving organisation of systems.

These principles inform the development of the EQUICARES measurement framework presented in the sections that follow. Table 2. synthesises the strengths and limitations identified across the reviewed literature and the design response adopted for each.

Table 2. Synthesis of strengths and limitations in the reviewed measurement literature, and how each informed the EQUICARES framework

Aspect	Strengths and limitations across the reviewed literature	How the EQUICARES framework responds
Experiential and contextual depth (qualitative)	**Strength:** qualitative instruments capture relational, contextual and unanticipated factors, and how each dimension is lived (Berger et al., 2020; Naheed et al., 2022; Schwarz et al., 2022;	A journey-staged demand instrument with dimension-informed prompts at each stage, preserving qualitative

	Salameh et al., 2025; Lowther-Payne et al., 2026). **Limitation:** experiences are often mapped to dimensions a posteriori, weakening cross-study comparability and obscuring which dimensions are under-addressed.	depth while ensuring conceptual coverage (journey-informed).
Construct precision and statistical testing (quantitative)	**Strength:** scales and author-developed items grouped by dimension, administrative-record extraction, and pathway/time-based measures enable dimension-specific modelling (Clifton & Hancock, 2025; Leclair et al., 2022; Martínez-Jaime et al., 2024). **Limitation:** the rationale for assigning constructs to dimensions is often implicit or inconsistent with Levesque's definitions.	An explicit dimension → component → indicator architecture, in which every item carries a stated conceptual referent (theory-driven).
Cross-cutting constructs	**Strength:** structural-equation approaches can model covariance between dimensions (Clifton & Hancock, 2025). **Limitation:** stigma, medical mistrust and social support operate across several dimensions; placing them in one dimension risks misclassification and underestimation.	Cross-dimensional components and a conflation rule; explicit causal mapping (e.g., directed acyclic graphs) recommended for quantitative work (theory-driven).
The supply–demand boundary	**Limitation:** several studies conflated the two sides, placing system characteristics under demand headings, or framing system gaps as fixed individual traits, and wording alone can decide which side an item captures.	A person-centred assessment logic with a wording convention and two interpretive distinctions (provision–reach; capability–use); supply is measured as experienced opportunity, demand as capacity to act.
Barriers as system-produced, not individual deficits	**Insight:** rurality, disability and language become barriers because systems fail to accommodate them, not because they are fixed properties of the person. **Limitation:** they are commonly operationalised as individual-level deficits, locating intervention at the wrong point in the causal chain.	An equity-oriented design that treats intersecting circumstances as conversion factors and locates responsibility for the supply–demand fit with the system (equity-oriented).
Dynamic, shifting populations	**Insight:** population needs shift (displacement, disasters, pandemics), and equity gains can reveal inequities previously hidden by non-use. **Limitation:** measurement frameworks tend to treat access as a static construct.	An adaptive framework, applicable across analytic levels and care tiers, designed to track a shifting supply–demand fit over time (adaptive).
Methodological sufficiency	**Limitation:** no single approach, qualitative or quantitative, captures this complexity in full.	Mixed methods are treated as required rather than optional within the EQUICARES assessment strategy.

3. Targeted Health System Performance Assessment Indicators Review

3.1. Introduction:

Health System Performance Assessment (HSPA) is a crucial process for evaluating how well health systems achieve their stated objectives (European Commission Expert Group on Health Systems Performance Assessment, 2025). It plays a vital role in ensuring that health

systems meet people's health needs and preferences, provide high-quality, accessible healthcare for all, and are resilient to changing environments (European Commission Expert Group on Health Systems Performance Assessment, 2018; OECD, 2024). HSPA involves rigorous measurement and analysis to monitor the extent to which health systems fulfil their goals (European Commission Expert Group on Health Systems Performance Assessment, 2025).

Over the past three decades, organisations like the OECD and WHO have developed comprehensive conceptual frameworks to guide HSPA. These frameworks have evolved to integrate new dimensions such as resilience, people-centredness, and environmental sustainability, and place increased emphasis on addressing inequalities. HSPA serves as a valuable instrument for policy-makers to identify areas requiring improvement, support efficient resource allocation, and assess the achievement of key policy objectives (OECD, 2024; WHO, 2022).

HSPA is vital for evaluating access to healthcare because it helps identify shortcomings and vulnerabilities in service provision, particularly for at-risk groups. Effective HSPA can support healthcare systems in improving overall health outcomes and better serving people in vulnerable situations. Health systems that fail to address accessibility issues risk remaining fragile, especially when faced with unexpected challenges (European Commission Expert Group on Health Systems Performance Assessment, 2021). HSPA employs various methodologies to measure accessibility, including population coverage, financial coverage, and the scope of benefits. While using complex index measures for accessibility is not a common practice, some countries are exploring alternative solutions, such as specific surveys and studies or grid-based data of population attributes like socio-economic factors and age groups, as seen in Finland (European Commission Expert Group on Health Systems Performance Assessment, 2021). Patient-reported indicators also offer robust and reliable data on health status, quality of life, and care experience, complementing other metrics to provide a more complete picture of performance (OECD, 2019).

Assessing mental health services is critical because mental health is recognised as a high-priority area within health systems. Effective mental health services contribute to overall population health and well-being. The OECD Mental Health System Performance Framework was developed specifically to address this by identifying core performance principles that should be measured in mental health, such as person-centredness, accessibility, high quality, prevention, cross-sectoral integration, good governance, and innovation (OECD, 2021a).

In this context, a targeted review of key HSPA documents was conducted to identify existing indicators relevant to access to mental health and care services. This review focused on how different frameworks and policy documents conceptualize and operationalise the notion of accessibility and aimed to extract indicators that align with the dimensions of the Levesque Framework (Levesque et al., 2013). By integrating insights from both general health system performance assessments and mental health specific frameworks, the review provided a foundational evidence base for the subsequent indicator mapping process and the development of a draft framework tailored to mental healthcare accessibility.

3.1.1. Objectives

This targeted document review aims:

1. to identify access related indicators relevant to mental health and care services, including system-level and individual-level measures,
2. to explore how access is conceptualized and measured in HSPA and mental health specific frameworks,
3. to extract and classify indicators according to the dimensions of the Levesque Framework,
4. and to consolidate findings from both the scoping review and the document review to inform the development of the draft assessment framework tailored to mental health contexts.

3.2. Methodology

A targeted document review was conducted to identify and analyse key Health System Performance Assessment (HSPA) frameworks and policy documents relevant to access to mental health services. The review focused on extracting accessibility related indicators and aligning them with the dimensions of the Levesque Framework to support the development of a draft access assessment framework.

The review was targeted and purposive rather than a systematic, database-driven search. Documents were identified from the publication repositories and websites of four institutions central to health-system performance assessment, the OECD, the WHO, the European Commission Expert Group on Health Systems Performance Assessment, and the Commonwealth Fund, and key documents were then selected by the reviewer (ÖT) on the basis of their authority and direct relevance to the assessment of access. Selection was guided by, rather than a formal screening against, three considerations: whether a document set out an HSPA conceptual framework or indicator set, or a mental-health-specific performance

framework, whether it addressed access or accessibility indicators; and whether it was a current and authoritative publication. The review was deliberately selective rather than exhaustive: the documents represent a purposive selection of influential reference points from the larger body of material these institutions produce, not the total available. Fourteen documents were included (Table 2): three from the European Commission Expert Group on HSPA, seven from the OECD, two from the WHO, and two from the Commonwealth Fund. Data extraction was conducted by a single reviewer (ÖT), focusing on identifying indicators relevant to the dimensions of the Levesque Framework. All indicators related to healthcare accessibility were systematically extracted from the selected HSPA documents and initially mapped under the corresponding dimensions of the Levesque Framework.

Following the initial extraction, the identified indicators and their assigned dimensions were reviewed by the study group (İK, EH, RSP, AÖM) to ensure consistency, clarity, and reliability in categorization. This collaborative review process allowed for refinement of the mapping decisions and helped maintain methodological rigor.

The extracted indicators were then cross mapped with key components identified through the scoping review. This integration enabled the consolidation of findings from both document sources policy-based and literature-based and supported the development of coherent operational definitions for each conceptual dimension of the framework. Moreover, the process enriched both supply-side and demand-side indicators, thereby enhancing the practical relevance and applicability of the draft access framework for mental health services.

3.3. Results

A total of 14 documents were included in the targeted HSPA document review. All indicators related to the dimensions of the Levesque Framework were systematically extracted and grouped under the relevant dimensions. The majority of the selected indicators were associated with supply-side domains, reflecting the predominant focus of HSPA documents on assessing health system performance from a system-level perspective. This emphasis resulted in a relative lack of demand-side indicators. To address this limitation, the scoping review was used to complement the findings by providing insights into the demand-side aspects of access, particularly from the perspective of service users.

Table 3. HSPA Documents Included in the Targeted Review

Institution/Source	Title of the Document

European Commission Expert Group on HSPA	1. A new drive for primary care in Europe: rethinking the assessment tools and methodologies: report of the expert group on health systems performance assessment 2. Identifying, measuring and reducing low-value care in the context of health system performance assessment 3. Improving access to healthcare through more powerful measurement tools: an overview of current approaches and opportunities for improvement
OECD	4. Health at a Glance: Europe 2024: State of Health in the EU Cycle 5. A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health 6. Does Healthcare Deliver?: Results from the Patient-Reported Indicator Surveys (PaRIS) 7. Establishing standards for assessing patient-reported outcomes and experiences of mental health care in OECD countries: Technical report of the PaRIS mental health working group pilot data collection 8. Health for the People, by the People: Building People-centred Health Systems 9. Measuring What Matters: The Patient-Reported Indicator Surveys 10. OECD Guidelines on Measuring Subjective Well-being
WHO	11. Comprehensive Mental Health Action Plan 2013-2030 12. Health system performance assessment: A renewed global framework for policy-making
Commonwealth Fund	13. Mirror, Mirror 2017: International Comparison Reflects Flaws and Oppotunities for better U.S. Healthcare System 14. Mirror, Mirror 2024: A Portrait of the Failing U.S. Healthcare System

A targeted review of 14 Health System Performance Assessment (HSPA) documents was conducted to identify indicators relevant to access to mental health services and to explore how access is conceptualised and measured across major international health system performance frameworks. The selected documents span a range of institutional sources

including the OECD, the World Health Organization, the European Commission Expert Group on Health Systems Performance Assessment, and the Commonwealth Fund and reflect both general health system performance frameworks and mental health-specific assessment tools. Temporally, the documents range from 2017 to 2025, capturing a period of significant evolution in HSPA methodology, marked by growing emphasis on people-centredness, equity, resilience, and the integration of patient-reported measures into system performance monitoring.

The corpus is methodologically diverse. Several documents present overarching conceptual frameworks for health system performance assessment, offering structured taxonomies of dimensions, subfunctions, and indicative measures applicable across health system domains (European Observatory on Health Systems and Policies & WHO, 2023; OECD & European Commission Expert Group on Health Systems Performance Assessment, 2024). Others are thematically focused, addressing specific aspects of performance measurement such as access (European Commission Expert Group on Health Systems Performance Assessment, 2021), low-value care (European Commission Expert Group on Health Systems Performance Assessment, 2025), primary care assessment (European Commission Expert Group on Health Systems Performance Assessment, 2018), and people-centred health systems (OECD, 2021b). Two documents provide international comparative data through patient-reported surveys, the Commonwealth Fund's Mirror, Mirror series (Schneider et al., 2017; Blumenthal et al., 2024) while others focus specifically on the development and standardisation of patient-reported outcome and experience measures, including in mental health contexts (OECD, 2019; OECD, 2022). The only document exclusively dedicated to mental health system performance is the OECD's A New Benchmark for Mental Health Systems (OECD, 2021a), which presents a purpose-built framework for assessing mental health system performance across six key dimensions, supported by 23 indicators.

As reflected in the findings summarised below, the majority of indicators identified across the reviewed documents are associated with supply-side dimensions of access, consistent with the predominant focus of HSPA frameworks on system-level performance measurement. Demand-side indicators particularly those capturing individual-level barriers to perceiving need, seeking care, and engaging with services are markedly underrepresented, a gap that the scoping review findings were drawn upon to address in the subsequent indicator mapping process.

3.3.1. Access and Unmet Need

Access indicators in HSPA documents are predominantly operationalised along three axes: financial, geographic, and temporal. The core cross-national indicator is unmet need for health care, defined as whether an individual felt they needed care but did not receive it in the previous twelve months, and if so, the primary reason; cost, waiting time, or distance (OECD & European Commission Expert Group on Health Systems Performance Assessment, 2024; OECD, 2021b). For mental health specifically, the access gap is conceptualised as the percentage of individuals with any mental illness who used mental health services in the past year, disaggregated by population group (OECD, 2021a).

Geographic access is assessed through facility density and sub-national distribution of services and workforce, with variation across regions identified as a critical equity concern (European Commission Expert Group on Health Systems Performance Assessment, 2021; European Observatory on Health Systems and Policies & WHO, 2023). Temporal access indicators include average waiting times by service type, the availability of after-hours care, and whether services can be accessed without a referral (OECD, 2021a; Schneider et al., 2017; Blumenthal et al., 2024). The number of individuals attending mental health outpatient clinics per 1,000 population and the number under care in community mental health teams per 1,000 population serve as utilisation proxies for access (OECD, 2021a). Whether telemedicine or online counselling is available for mental health care is increasingly included as an access indicator reflecting service flexibility (OECD, 2021a; Blumenthal et al., 2024).

3.3.2. Quality, Safety and Patient Experience

Quality indicators span system-level outcome measures and patient-reported measures. At the system level, key indicators include the rate of repeated emergency department visits for psychiatric reasons (four or more times in a year), the percentage of patients readmitted to inpatient care three or more times annually, and suicide rates within thirty days of discharge from inpatient psychiatric care (OECD, 2021a; OECD & European Commission Expert Group on Health Systems Performance Assessment, 2024). Post-discharge follow-up within a nationally recommended period functions as a continuity-of-care quality indicator (OECD, 2021a).

Patient-reported outcome measures (PROMs) constitute an expanding area of HSPA-based quality assessment. The PaRIS initiative recommends the WHO-5 Well-being Index, PROMIS Global Health, and recovery-oriented measures for routine mental health outcome monitoring (OECD, 2022; OECD, 2025). Condition-specific instruments including the PHQ-9, GAD-7,

CORE, HoNOS, Beck Depression Inventory, and Beck Anxiety Inventory are catalogued for use in specialist settings (OECD, 2022; OECD, 2019).

Patient-reported experience measures (PREMs) assess the relational quality of care. Core items across documents include whether individuals felt treated with courtesy and respect, received easy-to-understand explanations, spent sufficient time with their provider, and were involved in decisions about their care (OECD, 2021b; OECD, 2022; OECD, 2025).

3.3.3. Person-Centredness

Person-centredness is operationalised across five sub-dimensions in OECD frameworks. Under *voice*, the key indicator is whether patients have a formal role in health policy decision-making bodies, assessed across five areas: pharmaceutical licensing, coverage and reimbursement decisions, health technology assessment, service planning, and definition of public health objectives (OECD, 2021b). For mental health specifically, whether people with mental disorders and psychosocial disabilities have formal authority to influence the design, planning, and implementation of policy and services is a distinct governance-level indicator (WHO, 2021).

Under *choice*, the availability of provider selection across primary, specialist, and hospital levels is assessed on a graduated scale (OECD, 2021b). Under *co-production*, indicators include the share of patients receiving accessible information from their provider, the share involved in care decisions, the availability of personal care plans that include service user and carer input, and the proportion using digital tools such as patient portals and health apps (OECD, 2021a; OECD, 2021b). Whether peer-delivered services exist including peer listening, peer education, and peer mediation is an additional co-production indicator specific to mental health (OECD, 2021a). Under *integration*, the use of electronic clinical records by primary care practices and patients' reported experience of care coordination following hospitalisation are the principal indicators (OECD, 2021b; OECD, 2025). Under *respectfulness*, indicators assess whether patients were treated with courtesy and respect by doctors and nurses, whether they felt fairly treated, and whether they spent enough time with their provider (OECD, 2021b; OECD, 2022).

3.3.4. Financing and Resource Use

Financing indicators are drawn primarily from National Health Accounts and reflect both the adequacy and equity of health system funding. Core measures include current health expenditure as a percentage of GDP, government health expenditure as a share of total health

expenditure, and out-of-pocket (OOP) payments as a share of current health expenditure and of household consumption (European Observatory on Health Systems and Policies & WHO, 2023; OECD & European Commission Expert Group on Health Systems Performance Assessment, 2024). Mental health spending as a percentage of total government health spending is a specific governance and financing indicator that signals system-level prioritisation (OECD, 2021a). Although widely used, this is an imperfect proxy for prioritisation: it captures only expenditure recorded within the health budget, whereas mental health is also supported and funded through other sectors such as social care, housing and homelessness services, and education, which the measure does not reflect.

The equity implications of financing are assessed through the incidence of catastrophic and impoverishing health spending, Kakwani indices measuring the progressivity of each financing source, and the distribution of OOP payments across income groups (European Observatory on Health Systems and Policies & WHO, 2023). The depth of the benefit package for mental health whether psychological therapies, outpatient care, inpatient services, and pharmaceuticals are fully or partially covered is assessed by service type, as is the level of co-payment required and whether priority population groups receive additional coverage (OECD, 2021a; European Commission Expert Group on Health Systems Performance Assessment, 2018).

3.3.5. Workforce and Infrastructure

Workforce availability is the most consistently measured supply-side dimension across HSPA documents. Core indicators are density per 1,000 population for psychiatrists, psychologists, mental health nurses, social workers, and counsellors (OECD, 2021a; European Observatory on Health Systems and Policies & WHO, 2023). Distribution indicators capturing geographic variation, age profile, and gender composition of the active health workforce complement density measures (European Observatory on Health Systems and Policies & WHO, 2023). Whether national systems for continuing professional development and in-service training exist is assessed as a workforce quality indicator.

Infrastructure indicators include health facility density and distribution, hospital bed density and occupancy, and the availability of electronic health management information systems (European Observatory on Health Systems and Policies & WHO, 2023; OECD & European Commission Expert Group on Health Systems Performance Assessment, 2024). For mental health specifically, the availability of community-based services and day care facilities, the integration of mental health into primary care, and the use of telemedicine in mental health service delivery are assessed as infrastructure indicators (WHO, 2021; OECD, 2021a).

3.3.6. Governance and Policy

Governance indicators span strategic, legislative, and participatory dimensions. The existence of a comprehensive national mental health law, policy, or action plan is a foundational indicator, as is the presence of population-specific strategies addressing children and young people, older adults, LGBTQ+ individuals, migrants, refugees, homeless people, and the prison population (WHO, 2021; OECD, 2021a). Whether mental health plans are integrated with education, employment, social services, and general health policies and whether specific ministries have a dedicated mental health strategy supported by a ring-fenced budget reflects the multi-sectoral governance dimension (OECD, 2021a).

Anti-discrimination legislation covering mental health status, ethnicity, gender identity, disability, and sexual orientation is assessed as a legal governance indicator (European Observatory on Health Systems and Policies & WHO, 2023). The level of stigma in a society measured through national attitude surveys is identified as both a governance-level system performance indicator and a demand-side barrier, given that public stigma conditions individuals' willingness to seek care (OECD, 2021a). Whether mental health–related indicators are systematically collected and a corresponding national dataset exists is a data governance indicator that is a prerequisite for any dimension-specific assessment (WHO, 2021). A comprehensive approach to equity requires that routine data collection include disaggregation by sex, age, income, employment status, disability, ethnicity, migratory status, territorial location, and sexual orientation (European Commission Expert Group on Health Systems Performance Assessment, 2021).

3.3.7. Low-Value Care in Mental Health

The identification and reduction of low-value care is an emerging area of HSPA work with direct relevance to mental health service quality and resource allocation. Low-value medication indicators include antidepressant monotherapy in bipolar disorder, the concurrent prescription of two or more antipsychotic medications, antipsychotic prescription as a first-line treatment for behavioural and psychological symptoms of dementia, and tricyclic antidepressant prescription for children without comorbid psychological disorders (European Commission Expert Group on Health Systems Performance Assessment, 2025). The use of electroconvulsive therapy in children is identified as a low-value procedure indicator.

Geographic variation in prescribing practices including rates of antidepressant and antipsychotic use per 1,000 population per day, disaggregated by region, age group, gender, social status, and care setting is used to identify unwarranted variation that may reflect

inequitable or inappropriate care (European Commission Expert Group on Health Systems Performance Assessment, 2025). Country-level examples highlight the prescribing of benzodiazepines for generalised anxiety disorder and antihistamines or neuroleptics for alcohol withdrawal syndrome as practices flagged for reduction (European Commission Expert Group on Health Systems Performance Assessment, 2025).

3.3.8. Approaches to Measuring Access: Gaps and Opportunities

The Expert Group on Health System Performance Assessment's report on measurement tools offers a critical assessment of the conceptual adequacy of existing access measurement rather than a catalogue of indicators (European Commission Expert Group on Health Systems Performance Assessment, 2021). The report argues for a holistic approach integrating both a cost-effectiveness perspective and a patient perspective and is candid about what current indicators cannot capture: they fall short of revealing how intersecting socioeconomic characteristics shape access to specific services, particularly for groups whose barriers remain invisible in administrative data. The patient vignette approach combining qualitative inquiry with targeted quantitative analysis is proposed as a methodological response to this limitation.

The report identifies several structural gaps in existing measurement. Sub-national data are underdeveloped, with most indicators operating at NUTS 2 level or above and obscuring within-region variation. Access to health promotion and prevention services is almost entirely unmeasured beyond vaccination rates. On equity, the report specifies that routine data collection should disaggregate by sex, age, income, employment status, disability, ethnicity, migratory status, territorial location, and sexual orientation, on the grounds that availability does not translate into access equally across groups. Structured items for measuring discrimination in healthcare encounters covering mental health status, ethnicity, gender identity, age, disability, income, and sexual orientation are proposed as tools for assessing acceptability and help-seeking barriers that aggregate indicators cannot capture.

3.4. Conclusion

The targeted review of 14 HSPA documents identified a broad range of indicators relevant to mental health service accessibility, spanning financial protection, geographic and temporal access, workforce availability, governance, and patient-reported experience. Across frameworks, access is predominantly operationalised through supply-side measures such as facility density, workforce ratios, waiting times, and benefit package coverage reflecting the macro- and meso-level orientation of HSPA methodology. Demand-side indicators capturing

how individuals perceive need, seek care, and engage with services remain markedly underrepresented, particularly for groups whose barriers are not visible in administrative data.

Alongside these established measures, newer approaches signal an important shift in HSPA towards dimensions that were historically difficult to quantify. Person-centredness, service user involvement in policy and service design, peer-delivered care, and co-production indicators reflect a growing recognition that system performance cannot be adequately assessed without attending to individual experience and agency. Crucially, these measures also point to a more dynamic conception of health system performance one that moves beyond static snapshots of supply and demand towards ongoing feedback loops that enable systems to adapt to changing needs and contexts.

The review also illuminates significant measurement gaps with equity implications. Most indicators operate at NUTS 2 level or above, obscuring within-region variation and rendering the experiences of specific population groups invisible in aggregate data. Routine disaggregation by income, disability, ethnicity, migratory status, and sexual orientation, alongside structured measurement of discrimination in healthcare encounters, are identified as prerequisites for equity-sensitive assessment. Approaches such as patient vignettes and targeted sub-national analyses are proposed as tools for capturing intersecting barriers that administrative data alone cannot reveal. As a purposive review, the corpus is intended to be illustrative of the indicator types used in authoritative HSPA frameworks rather than an exhaustive census, and other relevant documents may exist.

4. Indicator Mapping Workshop: Collaborative Validation and Refinement

To support the development of the draft accessibility framework, a participatory workshop was conducted on June 12th, 2025, during the second project meeting of the EQUICARES consortium. The main objective of this workshop was to validate and refine the preliminary indicator mapping that had emerged from the scoping review and the targeted HSPA document analysis. By engaging project stakeholders in a structured group activity, the workshop aimed to ensure that the draft framework would be both conceptually sound and grounded in practical relevance. The preliminary framework used as the basis for this workshop is provided in Annex 3. It should be noted that this preliminary version was subsequently revised and expanded following the completion of the full scoping review, and

the present document reflects the updated framework informed by the complete evidence base.

4.1. Workshop Design and Methodology

Participants, from the EQUICARES consortium were divided into five small groups one of which participated online. Each group was provided with a mandala diagram representing the ten dimensions of the Levesque Framework, along with a set of post-it notes labelled with access related components derived from scoping review. Groups were instructed to collaboratively map each component to the relevant dimension(s), with the flexibility to reassign or duplicate items across dimensions using blank post-its. They were also encouraged to reflect on the micro-, meso-, or macro-level nature of each component and position them accordingly on the mandala.

4.2. Data Consolidation

Following the workshop, data from all five groups were compiled into an Excel-based database to allow for systematic comparison and synthesis. This database captured the placement of each component across dimensions and the frequency of their appearance. Additionally, it documented which group assigned each component to which dimension, along with the corresponding classification of each component as micro-, meso-, or macro-level. This facilitated a comparative analysis of group perspectives and helped identify areas of convergence and divergence across different stakeholder interpretations.

4.3. Workshop Results

At the sixth-month EQUICARES consortium meeting in Istanbul, the preliminary outputs from the scoping review and HSPA analysis were brought to a participatory workshop involving project partners. Participants from across the consortium were organised into five inter-disciplinary groups and used mandala diagrams to map access-related components onto the ten dimensions of the Levesque Framework, while also reflecting on the micro-, meso-, and macro-level nature of each concept.

The exercise enabled cross-team validation of the component structure and surfaced variation in how different professional and disciplinary perspectives assign meaning to framework dimensions. Key areas of consensus included: transparent and accessible information channels and visibility of services under Approachability; structural discrimination under

Acceptability; staff availability and capacity, coordination between services, and continuity of care under Availability and Accommodation; public financing and investment in health services, breadth and depth of insurance coverage, direct costs of care, equity in cost burden, financial protection mechanisms for vulnerable groups, and indirect and opportunity costs of care under Affordability; need-responsiveness and technical quality of care under Appropriateness.

On the demand side, perceived trustworthiness of services and symptom awareness and interpretation were most consistently mapped under Ability to Perceive; awareness of available health services under Ability to Seek, a component that had been placed under Ability to Perceive in the preliminary framework but was consistently mapped under Ability to Seek by workshop participants; geographic proximity, individual mobility, and occupational and time flexibility under Ability to Reach; income stability, economic vulnerability, and access to health insurance or public coverage and risk of catastrophic expenditure under Ability to Pay; empowerment, self-efficacy, self-management, and communication skills under Ability to Engage.

Beyond areas of consensus, the workshop mapping exercise also revealed a number of cross-dimensional ambiguities that proved analytically informative. Approachability and Availability and Accommodation were frequently conflated, with components mapped under one dimension often reassigned to the other across groups, suggesting that the boundary between service visibility and service presence is not intuitively clear to practitioners. A similar pattern and arguably a more pronounced one emerged between Acceptability and Appropriateness, where relational and quality-related components were regularly mapped interchangeably across the two dimensions. Availability and Accommodation also showed considerable overlap with Ability to Reach, with supply-side concepts such as the physical presence of services which operate at the system level frequently mapped onto this demand-side dimension, indicating that the supply-demand distinction embedded in the Levesque Framework is not always legible in practice. By contrast, Affordability emerged as the most consistently mapped dimension, with participants reliably assigning cost-related components to it regardless of group or professional background. A parallel consistency was observed for Ability to Pay, with the two dimensions remaining analytically distinct in participants' mappings. Ability to Perceive and Ability to Seek were frequently conflated, as were Ability to Seek and Ability to Engage, suggesting that the sequential logic of the demand-side journey from recognising a need, to deciding to seek care, to sustaining engagement is experienced and conceptualised as more fluid and overlapping than the framework's discrete structure implies (Annex 3. Heat Map and Summary of Workshop Mapping Results).

5. Map the Gap Hackathon

5.1. Event Overview

The Map the Gap Hackathon took place on 2 April 2026 at Mundo Madou, Brussels, Belgium. The event ran as a full-day collaborative workshop from 09:00 to 17:00, preceded by a registration and welcome coffee session from 08:30. Coffee breaks and a lunch break were integrated into the programme to allow for rest and informal exchange among participants. The event was conducted entirely in English.

The hackathon was led by Koç University as part of the EQUICARES project, in collaboration with three partner organisations including DIESIS, EUCOMS, and EASPD who contributed to participant outreach and logistical coordination, including venue arrangements at Mundo Madou.

In preparation for the event, participants received a Pre-Event Information Pack approximately one week prior to the hackathon. The pack was designed to ensure that all participants arrived with a shared understanding of the event's purpose and conceptual background. It included an overview of the EQUICARES project and the aims of the hackathon, a description of how the day would be structured and what participants would be expected to do, a detailed introduction to the Levesque Framework for Access to Health Care, and a curated list of recommended readings for those who wished to engage more deeply with the conceptual background ahead of the event.

The event brought together 20 participants from Turkey and Belgium, representing a broad range of institutional backgrounds and professional profiles. Participants included individuals with lived experience or caregiving backgrounds alongside academics and researchers, health and social care practitioners, policy officers, NGO and advocacy representatives, and health technology experts. Their areas of expertise spanned mental health policy, migrant and refugee health, disability rights, child and youth welfare, Roma community advocacy, digital health, and social economy reflecting the inter-disciplinary and cross-sectoral nature of the event. Participants were organised into four inter-disciplinary groups, each working simultaneously through the same structured methodology throughout the day.

The hackathon followed a structured programme organised around four thematic blocks. The morning session focused on identifying and mapping access challenges onto the Levesque Framework, with participants working collaboratively to surface both individual-level and

systemic barriers to mental healthcare access. Following lunch, the afternoon session shifted towards operationalisation, with groups developing and refining measurement questions for each dimension of the framework. The day concluded with a prioritisation exercise and a collective reflection session.

5.2. Objectives and Expected Outcomes

The overall aim of the hackathon was to collaboratively identify and prioritise key concepts shaping access to mental healthcare for people in vulnerable situations, to inform the development of an equity-focused accessibility assessment tool.

More specifically, the hackathon aimed to operationalise these concepts by developing measurement questions for each dimension of the Levesque Framework, with a minimum of two questions per dimension, and to produce a draft accessibility assessment tool of at least 20 items in total.

5.3. Methodology

The hackathon followed a cooperative, participatory format grounded in principles of co-design and collaborative problem-solving. Rather than a competitive event, it was structured as a collective knowledge-generation exercise in which four groups worked simultaneously through the same ten-step methodology, contributing to a shared goal.

The hackathon's design was deliberately informed by the preceding stages of the work, so that it built on the emerging evidence rather than starting afresh. The personas drew on the populations and barrier patterns surfaced in the scoping review, allowing discussion to begin from evidence rather than assumption. The mapping activity used the Levesque structure and its paired supply–demand dimensions as refined in the M6 Indicator Mapping Workshop, and explicitly accommodated challenges spanning more than one dimension, a direct response to the cross-cutting, conflation-prone constructs identified in the scoping review. The requirement to cover all ten dimensions, with an even supply–demand split and a minimum number of questions per dimension, ensured balanced coverage that countered the imbalance found in both the scoping review (where Approachability and the Ability to Engage were comparatively underexplored) and the HSPA review (where demand-side indicators were markedly underrepresented). The equity check, which pushed groups beyond the personas to population-level barriers, reflected the project's equity focus and the finding that access is most fragile for people at the intersection of several disadvantages.

A central methodological tool was the use of fictional personas narrative profiles representing individuals in vulnerable situations facing barriers to mental healthcare access. Each persona was carefully constructed to foreground a distinct set of structural and experiential challenges, serving as a collective lens for the group rather than as an individual case to be solved. The personas were distributed to participants at the start of the event and used as the primary entry point for identifying and discussing access challenges throughout the day (Annex 4. Personas Used in Hackathon)

The methodology was organised around four thematic blocks:

Part 1: Identifying Patterns and Equity Gaps

Participants began by reading a set of fictional personas representing individuals in vulnerable situations. Working in groups, they identified access challenges that appeared across multiple cases as well as those unique to specific individuals, distinguishing between individual-level and systemic barriers. Groups then conducted an equity check, moving beyond the cases provided, to consider what additional challenges might emerge at the population level, ensuring that overlooked or underrepresented barriers were captured. Each challenge was recorded on a separate Post-it note and placed on a shared board.

Part 2: Mapping the Challenges

Groups mapped their Post-it notes onto the dimensions of the Levesque Framework, positioning each challenge within the relevant supply-side or demand-side dimension. Where a challenge spanned multiple dimensions, Post-its were duplicated accordingly. Participants then identified corresponding challenges in paired dimensions and conducted a final fine-tuning review, cross-referencing their mapping with the Levesque Framework. This block concluded with a rotating tables exercise, in which participants moved between groups to review each other's work, add new insights using a different coloured Post-it, and bring fresh perspectives to each board (Annex 5. Challenge Mapping Boards).

Part 3: Operationalising the Challenges

Following lunch, participants shifted to laptop-based work. For each challenge mapped onto the framework, groups developed at least one corresponding measurement question formulated from the perspective of a researcher, policymaker, or practitioner seeking to assess barriers to mental healthcare access. Groups then reviewed their question sets to identify any gaps and added missing questions where needed (Annex 6. And Annex 7.).

Part 4: Refinement and Beyond

In the final block, participants prioritised their questions within each Levesque's Framework dimension, ranking them according to their perceived importance for understanding barriers to mental healthcare access. Drawing on this prioritisation, groups produced a draft accessibility assessment tool capped at 40 items, with an even split between supply-side and demand-side questions and coverage of all ten dimensions. The day concluded with a collective reflection session, Reimagining Access, in which each participant was invited to identify the single most impactful change they would make to improve access to mental healthcare (Annex 6.).

5.4. Participant Profile

The hackathon brought together 20 participants from Turkey and Belgium, representing a diverse range of professional backgrounds, institutional affiliations, and areas of expertise. Participants were recruited through the networks of the organising and partner organisations, with the aim of assembling a multidisciplinary group capable of bringing complementary perspectives to the co-creation process.

In terms of professional profile, participants included academics and researchers, healthcare and social care practitioners, policy officers, NGO and advocacy representatives, a health technology expert, and individuals with lived experience or caregiving backgrounds. The distribution across profiles is presented in Figure 3.

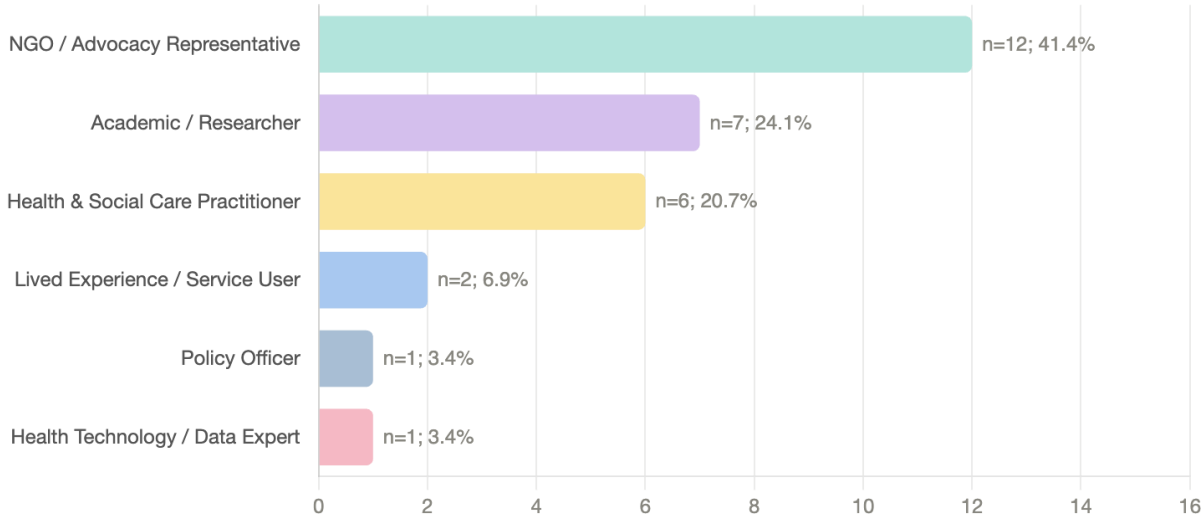

Figure 3. Participant profile distribution

Thematically, participants brought expertise across a wide range of areas relevant to the hackathon's focus, including mental health policy, migrant and refugee health, disability rights, child and youth welfare, Roma community advocacy, digital health, and social economy. This breadth of expertise ensured that the challenges and questions generated during the event reflected a wide spectrum of perspectives and population groups.

Participating organisations spanned European-level NGOs and advocacy bodies, research institutions, health and social care service providers, and regional and local health authorities.

5.5. Overview of Outputs

The Map the Gap Hackathon generated substantive outputs across all ten dimensions of the Levesque Framework. Across the four inter-disciplinary groups, a total of 262 challenges were mapped, and 198 measurement questions were developed, of which 139 were prioritised for inclusion in the draft accessibility assessment tool. The most extensively mapped dimensions were Availability and Accommodation (42 challenges), Ability to Seek (40 challenges), and Appropriateness (38 challenges), reflecting participants' strong awareness of both structural and relational barriers to mental healthcare access (Annex 5., 6, and 7.).

5.5.1. Contribution to Conceptual Development: New and Expanded Themes

A systematic comparison of hackathon outputs with the conceptual framework established through the scoping review and HSPA analysis revealed that the co-creation process both validated existing components and surfaced a range of themes and operationalisation approaches that had not emerged from the literature- and document-based phases. These are documented below by dimension.

Table 4. summarises the supply-side dimensions, setting out the new components and themes the hackathon contributed alongside the existing ones it expanded or repositioned; each is discussed in turn below.

Table 4. New and expanded SUPPLY-SIDE themes and components contributed by the Map the Gap Hackathon (relative to the scoping review, the HSPA review, and the Indicator Mapping Workshop)

Levesque dimension	New components / themes (not previously identified)	Existing components expanded or repositioned

Approachability	AI as an information source (services and conditions); language-inclusive online information channels; information on insurance coverage; information on the cost of care; information on service pathways, referral procedures and appointment arrangements; Continuing Professional Development (provider competency).	Trustworthiness positioned at first contact (from Ability to Seek); interpersonal quality treated as a first-contact concern; the visibility component substantially enriched.
Acceptability	Cybersecurity of mental-health data; cultural mediators; responsiveness to intersecting vulnerabilities; power imbalance in the care relationship; complexity of the care process; absence of a holistic approach to care; depersonalisation of care.	Stigma operationalised at multiple levels (anticipated, differential, intersectional); privacy/confidentiality extended to digital data security.
Availability and Accommodation	Alignment of opening hours with users' needs; administrative complexity and documentation requirements; digital accessibility of services; information on pathways/referral/appointments; patient-record sharing and coordination; overburdened services (existing but beyond capacity).	Caregiving support repositioned from indirect cost to a service-design feature; outreach and integration extended from Approachability; continuity of care repositioned as a structural availability property.
Affordability	Subsidised medication schemes; state financial support; reimbursement of additional (ancillary) costs; transport, childcare, interpretation; fragmentation of care as a financial burden; cost/insurance information as financial exclusion through uncertainty.	Financial protection broadened beyond direct clinical costs. (Indirect and opportunity costs were comparatively under-discussed, a noted gap rather than a new theme.)
Appropriateness	Responsiveness to intersecting needs; responsiveness to social needs (social determinants); adequacy of consultation time (patient perspective); power imbalance; responsiveness to multiple cultural/social backgrounds; Continuing Professional Development (clinical quality); effective referral and coordination; holistic approach to care; consent and coercive practices (rights-based); complexity of the care process.	—

5.5.1.1. Approachability

The hackathon validated several components already identified in the scoping review, including the visibility of services and accessible information channels, community-based outreach and prevention programs, provider awareness of referral pathways, and the importance of integration across health and non-health sectors in facilitating first contact with care. Beyond these, a number of new themes emerged, and existing components were meaningfully extended.

Trustworthiness of services was mapped as an approachability-level barrier the extent to which services are perceived as credible and safe before any contact is attempted. In the scoping review, trust appeared primarily under Ability to Seek; the hackathon's positioning of trust at the approachability level reflects participants' view that perceived safety shapes whether individuals consider engaging with services at all, prior to any direct encounter.

Interpersonal quality of care was raised as an approachability-level concern in a distinct sense: where provider attitudes are perceived as unwelcoming or judgmental, individuals may not feel they have the opportunity or courage to ask questions or raise concerns at first contact, losing a critical opportunity to learn about available services, understand their condition, or identify appropriate care pathways. This differs from the scoping review's treatment of interpersonal quality, which was addressed primarily under Acceptability and Appropriateness in the context of ongoing care relationships.

The visibility of services and accessible information channels component, present in the scoping review, was substantially enriched through the hackathon. Participants identified a range of sub-components that had not been captured in the literature, including: the use of AI as an information source for both available services and mental health conditions; accessible and language inclusive online information channels; information on insurance coverage; information on the cost of mental health services; and information on service pathways, referral procedures, and appointment arrangements. These sub-components move the concept of visibility beyond the general availability of information toward the specificity, accessibility, and comprehensibility of what is communicated and to whom. While information on insurance coverage and the cost of care was mapped under Approachability as part of the broader visibility component, it warrants particular attention as a distinct concern in its own right. Individuals in vulnerable situations often do not know what they are entitled to or what care costs before they attempt to access services, a barrier that shapes the decision to approach care before any financial transaction occurs. Although such concerns are frequently associated with Affordability, their emergence at the approachability level points to an earlier

and often overlooked dimension of financial exclusion: not the inability to pay, but the inability to know whether care is payable at all.

Under Providers' awareness and knowledge, a component identified in the scoping review, the hackathon added Continuing Professional Development as a distinct sub-component, operationalising provider competency not only as a static characteristic but as a systemic feature dependent on ongoing training and institutional support.

Several components mapped under Approachability by participants warrant analytical attention regarding their dimensional placement. Cultural and language inclusiveness and the opportunity to choose a provider align more closely with Acceptability, as they concern the perceived characteristics and responsiveness of services rather than their initial visibility. The availability of translation services and barriers to digital health service access are more closely related to Availability and Accommodation, as they reflect structural features of service delivery rather than approachability in the strict sense. Need-responsiveness through care plan involvement and satisfaction aligns most naturally with Appropriateness, as it concerns the quality and fit of care once engaged rather than the conditions of first contact.

The overlap between Approachability and Availability and Accommodation is particularly worth noting. For a service to be approachable, it must first exist its physical or virtual presence is a precondition for any awareness or first contact to occur. The frequency with which participants mapped availability-related concepts under Approachability likely reflects this interdependence: in contexts where services are absent or difficult to locate, the boundaries between not knowing a service exists and knowing it exists but being unable to reach it become analytically blurred. This mapping pattern suggests that for people in vulnerable situations, approachability and availability are experienced as deeply intertwined rather than as discrete sequential steps.

A parallel observation applies to cultural and language inclusiveness. While this component is analytically grounded in Acceptability concerning how services are experienced once contact is made the availability of language-inclusive and culturally adapted information channels is also a condition of approachability for vulnerable groups. When information about services is only available in a dominant language or fails to reflect the cultural contexts of those it is intended to reach, the system becomes effectively invisible to those populations before any direct encounter occurs. In this sense, cultural and linguistic inclusiveness operates simultaneously as an acceptability feature and as a structural determinant of whether services can be approached at all.

5.5.1.2. Acceptability

The hackathon confirmed the centrality of stigma and discrimination, cultural and gender concordance between providers and users, confidentiality and privacy regulations, and interpersonal quality of care, all well-documented in the scoping review. The three most extensively discussed areas were stigma and discrimination, privacy and confidentiality regulations, and cultural responsiveness of care, each of which was both validated and meaningfully extended through the co-creation process.

Stigma and discrimination emerged as the most prominent concern across groups, with participants operationalising it at multiple levels: anticipated stigma shaping decisions before any care contact is made, differential treatment based on mental health status, and discrimination rooted in intersecting characteristics such as ethnicity, gender identity, and migration status.

Privacy and confidentiality were raised with particular intensity, and the hackathon extended this component in an important direction not captured in the scoping review: cybersecurity. As mental health information increasingly moves through digital systems, concerns about who controls access to personal data, what providers do with that information, and the security of digital health records constitute a distinct and growing dimension of privacy that extends well beyond the traditional framing of confidentiality in face-to-face care settings.

Cultural responsiveness of care was the third most extensively mapped area. Two sub-components emerged that had not been captured in the scoping review. Cultural mediators were operationalised as a concrete, assessable feature of service design, moving beyond the conceptual recognition of cultural barriers to the formal availability of intermediary figures capable of bridging cultural and linguistic gaps between service users and providers. Responsiveness to intersecting vulnerabilities was identified as a distinct concern, reflecting participants' recognition that cultural responsiveness cannot be reduced to a single identity dimension; services must be capable of recognising and responding to the compounding effects of multiple, overlapping vulnerabilities such as migration status, gender identity, disability, and ethnicity.

Under interpersonal quality of care, power imbalance was identified as a distinct sub-component not present in the scoping review, which had addressed this area primarily in terms of respectfulness and non-judgment. The hackathon extended this to the structural asymmetry inherent in the provider-patient relationship and how it shapes individuals' ability to express needs, disagree with providers, or exercise meaningful agency within the care encounter.

Three further themes emerged under Acceptability that had not been captured in the scoping review. The complexity of the care process was identified as a barrier, with individuals required to navigate fragmented systems and repeat their personal histories across multiple service contacts a concern that reduces the acceptability of care independently of the quality of clinical encounters themselves. The absence of a holistic approach to care was raised as a distinct concern, reflecting the failure of services to address the full range of an individual's needs beyond presenting symptoms. Depersonalisation of care emerged as a related theme, encompassing the experience of being treated as a case rather than a person through standardised interactions, insufficient consultation time, and the absence of genuine engagement with individuals' specific circumstances.

Three components mapped under Acceptability by participants, self-efficacy in care-seeking, fear of anticipated consequences, and past experiences with mental healthcare align more closely with Ability to Seek in the framework's conceptual logic, as they concern individuals' decision-making process around whether to pursue care. However, it is important to note that these are not purely individual-level phenomena. Fear of anticipated consequences is deeply shaped by the system's privacy and confidentiality measures and the extent to which individuals trust that their information will be protected; where these measures are weak or perceived as unreliable, fear of consequences is a rational response to real structural conditions. Similarly, past negative experiences with mental healthcare whether rooted in poor interpersonal quality, discrimination, or lack of cultural responsiveness reflect low Acceptability or Appropriateness at the service level, manifesting as individual-level reluctance to seek care. In this sense, what appears as a demand-side barrier is often the individual-level expression of supply-side failures, underscoring the inherently dynamic and bidirectional relationship between the framework's dimensions.

5.5.1.3. Availability and Accommodation

The hackathon confirmed several components already identified in the scoping review, including the absence or insufficiency of mental health services, geographic inequalities in service distribution, physical accessibility of services, and referral and coordination mechanisms. Beyond these, a number of new themes emerged and existing components were meaningfully extended.

Several new themes emerged that had not been captured in the scoping review. Alignment of opening hours with users' needs was identified as an accommodation concern, reflecting the extent to which rigid service schedules create practical barriers for individuals with caregiving responsibilities, employment constraints, or unpredictable daily circumstances.

Caregiving support availability, whether services actively provide or facilitate childcare and other caregiving arrangements during appointments, was repositioned from its framing as an indirect cost in the scoping review to a concrete feature of service design that determines whether attendance is practically possible.

Administrative complexity and documentation requirements were identified as a structural barrier, with bureaucratic processes and paperwork demands reducing the effective accessibility of services for individuals with limited literacy, language proficiency, or administrative capacity.

Alternative care delivery models, including telehealth and mobile services, were identified as availability-level features, with digital accessibility of services emerging as a distinct sub-component reflecting the growing role of virtual care in expanding or constraining reach.

Outreach and integration between services were both present in the scoping review primarily under Approachability, where they were recognised as mechanisms that make services visible and accessible at first contact. The hackathon extended their relevance to Availability and Accommodation, reflecting participants' view that both components shape not only whether services are known but whether they are structurally present and reachable. Outreach concerns the active deployment of services into communities bringing care to individuals rather than relying solely on them to present at fixed locations and its absence constitutes a structural gap in availability that awareness alone cannot bridge. Integration between services operates through a distinct mechanism: when mental health care is embedded within primary care, social services, or other health sectors, it expands the geographic and institutional presence of mental health provision. A community that lacks a dedicated mental health facility may nonetheless have mental health care available through its general practitioners, social care teams, or community health workers. Integration thus increases the physical reachability of services and ensures their presence in settings where people in vulnerable situations are already present, making it a determinant of availability as much as of approachability.

Under referral and coordination mechanisms, a component present in the scoping review, the hackathon added important operational specificity through two sub-components. Information on service pathways, referral procedures, and appointment arrangements was identified as a distinct concern moving beyond the existence of referral systems to the clarity and accessibility of the information available to individuals navigating them. Patient record sharing and coordination between services was operationalised as a concrete feature of system organisation, reflecting participants' recognition that continuity of care depends not only on

whether referrals are made but on whether information follows the individual across service contacts.

Under service availability and capacity, the overburdened nature of healthcare systems emerged as a distinct sub-component. Beyond the absence or insufficiency of services, participants identified the situation where services formally exist but are operating beyond their capacity as a structurally different and equally significant barrier one that produces long waiting times, reduced quality of care, and effective inaccessibility even where provision nominally exists.

Several components mapped under Availability and Accommodation by participants align more closely with other dimensions analytically. Awareness of available mental health services was mapped here but is more closely related to Ability to Perceive, as it concerns individuals' knowledge of the service landscape rather than the structural availability of services themselves. Privacy and confidentiality arrangements align more naturally with Acceptability. Financial protection mechanisms and the availability of low-cost and free services are more appropriately addressed under Affordability, though it is worth noting that the availability of publicly funded care as distinct from its cost constitutes a genuine availability concern: whether a public or low-cost option exists is a question of service infrastructure, not solely of financing.

Continuity of care warrants particular analytical attention in this context. Participants consistently positioned it within the framework of system organisation through referral mechanisms, patient record sharing, and coordination between services rather than as a feature of the therapeutic relationship or clinical quality. This positioning suggests that continuity of care, when understood as a structural property of how services are organised and connected, belongs more naturally under Availability and Accommodation than under Appropriateness, where it has traditionally been placed in the literature.

This distinction also illustrates a broader analytical point about how the Levesque Framework is best read: as a journey rather than a static classification. Some concepts operate through different mechanisms across multiple dimensions simultaneously, and their impact may shift depending on where an individual is in the care-seeking process. Continuity of care may not be a salient concern at first contact, but its absence accumulates consequences across the journey. Structural failures in continuity, the inability to secure a follow-up appointment, fragmented record sharing, or poor coordination between services, constitute an Availability and Accommodation failure. However, these structural failures do not remain contained within this dimension: when system-level discontinuity persists, it inevitably damages therapeutic

continuity, the consistency of the care relationship, the coherence of treatment over time, and the provider's ability to respond to an individual's evolving needs. The downstream consequence is a failure of Appropriateness: care that is no longer responsive, coherent, or tailored to the individual. The same underlying gap thus originates as a structural availability problem and manifests as a quality-of-care failure, underscoring why the framework's dimensions are best understood not as discrete categories but as interconnected stages of a dynamic and cumulative process.

5.5.1.4. Affordability

The hackathon confirmed the core component set identified in the scoping review, including direct costs of care, breadth and depth of insurance coverage, financial support schemes, and public, low-cost or free provision of care. Several new themes and sub-components extended the dimension, while a notable gap in participant mapping also warrants attention.

The most extensively discussed area was direct cost of care, under which subsidised medication schemes emerged as a distinct sub-component not captured in the scoping review.

Under financial protection mechanisms, a component present in the scoping review, two sub-components emerged that had not been previously captured. State financial support was identified as a distinct concern, addressing the role of public welfare and social protection systems in offsetting the cost of mental healthcare for individuals in vulnerable situations. Reimbursement of additional costs was raised as a separate sub-component, reflecting participants' recognition that financial protection must extend beyond the direct cost of clinical encounters to cover the ancillary expenses such as transportation, childcare, and interpretation that accompany care-seeking.

Fragmentation of care was identified as a distinct affordability barrier not captured in the scoping review, which had addressed fragmentation solely under Availability and Accommodation. The hackathon surfaced its direct financial consequences: when individuals must navigate multiple providers, repeat assessments, or access care across several services to receive adequate support, the cumulative financial burden exceeds what any single service cost would suggest.

Information on insurance coverage and the cost of care was raised as an affordability-level concern, extending a theme that had also emerged under Approachability. While awareness of costs and entitlements was mapped under Approachability as a barrier to first contact, the hackathon also identified it as an affordability concern in its own right: individuals who do not

know what their insurance covers, what out-of-pocket costs they may incur, or what financial support schemes are available may forgo or delay care not because they cannot afford it but because they cannot assess whether they can. This reflects the same dynamic observed under Approachability financial exclusion operating through uncertainty rather than solely through inability to pay.

One important pattern observed in the hackathon mapping warrants explicit attention. Participants' discussion was concentrated heavily on direct costs of care, with indirect and opportunity costs including transportation expenses, childcare costs, income loss due to work absence, and the time burden of accessing care receiving comparatively limited attention. This may reflect the particular vulnerability profile of the population groups represented, for whom direct cost barriers are most salient and immediately experienced. However, indirect and opportunity costs are well-documented in the scoping review as significant dimensions of financial burden. Indirect costs include transportation expenses, technology-related costs such as devices and internet access required for virtual care, and interpreter fees borne by individuals themselves in the absence of publicly funded translation services. Opportunity costs arise from the economic consequences of taking time off work to attend appointments. Their relative absence from the hackathon mapping should be read not as evidence of their lesser importance but as a gap in the co-creation process that the preliminary framework informed by the scoping review helps to address.

5.5.1.5. Appropriateness

The hackathon confirmed the centrality of need-responsive care, involvement in decisions about care, perceived quality of care, structural discrimination, cultural responsiveness of care, coordination and continuity, and interpersonal quality of care, all well-documented in the scoping review. Several new themes and sub-components extended the dimension in meaningful ways.

Under need-responsiveness, a component present in the scoping review, the hackathon identified three sub-components that had not been previously captured. Responsiveness to intersecting needs reflected participants' recognition that need-responsiveness cannot be assessed along a single dimension of vulnerability; individuals in complex situations require care that acknowledges the interaction between mental health needs and other social, economic, and physical circumstances. Adequacy of consultation time was raised from the patient perspective whether there was enough time to express one's needs complementing the provider workload framing present in the scoping review, which had addressed this from a supply-side standpoint. Responsiveness to social needs extended the concept beyond

clinical responsiveness to encompass whether services address the broader social determinants shaping individuals' mental health, including housing, employment, and social isolation.

Under interpersonal quality of care, power imbalance was identified as a distinct sub-component. The scoping review addressed interpersonal quality primarily in terms of respectfulness and non-judgment; the hackathon extended this to the structural asymmetry inherent in the provider-patient relationship and how it shapes individuals' ability to express needs, disagree with providers, or exercise meaningful agency within the care encounter.

Under cultural responsiveness, responsiveness to multiple dimensions of cultural and social background emerged as a distinct sub-component, reinforcing the theme observed under Acceptability. Participants emphasised that cultural responsiveness cannot be reduced to a single dimension, services must be capable of recognising and responding to the compounding effects of multiple, overlapping cultural and social backgrounds.

Under clinical quality of care, Continuing Professional Development was identified as a distinct sub-component, operationalising provider competency not only as a static characteristic but as a systemic feature dependent on ongoing training and institutional support, an echo of the same sub-component identified under Approachability, where CPD shapes providers' awareness and knowledge at first contact.

Under integration across services, adequate referral and coordination between services was identified as a distinct sub-component, moving beyond the general recognition of fragmentation to the quality and effectiveness of the mechanisms through which individuals are transferred between providers and levels of care. While the structural presence of referral and coordination mechanisms was addressed under Availability and Accommodation, the hackathon's positioning of this sub-component under Appropriateness reflects a complementary concern: not merely whether such mechanisms exist, but whether they function effectively and ensure that individuals receive coherent, responsive care across transitions.

Three further themes emerged under Appropriateness that had not been captured in the scoping review. A holistic approach to care was identified as a concern the failure of services to address the full range of an individual's needs beyond presenting symptoms, which reduces the perceived relevance and effectiveness of care for people facing compounding challenges. Consent and compulsory treatment and coercive practices were operationalised through a rights-based lens, with participants raising questions about whether individuals are actively

involved in decisions about their treatment, whether they are aware of their rights when coercive practices occur, and whether complaint mechanisms and the right to appeal are accessible. Complexity of the care process was identified as a barrier to appropriateness, with fragmented pathways, administrative burdens, and the need to repeatedly explain one's history across service contacts undermining the coherence and responsiveness of care.

One component mapped under Appropriateness by participants aligns more closely with another dimension analytically. Satisfaction with care was mapped here but aligns more naturally with Ability to Engage, as individuals' subjective assessment of their care experience shapes their willingness and motivation to remain engaged with services over time.

Table 5. presents the corresponding summary for the demand-side abilities, again distinguishing newly identified components from those that were expanded or repositioned; each is discussed in turn below.

Table 5. New and expanded DEMAND-SIDE themes and components contributed by the Map the Gap Hackathon (relative to the scoping review, the HSPA review, and the Indicator Mapping Workshop)

Levesque dimension	New components / themes (not previously identified)	Existing components expanded or repositioned
Ability to Perceive	Self-diagnosing (informal self-labelling); reliability of AI-generated health information; general literacy level; disabilities affecting recognition of need; social isolation and exclusion.	Digital literacy and access repositioned from Ability to Reach; trust in services and stigma repositioned from Ability to Seek (operating at self-recognition).
Ability to Seek	Concerns about the consequences of service use (residence status, child custody, professional repercussions); fear of discrimination; autonomy to seek care independently; self-efficacy in care-seeking; self-advocacy; perceived safety of care-seeking (summary item); social isolation and exclusion.	—
Ability to Reach	Living in rural/remote areas (compounded distance, transport and sparse provision); social isolation and exclusion (loss of practical support for reaching care).	—
Ability to Pay	Financial independence (autonomous control over one's resources); social network and support as a financial function (direct help and cost-sharing).	—

Ability to Engage	Mental-health literacy at the engagement stage; empowerment and self-efficacy; care responsibilities; fear of discrimination and stigma within care; autonomy over treatment (including the right to pause or discontinue); capacity and emotional resilience for sustained navigation; satisfaction with care and treatment.	—

5.5.1.6. Ability to Perceive

The hackathon confirmed the centrality of interpretation and perception of mental health needs, access to trustworthy information channels, language barriers, mental health literacy, and social support, all well-documented in the scoping review. Several new themes and sub-components extended the dimension in meaningful ways.

Under symptom interpretation and awareness, self-diagnosing emerged as a distinct sub-component not captured in the scoping review. Participants identified the growing tendency of individuals to interpret and label their own mental health experiences through informal channels including online resources and peer networks before any professional contact, a practice that can both facilitate and hinder the recognition of care needs depending on the quality and accuracy of the information accessed.

Under social support, social isolation and exclusion was identified as a distinct sub-component, reflecting the extent to which the absence of supportive networks reduces individuals' exposure to information, peer experiences, and community-level awareness of mental health and available services. Importantly, social isolation and exclusion in the context of people in vulnerable situations cannot be reduced to the absence of social networks alone. Individuals may have existing social connections yet remain isolated in ways that are specific to their situation discrimination, stigma, language barriers, or migration-related displacement can sever individuals from communities that would otherwise provide mental health-relevant information and support or render existing networks unable or unwilling to engage with mental health concerns. Social isolation and exclusion is thus both a condition that shapes the ability to perceive and a consequence of the very circumstances that make access to care more difficult.

Four further themes emerged under Ability to Perceive that had not been captured in the scoping review. Digital literacy and access was mapped under this dimension by participants, extending its positioning under Ability to Reach in the scoping review. The hackathon's

repositioning reflects the view that digital channels are now a primary route through which individuals become aware of and interpret mental health information making the ability to find, understand, and critically evaluate online health content a perceive-level capacity. Within this theme, the reliability of AI-generated health information emerged as an entirely new concern, reflecting the growing role of tools such as ChatGPT in everyday health information-seeking and the risks associated with acting on inaccurate or misleading AI-generated content.

Literacy level was identified as a distinct perceive-level barrier, extending beyond mental health literacy specifically to encompass general reading and comprehension capacity as a determinant of individuals' ability to access and make sense of health information.

Trust in services was raised as a perceive-level concern, reflecting the extent to which distrust in formal mental health provision shapes whether individuals recognise professional care as a viable or relevant option for their needs, a dynamic present in the scoping review primarily under Ability to Seek, but positioned here as shaping the perception of care options prior to any decision to seek help.

Disabilities were identified as a distinct perceive-level barrier, encompassing the ways in which cognitive, sensory, or communication-related impairments can affect individuals' capacity to recognise, interpret, and articulate their mental health needs.

Stigma around mental health conditions was raised as a perceive-level concern, reflecting the extent to which internalised stigma and community-level stigmatising beliefs shape whether individuals recognise their experiences as mental health needs at all, a theme present in the scoping review primarily under Ability to Seek, but positioned here as operating earlier in the journey, at the level of self-recognition rather than care-seeking behaviour.

Two components mapped under Ability to Perceive by participants align more closely with other dimensions analytically. Availability of translation services was mapped here but aligns more naturally with Availability and Accommodation and Approachability, as it concerns a structural feature of service infrastructure rather than an individual-level capacity. Interpersonal quality of care was also raised under this dimension but is more closely related to Acceptability, as it concerns the relational characteristics of care encounters rather than individuals' capacity to perceive their needs.

5.5.1.7. Ability to Seek

The hackathon confirmed the centrality of stigma around mental health and care-seeking, social support, trust in services, and past experiences with mental healthcare, all well-

documented in the scoping review. Several new themes extended the dimension in meaningful ways.

Under social support, social isolation and exclusion emerged again as a distinct sub-component, reinforcing its appearance under Ability to Perceive. In the context of Ability to Seek, social isolation and exclusion shapes not only individuals' awareness of care options but their capacity to mobilise support for the decision to pursue care whether through encouragement from trusted others, practical assistance with navigating services, or the normalisation of help-seeking within one's immediate network.

Several new themes emerged that had not been captured in the scoping review. Concerns about the consequences of service use were identified as a prominent seek-level barrier, encompassing fears related to residence status, child custody, and professional repercussions.

Fear of discrimination was raised as a distinct concern, reflecting the extent to which anticipated discriminatory encounters based on ethnicity, gender identity, migration status, or mental health condition deter individuals from initiating contact with services.

Autonomy, the capacity to seek care independently without the permission or accompaniment of a partner, guardian, or family member, was identified as a seek-level barrier, particularly for individuals whose social circumstances constrain their freedom of movement or decision-making.

Self-efficacy in care-seeking was raised as a distinct component, reflecting individuals' sense of empowerment and confidence in their ability to navigate services.

Self-advocacy, the capacity to speak up, assert one's rights, and challenge discriminatory attitudes or practices when seeking care was identified as a distinct seek-level component not captured in the scoping review. Participants raised it specifically in the context of anticipated or experienced discrimination, reflecting the recognition that approaching services in contexts where dismissal or unfair treatment is expected requires not only the decision to seek care but the capacity to actively assert one's entitlement to it.

Perceived safety of care-seeking was raised as an overarching concern, captured through a single evaluative question rather than as a distinct conceptual component in its own right. As such, it functions as a summary indicator of the cumulative effect of the seek-level barriers already identified, stigma, fear of discrimination, concerns about the consequences of service

use, and lack of trust rather than adding a new dimension to the conceptual map. Its inclusion nonetheless reflects the value of a global safety assessment item as a complement to more specific barrier-focused questions.

Several components mapped under Ability to Seek by participants align more closely with other dimensions analytically. Privacy and confidentiality regulations and the opportunity to choose providers align more naturally with Acceptability, as they concern structural features of service design rather than individual-level seek behaviours. Cultural responsiveness and interpersonal quality of care were identified as relevant to both Acceptability and Appropriateness, as they concern the characteristics of services and care encounters rather than the individual's decision-making process.

Three components warrant particular attention regarding their cross-dimensional character. Autonomy, while mapped under Ability to Seek, also operates at the level of Ability to Reach, the same constraints that prevent individuals from deciding to seek care may equally prevent them from physically reaching it. Self-advocacy, and self-efficacy, may also be relevant to Ability to Engage, as the capacity to advocate for one's needs shapes not only the initial decision to seek care but the ability to remain actively engaged throughout the care process. Importantly, the dimensional placement of both autonomy, self-efficacy, and self-advocacy depends on where in the care-seeking journey the individual is situated: the same underlying capacity manifests differently depending on whether the barrier concerns the decision to seek care, the act of reaching services, or the ability to sustain engagement once care has begun. This context-dependence reinforces the importance of reading the Levesque Framework as a dynamic journey rather than a fixed classification system.

5.5.1.8. Ability to Reach

Across the hackathon groups, the barriers identified under Ability to Reach clustered around a set of well-established components: physical health, mental health, and disabilities as constraints on mobility, autonomy, access to transportation options, caregiving duties, and occupational flexibility, all documented in the scoping review. Two new sub-components extended the dimension beyond this established component set.

Under physical proximity to healthcare services, a component present in the scoping review, living in rural areas was identified as a distinct sub-component. While geographic proximity was already recognised in the scoping review as a structural determinant of reach, the hackathon brought greater specificity to the particular barriers faced by people in vulnerable situations residing in rural or remote areas, where the combined effect of distance, limited

transport infrastructure, and sparse service distribution creates compounding barriers to reaching care.

Under social network and support, a component present in the scoping review, social isolation and exclusion emerged as a distinct sub-component, as observed under Ability to Perceive and Ability to Seek, though operating through a distinct mechanism in the context of reaching care. In this dimension, social isolation and exclusion concerns the absence or inaccessibility of supportive networks that enable individuals to reach care through accompaniment to appointments, assistance with transportation, or help navigating service systems. Individuals may lack such networks altogether or may have existing social connections yet remain unable to draw on them due to discrimination, stigma, or marginalisation that severs the practical link between social proximity and meaningful support. Both circumstances fall disproportionately on people in vulnerable situations, for whom informal networks often constitute the primary means of bridging the distance between themselves and available care.

Several components mapped under Ability to Reach by participants align more closely with other dimensions analytically. Remote provision of care, outreach, and flexible provision of care and different modes of contact were mapped here but align more naturally with Availability and Accommodation, as they concern structural features of how services are organised and delivered rather than individual-level capacities to reach them. Their appearance under Ability to Reach nonetheless reflects a lived reality: for people in vulnerable situations, the structural absence of flexible or remote service options and the individual-level inability to reach fixed service locations are experienced as inseparable the supply-side gap and the demand-side barrier produce the same outcome.

Stigma around mental healthcare was also mapped under Ability to Reach by participants. However, the questions generated around this theme concerned the decision-making process around whether to seek care rather than the practical act of reaching services. Analytically, this component therefore aligns more closely with Ability to Seek, reflecting once again the fluid boundary between the sequential stages of the Levesque Framework as experienced in practice.

A notable cross-cutting pattern observed across Ability to Perceive, Ability to Seek, and Ability to Reach was the consistent emergence of social isolation and exclusion as a barrier. While the mechanism through which it operates differs across dimensions, shaping awareness of care options under Ability to Perceive, constraining the decision to seek care under Ability to Seek, and limiting access to the practical support needed to reach services under Ability to Reach, its recurrence across three consecutive dimensions of the demand side underscores

its structural character. Social isolation and exclusion is not a barrier at a single point in the care-seeking journey but a condition that compounds across it, with its effects accumulating as individuals move from recognising a need to acting on it.

5.5.1.9. Ability to Pay

Across the hackathon groups, the barriers identified under Ability to Pay clustered around two well-established components shared with the scoping review: financial resources and capacity, and health insurance status. Two new themes extended the dimension beyond this established set.

Financial independence was identified as a distinct sub-component not captured in the scoping review. Participants raised the extent to which individuals in vulnerable situations may lack autonomous control over their financial resources depending on a partner, family member, or caregiver to cover healthcare costs as a distinct dimension of financial vulnerability that operates independently of household income level.

Social network and support emerged as a new theme under Ability to Pay, identifying a distinct financial function of informal networks not captured in the scoping review: the role of social connections in providing direct financial assistance and in reducing indirect costs associated with reaching care such as shared transportation, childcare arrangements, and practical support that offsets expenses individuals could not otherwise manage.

Several components mapped under Ability to Pay by participants align more closely with Affordability analytically. Direct, indirect, and opportunity costs including transportation expenses, interpreter fees, and income loss due to work absence concern the structure and level of costs as system-level features rather than individuals' capacity to meet them, and are therefore more appropriately addressed under Affordability.

5.5.1.10. Ability to engage

Trust in providers was the sole component under Ability to Engage confirmed by both the scoping review and the hackathon. Beyond this shared foundation, the hackathon generated a substantially expanded set of themes not previously identified in the literature.

Mental health literacy was identified as an engage-level barrier, extending its appearance under Ability to Perceive to the context of sustained engagement: individuals who lack the knowledge and understanding to interpret their condition, follow treatment plans, or make

sense of clinical information may struggle to remain meaningfully engaged with care even after accessing it.

Empowerment and self-efficacy were raised as engage-level components, reflecting individuals' sense of agency and confidence in their capacity to participate actively in their own care, to ask questions, express preferences, and take an active role in treatment decisions.

Care responsibilities, the ongoing demands of caring for children, elderly family members, or other dependants were identified as a distinct barrier to sustained engagement, as caregiving obligations may prevent individuals from attending follow-up appointments, completing treatment courses, or dedicating the time and energy required for meaningful participation in care.

Fear of discrimination and stigma was raised as an engage-level concern, reflecting the extent to which anticipated or experienced discriminatory encounters within care settings reduce individuals' willingness to disclose information, raise concerns, or continue engaging with services.

Autonomy, the capacity to make free and independent decisions about one's own treatment, including the right to pause or discontinue care was identified as a core engagement component, extending its appearance under Ability to Seek and Ability to Reach to the sustained care relationship.

Capacity and emotional resilience for navigating services was raised as a distinct engage-level barrier, extending its appearance under Ability to Reach. While under Ability to Reach it concerned the psychological cost of navigating complex systems in order to physically access care, under Ability to Engage it operates at a later stage of the journey: the cumulative burden of managing ongoing care pathways, coordinating between providers, and sustaining active participation across what may be a lengthy and demanding treatment process.

Satisfaction with care and satisfaction with treatment were identified as engage-level components, reflecting participants' recognition that individuals' subjective assessment of their care experience directly shapes their motivation and willingness to continue engaging with services over time.

Prior negative experiences were mapped under Ability to Engage, but their dimensional placement depends on when in the care journey they occur. Negative experiences prior to or between care episodes align more closely with Ability to Seek, as they shape the decision to

return to or initiate care and as documented in the scoping review, they may reduce the perceived acceptability of services over time. However, negative experiences occurring during an ongoing care episode operate differently: they directly undermine the individual's willingness and capacity to remain engaged, placing their consequences within Ability to Engage. The same underlying phenomenon thus manifests across different dimensions depending on its temporal position within the care-seeking journey.

Several components mapped under Ability to Engage by participants align more closely with Appropriateness analytically. Interpersonal quality of care, involvement in care, need-responsiveness, consent regulations, patient-centredness, and support groups concern structural and relational features of service design that create the conditions for engagement rather than individuals' capacity to engage and are therefore more appropriately addressed under Appropriateness. Their mapping under Ability to Engage nonetheless reflects an important insight: the boundary between what services offer and what individuals are able to do within them is experienced as fluid, and system-level appropriateness failures directly undermine individual-level engagement capacity.

Several components mapped under Ability to Engage by participants align more closely with Appropriateness analytically. Interpersonal quality of care, involvement in care, need-responsiveness, consent regulations, patient-centredness, and support groups concern structural and relational features of service design that create the conditions for engagement rather than individuals' capacity to engage and are therefore more appropriately addressed under Appropriateness. Privacy and confidentiality regulations operate across multiple dimensions depending on where in the care journey they are encountered. Concerns about confidentiality may deter individuals from initiating care altogether aligning with Acceptability while within an ongoing care relationship, perceived or actual limitations in privacy and confidentiality can undermine individuals' willingness to disclose openly and remain engaged, placing their consequences within Ability to Engage. As a structural feature of service design, the regulations themselves are most naturally addressed under Acceptability and Appropriateness.

5.5.2. Overview of Proposed Question

Across the four inter-disciplinary groups, a total of 198 measurement questions were developed spanning all ten dimensions of the Levesque Framework, of which 139 were prioritised for inclusion in the draft accessibility assessment tool. The question set as a whole reflects a strong co-creation output: broad in thematic scope, grounded in the lived realities

surfaced through the persona exercise, and structured around a clear supply-side / demand-side architecture (Annex 6. and Annex 7.)

5.5.2.1. Quantity and Distribution

The most question-rich dimensions were Ability to Seek (29 questions developed, 18 prioritised), Appropriateness (23 developed, 15 prioritised), and Ability to Engage (22 developed, 14 prioritised), suggesting that participants perceived relational and behavioural barriers as particularly multifaceted and difficult to capture in a small number of items. By contrast, Ability to Pay (18 developed, 9 prioritised) and Affordability (14 developed, 8 prioritised) generated comparatively fewer questions, a pattern that likely reflects the relative conceptual clarity of cost-related barriers rather than their lesser importance. Approachability was notable in that all 17 developed questions were prioritised, indicating strong group consensus around the relevance of information access and outreach as measurable dimensions.

5.5.2.2. Predominant Question Types

The vast majority of questions are formulated as first-person experience questions such as "Have you ever avoided seeking care due to fear of stigma?", "Do you trust that your provider will not share your information?" placing the individual's subjective experience at the centre of measurement. This reflects the user-centred orientation of the Levesque Framework and the hackathon's grounding in persona-based reasoning. A smaller subset takes a system-level perspective, asking whether services or mechanisms formally exist: "Is there an official translation service available?", "Is there a channel through which I can report my personal experiences?" These supply-side operational questions are concentrated primarily under Approachability and Availability and Accommodation, where the existence of infrastructure is itself a measurable feature.

5.5.2.3. Thematic Emphases

Several themes recur with particular intensity across dimensions. Stigma and discrimination whether anticipated, experienced, or internalised is addressed across Approachability, Acceptability, Ability to Seek, and Ability to Engage, making it one of the most consistently operationalised constructs in the tool. Trust in services and providers is similarly addressed across multiple dimensions, appearing under Acceptability, Ability to Seek, and Ability to Engage in ways that collectively capture its role at different stages of the care journey. Language and cultural responsiveness asking whether information, services, and providers are accessible in individuals' own languages and attentive to their cultural backgrounds is

present under Approachability, Acceptability, Ability to Perceive, and Ability to Engage, reflecting the structural and cross-cutting nature of this barrier. Financial concerns are addressed not only under Affordability and Ability to Pay but also under Availability and Accommodation and Ability to Perceive, capturing cost as both a structural and experiential barrier.

5.5.2.4. Cross-dimensional Complexity

A notable feature of the question set is the frequency with which questions were identified as relevant to more than one dimension. Questions on privacy and confidentiality appear under Acceptability, Ability to Seek, and Ability to Engage; questions on autonomy span Ability to Seek, Ability to Reach, and Ability to Engage; questions on continuity of care appear under both Availability and Accommodation and Appropriateness. This cross-dimensionality is analytically significant: it reflects the inherently overlapping nature of access barriers in practice and the extent to which a single question can illuminate conditions at multiple stages of the care-seeking journey. Rather than a limitation, it is a feature of the co-creation process that underscores the framework's dynamic character.

5.5.2.5. Gaps and Relative Underrepresentation

Despite the breadth of the question set, some areas received comparatively limited coverage. Indirect and opportunity costs transportation expenses, childcare costs, and income lost to appointments were acknowledged in the challenge mapping but generated fewer prioritised questions than direct cost barriers, a gap partially addressed by the scoping review's contribution to the preliminary framework. Digital health and telehealth, while mentioned under Availability and Accommodation and Ability to Perceive, are not yet systematically operationalised across the tool. Questions on coercive practices and patient rights, present under Appropriateness and Ability to Engage, represent an important rights-based dimension but remain limited in number.

5.5.2.6. Assessment of the Question Set in Relation to the Scoping Review

The question set generated through the hackathon both confirms and substantially extends the operationalisation landscape identified in the scoping review. The thematic priorities of the question set align broadly with the constructs identified as most frequently operationalised in the scoping review literature. Stigma and discrimination, cultural and linguistic responsiveness, trust in services and providers, and interpersonal quality of care are among the most extensively addressed areas in both the hackathon outputs and the qualitative studies reviewed. Questions on financial barriers, service fragmentation, and geographic

accessibility echo the constructs operationalised across studies including Leclair et al. (2022) and Hollingdrake et al. (2023). The pathway-based logic of the Levesque Framework is preserved: questions are distributed across all ten dimensions and collectively trace a recognisable journey from awareness of need through to sustained engagement with care, consistent with the sequential structure favoured by the strongest instruments reviewed, including Lowther-Payne et al. (2026) and Salameh et al. (2025).

The hackathon's most distinctive contribution lies in the specificity and contextual grounding it brought to constructs that the scoping review identified as frequently operationalised but rarely with precision. Several of these extensions are analytically significant for instrument development.

The most substantial new ground was covered in areas the scoping review found either underrepresented or operationalised only in partial and indirect ways. AI and digital information-seeking including individuals' capacity to critically evaluate AI-generated health content emerged as a perceive-level concern that points to an important gap in how information access is currently measured. As digital and AI-mediated channels increasingly function as primary routes through which individuals first encounter mental health information and service options, the scoping review's instruments suggest this dimension has not yet been systematically incorporated into access measurement frameworks, making the hackathon's attention to it a timely contribution.

Cybersecurity as a dimension of privacy and confidentiality surfaced with an emphasis that goes beyond how the topic appeared in the reviewed literature, which addressed confidentiality primarily in the context of face-to-face care relationships. The hackathon's extension of this concern to the security of digital health records and data-sharing practices in digital systems reflects a shift in how privacy is experienced in contemporary care settings a shift that the co-creation process proved well-positioned to capture.

The hackathon highlighted that financial uncertainty, not knowing what care costs or what insurance covers, can function as a barrier before any financial transaction occurs, shaping whether individuals approach services at all. This concern emerged across both Approachability and Affordability dimensions, reflecting a distinction between not knowing whether one can afford care and not being able to afford it that the scoping review's instruments tended to collapse under Affordability alone. Treating this earlier-stage barrier as a conceptually distinct phenomenon points to a refinement in how financial exclusion is operationalised that the instrument development phase may wish to carry forward.

The rights-based operationalisation of coercive practices and consent mechanisms under Appropriateness and Ability to Engage is more explicit and practically formulated in the hackathon question set than in the reviewed instruments, where these concerns were often raised at a conceptual level without translating into directly assessable items. Questions asking whether individuals were informed of their rights, whether complaint mechanisms were accessible, and whether supported decision-making services were available suggest that rights-based dimensions of access may be underrepresented in existing measurement approaches relative to their importance for people in vulnerable situations.

Cultural mediators operationalised here as a concrete and assessable feature of service design rather than as a general acknowledgement of cultural barriers, represent a level of specificity that was largely absent from the reviewed instruments, where cultural responsiveness tended to be addressed through broad attitudinal or experiential questions. Similarly, the role of informal social networks as a financial resource for offsetting indirect costs of care, surfaced under Ability to Pay, points to a dimension of financial capacity that the scoping review's instruments addressed only at the level of household income or insurance status, leaving the social economy of care largely unmeasured.

The scoping review identified a recurring pattern across both qualitative and quantitative instruments: constructs that are cross-dimensional in nature tend to be placed under a single dimension in a way that does not fully capture their reach across the access pathway. The hackathon question set shows a similar tendency. Stigma, trust, and language barriers recur across multiple dimensions which the conceptual analysis in Section 5.5.1 addresses in detail and the cross-dimensional character of these constructs is explicitly acknowledged throughout. However, translating that acknowledgement into measurement questions that specify through which mechanism each construct operates at each stage of the pathway remains a task for the instrument development phase. As the scoping review suggested, thematic coverage alone is not sufficient for a fully rigorous instrument; what is also needed is an explicit causal logic specifying which factors operate through which dimensions and via which mechanisms. The hackathon outputs provide a rich basis for developing such a logic, and the conceptual analysis in Section 5.5.1 takes important steps in that direction.

Indirect and opportunity costs identified in the scoping review as a dimension of Affordability that tends to receive less systematic attention than direct cost barriers were comparatively less prominent in the hackathon mapping as well, consistent with the pattern observed across the reviewed instruments. This likely reflects the relative salience of direct cost barriers for the

participant profiles represented in both the literature and the hackathon, rather than a judgement about their importance.

The supply-demand boundary, which the scoping review identified as a persistent challenge in instrument design, is similarly present in the hackathon outputs. Several questions formulated under demand-side dimensions capture individuals' experiences of supply-side conditions the absence of flexible hours, the unavailability of translation services, the inaccessibility of digital tools rather than the individual-level capacities and constraints that more precisely constitute demand-side barriers. As the scoping review noted, this pattern is not straightforwardly a design flaw; it reflects the lived reality that for people in vulnerable situations, the supply-side gap and the demand-side barrier are often experienced as inseparable (Annex 6. and Annex 7.).

5.5.2.7. Contribution of Hackathon to the Measurement Framework

Assessed against the four principles the scoping review proposed, journey-informed, theory-driven, equity-oriented, and adaptive, the hackathon question set performs strongest on equity-orientation and journey-coverage.

The co-creation process revealed where barriers are felt most acutely by people in vulnerable situations. The concentration of challenges and questions around Ability to Perceive, Ability to Seek, and Ability to Engage on the demand side, and Approachability, Acceptability, and Appropriateness on the supply side, reflects a collective emphasis on the relational, experiential, and structural dimensions of access that generic instruments tend to underweight. This distribution provides an equity-oriented lens that the scoping review's literature-based phase could not have generated alone, and it directly informs which dimensions of the EQUICARES instrument will require the most careful and context-sensitive operationalisation.

Part II

The EQUICARES Service Assessment Framework

Part II sets out the consolidated EQUICARES Service Assessment Framework. It draws together the four evidence activities reported in Part I each of which contributed defined concepts, findings, and outputs to the framework, as summarised in Table 6.

Table 6. Integration of the four evidence activities: objectives, key findings, and their contributions to the EQUICARES framework

Activity and objective	Key findings	Contribution to the framework
Scoping review *Phase 1–2, M1–M16* How has the Levesque framework been applied to mental-health access, and how are its dimensions defined and measured?	• 38 studies; ~80 components across the 10 dimensions • supply- and demand-side measures frequently conflated in instruments • imbalance: Approachability and Ability to Engage underexplored • access is relational, not a supply- or demand-side phenomenon alone	• conceptual definitions of the 10 dimensions and ~80 components • the person-centred assessment logic and the conflation fix • demand-side evidence to complement system data
Targeted HSPA review *Phase 1–2, M1–M16* How is access conceptualised and measured at the system level, and how do those indicators map to Levesque?	• 14 authoritative HSPA and mental-health performance documents • indicators predominantly supply-side (financing, workforce, governance, PROMs/PREMs) • demand side underrepresented; within-region variation obscured (NUTS-2+)	• the meso–macro (system) indicator set, mapped to the same dimensions • care-tier and efficiency-as-utilisation framing • the intersectional-registries recommendation
Indicator Mapping Workshop *M6, consortium partners* Validate and refine the draft component structure across the ten dimensions with consortium partners.	• cross-disciplinary agreement and points of ambiguity recorded (heat map) • component structure refined and consolidated	• a validated preliminary framework that structured the hackathon
Map the Gap Hackathon *M16, stakeholders incl. lived experience* Co-identify and prioritise the concepts shaping access for people in vulnerable situations, and develop measurement questions.	• 262 challenges and 198 questions (139 prioritised) • validated components and surfaced new themes (e.g., AI information, cybersecurity, cultural mediators) • confirmed cross-dimensional / conflation patterns	• prioritised questions feeding the item bank • new components added to the architecture • lived-experience grounding

The EQUICARES Service Assessment Framework operates at two complementary levels of one design. The **micro–meso level** (Chapter 6) assesses access as it is *realised by the person*: a capability-based, person-centred, mixed-methods reading of whether a given individual, in their circumstances, has the opportunity and the capacity to obtain care. The **meso–macro level** (Chapter 7) assesses whether the *system* is governed, resourced, financed, and organised to *produce* accessible care at scale, using the established architecture of Health System Performance Assessment (HSPA). The two are not separate frameworks but two sides of the same relationship, indeed the two halves of the provision, reach distinction seen at scale: the meso–macro level describes provision and the conditions for it, the micro–meso level describes what reaches and works for the person. They are joined by a shared unit, the **component**, and by a shared theory, the capability approach, in which the system level is the upstream production of the opportunity structure and conversion factors that the person level measures as realised.

6. Micro–Meso Level Assessment

6.1. Conceptual Structure and Theoretical Grounding

The EQUICARES Service Assessment Framework is an adaptation of the patient-centred conceptual framework for access to health care developed by Levesque et al. (2013). That framework was itself a synthesis of earlier access scholarship notably the supply–demand correspondence of Penchansky and Thomas (1981) and the behavioural and equity-of-access models of Aday and Andersen (1974) and Andersen (2008), and it advanced the field by conceptualising access not as a single point of contact, nor as a property of services alone, but as a dynamic process arising at the *interface* between health systems and populations. On the system side it distinguishes five supply-side dimensions, *Approachability, Acceptability, Availability and Accommodation, Affordability,* and *Appropriateness*; on the population side it distinguishes five corresponding demand-side abilities, *Ability to Perceive, Ability to Seek, Ability to Reach, Ability to Pay,* and *Ability to Engage*. The preceding chapters established, through the scoping review, the targeted HSPA review, the Indicator Mapping Workshop, and the Map the Gap Hackathon, both the analytical value of this structure for mental health and care services and the adaptations required to make it sensitive to people in vulnerable situations. This chapter draws those findings together into a single framework, setting out its conceptual structure, its theoretical grounding in the capability approach (this section) and in intersectionality (Section 6.2) the logic by which it is operationalised, and the resources through which it can be applied.

6.1.1. From a patient-centred process to a person-centred journey

The first and organising adaptation is the framing. Where Levesque et al. (2013) describe a patient-centred *process*, the EQUICARES framework reconstructs access as a person-centred journey. The shift in vocabulary is deliberate and has consequences for what is assessed and whose standpoint defines it. The term “patient” presupposes an existing relationship with a service; yet for people in vulnerable situations, many of the most consequential barriers arise precisely where no such relationship yet exists before a need is recognised, between disconnected episodes of care, or after a discouraging encounter that is not repeated. Framing access as a journey that a *person* undertakes, rather than a process a *patient* passes through, keeps in view the stages that precede and surround formal contact, and treats the individual, rather than the encounter or the institution as the unit through which accessibility is realised.

This framing aligns with the concept of *candidacy* developed by Dixon-Woods et al. (2006), whose critical interpretive synthesis of the literature on access for vulnerable groups recast access as a dynamic, jointly negotiated process rather than a fixed property of services. In their account, a person’s eligibility for care, their candidacy, is continually produced and re-produced across a series of stages: identifying oneself as a legitimate candidate for care; navigating and reaching services; the *permeability* of those services (how much work, knowledge, or cultural alignment a service demands of a person before it can be used); asserting one’s candidacy at the point of contact; and the *adjudications* through which professionals accept, qualify, or reject it. Two features of their account matter especially for the present framework. First, candidacy is *recursive*: each encounter, positive or negative, shapes whether and how a person presents the next time, so access at any moment is conditioned by the history of prior contacts. Second, it is *unevenly demanding*: asserting candidacy requires resources and competencies that are not equally distributed, and professional adjudications can systematically disadvantage those who do not present in expected ways. This is why a static, service-centred snapshot is insufficient for the populations EQUICARES addresses, and why the framework treats access as a journey *co-produced* between person and system rather than as a service attribute alone a reading that also anticipates the bidirectional view of the dimensions developed below.

The reframing carries a methodological commitment that runs through the framework and is developed in Section 6.3: accessibility is realised in the individual, and the individual is therefore the standpoint from which every dimension is assessed. A service may, in principle, be approachable, available, and affordable; whether it is *accessible* depends on whether a

given person, in their particular circumstances, can convert those system properties into care actually received.

6.1.2. Theoretical grounding: bridging Levesque and Sen's capability approach

The Levesque framework is, in essence, a map. It tells us what the parts of access are five characteristics of services and five matching abilities of people and that access occurs where the two meet (Levesque et al., 2013). This is its strength, and the reason it has been so widely adopted. But a map of the parts does not, by itself, settle three questions that any assessment must answer. First, what *is* access: is a service "accessible" when it exists, when a person *could* use it, or only when they *do* use it? Second, why should the service side and the person side be assessed in different ways rather than treated as one? Third, how should a person who has good access but does not use it be counted? Earlier access traditions left these questions largely open (Penchansky & Thomas, 1981; Aday & Andersen, 1974), and, as the scoping review shows, studies applying Levesque Framework have answered them inconsistently measuring what is provided in one study, what a person perceives in another, and whether care is used in a third (Cu et al., 2021; see Section 6.3). When the underlying question is left unanswered, two assessments can both claim to measure "access" while in fact measuring different things.

Amartya Sen's capability approach (Sen, 1992, 1999) supplies that missing answer, which is why bridging the two is a requirement for coherent assessment rather than an enrichment. Sen separates three things that ordinary language tends to merge. *Resources* are what is nominally provided the service in principle. *Capability* is the real, effective freedom a person has to use it, what they are genuinely able to do, given their circumstances. *Functioning* is what the person actually does, whether they use the service. A concrete case makes the difference plain: a city may fund free counselling (a resource), but a refugee woman who cannot read the language of the leaflet, cannot travel without a relative's agreement, and fears being reported has little real freedom to use it, the resource exists, yet for her the *capability* does not, and so no *functioning* follows. What explains that gap is what Sen calls *conversion factors*: the personal (e.g., health, literacy), social (e.g., norms, discrimination), and environmental (e.g., distance, transport) circumstances that determine how much real opportunity a given resource confers on a given person. The same service therefore yields very different access for different people.

This is precisely what the Levesque framework requires and does not itself provide. The capability approach gives "access" a single, clear meaning, access is a **capability**, a real

opportunity, distinct from both mere provision and actual use, and from that one idea the rest of the framework follows. It explains why the two sides must be assessed differently: the service side describes opportunities, the person side describes the capacity to convert them, which is the basis of the conflation fix in Section 6.3. It supplies the conversion-factor concept that explains why access remains unequal even when provision is equal, which is the engine of the equity and intersectionality analysis in Section 6.2. And, by separating capability from functioning, it offers a principled way to treat non-use: a person who could use a service but freely chooses not to still *has* access, and only the absence of a real opportunity is a failure (Section 6.3, the capability–use distinction). In short, Levesque tells us *where* to look; Sen tells us *what we are looking at* and *how to weigh what we find*. Labelling the demand side as "ability to perceive, seek, reach…" already gestures toward capability; making the capability approach explicit turns that gesture into a usable theory.

Bridging the two is, moreover, well established rather than speculative. The capability approach is now a recognised lens in health evaluation, albeit one applied in methodologically varied ways (Mitchell et al., 2016), and it has been operationalised specifically for mental health, including through purpose-built instruments such as OxCAP-MH (Simon et al., 2013). It has been applied to the very populations EQUICARES concerns: people with mental health problems and histories of homelessness, where services were found to help people "survive" rather than "live" (Kerman & Sylvestre, 2020); inequalities in care for people with severe mental illness, where barriers operated at personal, relational-societal, and organisational levels that echo the macro/meso/micro structure used here (Lavie-Ajayi et al., 2018); the effect of disabling conditions on primary-care use, where societal and socioeconomic conversion factors were the principal determinants (Bussière et al., 2016); and mental health provision in low-resource rural settings (Benjamin et al., 2021). The application closest to the framework's demand side is Gadsby's (2013) study of lower-income families in England, which conceptualises the *capability to access health care* as resting on a person's *personal capital* the knowledge, skills, material resources, and social relationships they are able to draw on when they need care. Personal capital is, in the terms used here, the demand-side abilities themselves: the conversion capacity through which a person turns an available service into realised access. Reading the demand side as personal capital underscores two points central to this framework that this capacity is unequally distributed across people in vulnerable situations, and that, consistent with the bidirectional reading below, it is not fixed but shaped by the supply side it meets and can be supported or eroded by it. Building the bridge therefore consolidates a tested line of work and applies it where it is most needed, to mental-health access for people in vulnerable situations, where conversion factors and the freedom to act weigh most heavily.

Mapped onto the Levesque structure, the capability approach yields a reading of what each side of the framework represents:

1. **Supply-side dimensions describe the opportunity structure.** Approachability, Acceptability, Availability and Accommodation, Affordability and Appropriateness are the resources and environmental conditions a system makes available. In Sen's terms they expand or constrain the person's *capability set*, the range of real opportunities to obtain care. They are necessary but not sufficient for access.

2. **Demand-side abilities describe conversion capacity and agency.** The five abilities are the personal capacities, and the agency, through which a person converts an available opportunity into use, closely analogous to Sen's conversion factors combined with the freedom to act. They, too, are necessary but not sufficient.

3. **Achieved access is a functioning**, realised only when an opportunity exists *and* the person has the capability to convert it. Access can fail on either side: an opportunity the person cannot convert, or a capacity for which no opportunity exists.

This three-part structure also matches what a capability-based health assessment is independently argued to require. López Barreda, Robertson-Preidler and Bedregal García (2019) hold that assessing health through the capability approach should combine indicators of the achieved dimension (*functioning*), of resources and conversion factors (*capability*), and the element most often neglected, of the freedom to act (*agency*); assessing outcomes alone, they warn, risks paternalism. The EQUICARES framework is built to satisfy all three: achieved access is the functioning, the paired supply/demand structure captures capability, and agency runs through the framework's treatment of choice and non-use (Section 6.3) and of collective deliberation (Section 6.7).

This grounding is drawn on throughout the chapter: it indicates why the two sides are assessed differently (Section 6.3), it underpins the capability–use distinction (Section 6.3), and it leads into the equity grounding of the next section, where intersecting social positions are read as the differential *conversion factors* the capability account requires (Section 6.2).

6.1.3. The relational reading of the pairings

An observation that recurs across the scoping review, and is articulated in *Towards an Equitable Access Journey*, is that access is not readily read as a supply-side or a demand-side phenomenon in isolation. Because Levesque et al. (2013) locate access at the *interface* between systems and populations, the ten dimensions are best understood as

complementary and mutually constitutive, each supply-side dimension and its paired demand-side ability shape one another, in both directions.

Table 7. Supply-side and demand-side dimensions in the Levesque's Framework

Supply-side dimension (opportunity)	relates to	Demand-side ability (capacity)
Approachability	↔	Ability to Perceive
Acceptability	↔	Ability to Seek
Availability and Accommodation	↔	Ability to Reach
Affordability	↔	Ability to Pay
Appropriateness	↔	Ability to Engage

The relationship runs in two directions, and both are relevant to assessment. In the first direction, a supply-side dimension can enable and strengthen its paired ability: clear and visible information (approachability) supports a person's capacity to recognise a need (ability to perceive); acceptable, non-stigmatising services (acceptability) make it safer to seek care (ability to seek); affordable provision (affordability) supports the means to pay (ability to pay). In the second direction, the abilities, and the needs they express, feedback to shape supply. Where people perceive and articulate needs, an *approachable* system is one with the institutional capacity to respond: to design, organise, or reorient service provision around the needs that are surfacing. A pattern of unmet or newly recognised need is, in this reading, information to which a responsive system adapts its outreach, screening, and configuration. In capability terms, the population's exercised and expressed capabilities feedback into the opportunity structure, and an equitable system is one that adjusts that structure accordingly.

Reading the pairings as bidirectional has a practical consequence for assessment: it locates responsibility on both sides and allows a shortfall to be attributed correctly (Cu et al., 2021). A gap at a given pairing may reflect a supply-side failure to provide or to reach, a demand-side limit on capacity, or a failure of the system to respond to needs that are in fact being expressed. Because individuals do not arrive with equal knowledge, resources, or freedom of movement, a system that leaves the burden of conversion primarily on the individual may systematically disadvantage those whose circumstances make that burden heaviest. Equitable design may therefore call for supply-side dimensions to be configured, and reconfigured, to compensate for unequally distributed conversion capacity, a reading consistent with the capability approach and with the responsiveness that the relational view of the pairings implies.

The pairings are the primary, organising relationship, but not the only one. Across the access journey the dimensions also interact more widely, within a side (insufficient availability, for instance, generates affordability barriers through dependence on private provision), across non-paired dimensions, and over time, as each encounter conditions the next. D1.5 documents this directly: barriers such as transport, stigma, trust and prior experience interact across the whole journey, its stages are interconnected rather than discrete, early barriers shape later ones, and engagement or disengagement feeds back into future help-seeking; the scoping review's cross-cutting determinants (language, stigma, social network and support) behave the same way. Access is therefore better pictured as an interacting, at times circular, system than as five independent pairs. The framework nonetheless retains the pairing as its organising unit, because it is what keeps assessment tractable and underpins the attribution logic of Section 6.3; the wider, systemic interactions are read as the context within which any single pairing's result must be interpreted.

6.2. Equity and Intersectionality: Theoretical Grounding

Section 6.1 grounded access in the capability approach, where its realisation depends on *conversion factors*, the personal, social, and environmental circumstances that decide how much real opportunity a service confers on a given person. That account leaves one question open: *which* conversion factors matter, and how do they combine? This section answers it, and in doing so explains why intersectionality belongs with the Levesque framework rather than sitting beside it as an optional equity overlay (Crenshaw, 1991; Bowleg, 2012). Crenshaw's (1991) foundational insight is that disadvantage at the meeting point of several social positions is not the arithmetic sum of disadvantages taken one at a time; the combination produces a distinct, often compounded, experience. In the framework's terms, conversion factors do not act independently but interact, which is why the same nominal service can yield effective access for some people and none for others, or, in Gadsby's (2013) terms, why the *personal capital* a person brings to bear on access is patterned by their position. Intersectionality therefore specifies the structure of the conversion factors the capability account already requires.

What intersectionality brings to accessibility assessment in general is a correction to the way inequity is usually detected. Most assessment reports either population averages or single-axis breakdowns, access by gender, *or* by income, *or* by ethnicity, considered one at a time. Bowleg (2012) sets out why this is inadequate for health: additive, single-axis analysis can

misrepresent, and even cancel out, the disadvantage of people who sit at the intersection of categories, who are frequently the very people with the least access. An assessment that examines one axis at a time will tend to under-detect its most consequential inequities. Reading access intersectionally also changes what "vulnerability" is taken to mean: rather than a fixed label or a checklist of attributes that individuals carry, vulnerability becomes a relational and structural product, something systems do to people positioned in particular ways, which is the sense in which this framework uses the term. The case for an explicit intersectional framework in health and clinical settings, rather than ad hoc attention to "diversity", has been made directly (Wilson et al., 2019), as has its value for the design of services specifically (Corus & Saatcioglu, 2015).

This way of thinking connects the framework to the social determinants of health. The dominant framework for understanding how social conditions shape health distinguishes *structural* determinants, the socioeconomic and political context and the social positions it generates, such as class, gender, and ethnicity, from the *intermediary* determinants through which those positions affect health, including material circumstances, psychosocial factors, and the health system itself (CSDH, 2008; Solar & Irwin, 2010). In the terms used here, those determinants are precisely the conversion factors of Section 6.1: the social and environmental circumstances that decide how much real opportunity a service confers on a given person. Intersectionality is increasingly understood as a necessary complement to the social-determinants framework rather than a rival to it. Where that tradition has often treated social positions as separate, additive categories, intersectionality insists that they are co-constituted and interacting, and it restores the emphasis on the relations of power that produce them (Hankivsky & Christoffersen, 2008). Situating EQUICARES' equity lens in this way places it within established public-health thinking, the conversion factors *are* social determinants, and intersectionality specifies how those determinants combine, and it anticipates the structural orientation taken up in Section 6.7.

A corollary of this framing is that the assessment is deliberately asset-oriented, not purely deficit-based (Morgan & Ziglio, 2007). A framework built around barriers risks defining vulnerable groups by what they lack; yet the same capability logic that identifies barriers also directs attention to the resources people and communities mobilise to obtain care despite them, the informal, peer, and community support that several components already capture (for example *social network and support* and *peer-led services*), and that D1.5 documented as facilitators. Read in this asset-based way (Morgan & Ziglio, 2007), the demand side records the capabilities people actually exercise, not only the absence of formal provision, and connects to D1.3's forward-looking attention to mitigation, prevention, and resilience against

systemic trends. This orientation does not soften the structural emphasis: community resilience is a capability to be supported, never a substitute for system responsibility (Section 6.7).

For EQUICARES the case is especially direct, because the project's own population is defined intersectionally. "People in vulnerable situations" here are seldom positioned on a single axis: they are, for example, refugees who are also women, LGBTQI+ people who are also rural or older, or people with disabilities who are also on low incomes. Intersectionality is thus not imported into the project but is already implicit in how its target groups are constituted, and the variation in barriers across groups emerging from the WP1 field studies (T1.4, T1.5) is consistent with this. Adopting intersectionality as the framework's equity lens makes that logic explicit and assessable.

Intersectionality is therefore applied as a **cross-cutting lens across all ten dimensions, not as an eleventh dimension or a standalone barrier.** The mechanisms through which the lens is operationalised in assessment, its quantitative and qualitative arms, a service-responsiveness rubric, and a structural determinant lens are set out in Section 6.7, and the whole framework, including the equity lens, is illustrated in the worked example of Section 6.8. Equity is in this way threaded through the framework rather than appended to it: each later treatment of the dimensions and components carries an explicit intersectional consideration drawing on this grounding. With the conceptual foundation now in place, the person-centred journey, the capability bridge, and intersectionality, the remainder of the chapter turns from what the framework *is* to how it is *applied*, beginning with the assessment logic.

6.3. The Person-Centred Assessment Logic

The scoping review surfaced a recurring difficulty in how the Levesque framework has been measured. This section states that difficulty, sets out the logic by which the framework addresses it, and specifies the wording convention, the validity rule, and the two interpretive distinctions that govern the item bank in Section 6.5.

6.3.1. The problem: conflation of the two sides in assessment

Across the studies that operationalised the Levesque framework, the *side* an instrument set out to measure and the *construct it actually captured* frequently came apart: instruments intended to assess a supply-side dimension often, through their wording, captured the paired demand-side ability, or the reverse. The pattern is documented rather than assumed. In the most comprehensive review of applications to date, Cu et al. (2021) collected 147 unique

access items and found that 91 addressed the supply-side dimensions and 56 the demand-side abilities, while 73% were written from the patient's perspective, that is, the perspective from which an item is posed and the side of access it is meant to measure routinely diverge. The same slippage is visible in the present scoping review. In Clifton and Hancock (2025), for instance, an attitudinal construct ("Associate") is positioned under *Ability to Perceive*, yet its content, willingness to be socially associated with people with mental illness, reaches into *Ability to Seek* and into stigma that is properly a feature of *Acceptability*. The phenomenon also arose within the project's own work: in the Map the Gap Hackathon, several items developed under *Approachability* were, on review, reassigned to *Availability and Accommodation*, *Acceptability*, and *Appropriateness*.

Left unaddressed, this conflation weakens construct validity in a way that matters for action as well as for measurement (Bollen & Lennox, 1991; Streiner, 2003). If an item intended to gauge whether the *system* is approachable in fact records whether the *person* is able to perceive a need, then aggregating it describes neither the service nor the person, and it may misdirect intervention, attributing to individuals burdens that belong to systems, or the reverse. For a framework whose purpose is to locate where access fails for people in vulnerable situations, distinguishing the two sides cleanly is a prerequisite rather than a refinement.

6.3.2. The resolution: a person-centred assessment logic

The framework addresses the conflation not by moving assessment away from the individual, but by anchoring it there consistently and changing *what is asked about the individual* according to the side. Following the journey reframing and the capability grounding of Section 6.1, the **unit of assessment is always the person**; the supply/demand distinction is therefore not a distinction of *who answers* (always the person) but of *what is assessed about them*:

1. **Supply-side dimensions are assessed as experienced opportunity.** The dimension is a property of the system, but its accessibility is evidenced only when it reaches the person. Items therefore ask whether and how the individual *encountered, experienced, or was able to use* the supply-side activity. The grammatical subject is the person; the object is the system's activity. This captures the supply side as a *realised opportunity within the person's capability set*, not as an institutional claim about what is provided.

2. **Demand-side abilities are assessed as capacity and means to act.** Items ask whether the person has the *ability, resources, or freedom* to convert an available opportunity into use, Sen's conversion capacity together with agency.

3. **Achieved access is the functioning** that results when a realised opportunity meets sufficient capacity. The framework can thus locate a failure of access on the correct side: a person who experienced no opportunity (a supply gap) versus one who could not act on an opportunity that existed (a capacity gap).

6.3.3. Wording convention

The logic translates into an enforceable convention for writing and classifying items. The contrast below also explains why some existing draft items require re-wording: a supply item phrased as a personal ability silently becomes a demand item.

Table 8. Supply-side and demand-side item construction logic

	Assesses	Subject / object	Wording stem	Example
Supply-side	Experienced opportunity	Person experiences the *system's* activity	"When you needed care, were you able to / did you experience…"	*"When you needed support, was clear information about services made available to you?"*
Demand-side	Capacity / means to act	Person's *own* ability	"Are you able to / do you have the means to…"	*"Are you able to recognise when you might need mental health support?"*

6.3.4. The validity rule

From the convention follows a single rule applied to every item in the bank (Section 6.5):

An item assigned to a supply-side dimension must be answerable as an account of an opportunity the person experienced, and an item assigned to a demand-side dimension must be answerable as an account of a capacity the person holds. If an item can only be answered by reference to the person's own ability, it belongs on the demand side; if only by reference to a system property the person encountered, it belongs on the supply side.

Each component and item is therefore tagged with its dimension(s); its side; its paired counterpart; whether it expresses *opportunity* or *capacity*; its analytic level (and care tier,

Section 6.4); the respondent (the individual, by default); and the method best suited to capture it (Section 6.7). This tagging carries the conceptual logic of 6.1 through into the assessable instrument of 6.4–6.5.

6.3.5. Two interpretive distinctions

Anchoring assessment in the person addresses the conflation problem, but introduces two interpretive questions one on each side of the framework. Both follow from the capability grounding, and together they form the distinctions that govern how person-centred responses are read.

6.3.5.1. The provision–reach distinction (supply side)

A supply-side "no" is ambiguous. It may mean the activity was never provided (a **provision gap**) or that it was provided, the provider's records show it as delivered, but never reached this person, or reached them in an unusable form (a **reach/effectiveness gap**). Under the capability grounding of 6.1, a resource that confers no real opportunity on the person has not generated a capability: a leaflet that no one in a vulnerable group can find, read, or trust is, for that person, not an approachability resource. The person-centred measure is therefore set at the level of **realised opportunity (effective coverage)** rather than nominal provision. This corresponds to the later stages of Tanahashi's (1978) classic coverage cascade, availability → accessibility → acceptability → contact → effective coverage, in which each stage filters the population reached and inequity tends to accumulate at the transitions. The same logic underpins more recent effective-coverage frameworks, which integrate access, utilisation, and quality and treat *effective* coverage, care that reaches people in need and confers benefit, as the standard for universal health coverage (Shengelia et al., 2005; Ng et al., 2014). Input- and checklist-based assessment, including much of the HSPA indicator tradition reviewed in Chapter 3, characteristically stops at the earliest stages (does the service exist?), whereas the framework is concerned with the later ones (did it reach, and work for, the person?).

Where a system-data comparator is available, setting it against the person-centred response locates the failure:

Table 9.Interpreting provision and reach: system level and individual-level response patterns

Provided (system data)	Experienced (person)	Interpretation

Yes	Yes	Effective access: opportunity realised
Yes	No	**Reach / effectiveness gap:** the activity exists but fails to reach this person/group
No	No	**Provision gap:** the activity is genuinely absent

The “Yes / No” cell is of particular policy relevance, it points toward improving targeting and delivery rather than creating a service, and as Section 6.7 discusses, it tends to concentrate among more people in vulnerable situations. The system data here serves strictly as a *diagnostic comparator*; it is not itself a measure of accessibility, which remains anchored in the person.

6.3.5.2. The capability–use distinction (demand side)

The mirror question arises when provision is genuinely good and the person nonetheless does not engage. Here the capability/functioning distinction is central: the framework assesses the **capability to access** (the real opportunity plus the capacity to act), not the **functioning** of use. Sen’s reason for privileging capability over functioning is to preserve agency, a person with genuine, effective access who makes an informed decision not to engage is in a different position from one who is excluded, even though both produce the same record of non-use. Scoring such non-use as a barrier would conflate distinct situations; in mental health it may be counterproductive, since treating utilisation as the goal can tend toward coercion or over-medicalisation. Assessing achieved use alone, rather than the capability and the agency behind it, is precisely what risks paternalism (López Barreda et al., 2019). An accessible system, on this view, supports real freedom to choose, including the freedom to decline.

The way to keep this from being taken too far is to interrogate the *reason* for non-use rather than scoring the act. Drawing on Sen’s concept of agency, Nussbaum’s account of **adaptive preferences** (Nussbaum, 2000, 2001), whereby people lower their expectations to fit deprivation (“people like me don’t get help anyway”), and Dixon-Woods et al.’s (2006) concept of **candidacy**, the jointly negotiated, recursive process by which people come to see themselves, and to be seen by services, as eligible for care, the framework classifies non-use against whether the conditions for genuine choice were actually met:

Table 10. Interpreting non-use: distinguishing autonomous choice from constrained access

Effective opportunity (reached, acceptable, affordable, appropriate)	Reason for non-use	Interpretation
Present	Informed preference / values / autonomous coping; no need on reflection	**Autonomous non-use: access adequate; agency respected** (not a barrier)
Nominally present	Stigma, fear, anticipated discrimination, mistrust, prior harm, "won't help someone like me"	**Constrained non-use: a demand-side/relational barrier** (locate on Acceptability / Ability to Seek / Engage)
Absent	—	Provision or reach gap (the provision–reach distinction)

Candidacy (Dixon-Woods et al., 2006) is especially useful for reading the middle row. What presents as a person's "choice" not to engage is often, in candidacy terms, a failure of candidacy *identification* produced upstream, by prior adverse adjudications that taught the person they were not a credible candidate, or by services whose low permeability demands assertion work they cannot perform. Read this way, constrained non-use is a co-produced outcome of the person, system relationship rather than a free preference, which is precisely why the framework classifies it as a demand-side or relational barrier rather than as adequate access.

Two qualifications are built in. First, "I didn't think I needed it" is itself ambiguous in mental health, genuine no-need versus unrecognised need produced by the condition or by low literacy, so it is routed through *Ability to Perceive* rather than auto-classified as autonomous choice. Second, because constrained non-use and adaptive preferences concentrate among people in vulnerable situations, a pattern in which a particular vulnerable group disproportionately "chooses" not to use is a signal for scrutiny, not evidence of collective preference (Section 6.7).

Together, the two distinctions provide an interpretive grammar: they help distinguish a service that does not exist from one that fails to reach, and a person who is excluded from one who freely declines, and to locate each on the relevant side of the access relationship.

6.4. The Component Architecture and Indicator Set

The framework's assessable content is organised as a structured set of **components**, discrete, observable features of access, consolidated in the component matrix (Annex 8,9 and 10). Positioned by dimension, side, and level, this set functions both as a conceptual map and as the structure from which the assessment instrument is built. The components were derived inductively from how authors have operationalised the Levesque dimensions across the scoping-review corpus, validated and re-sorted in the Indicator Mapping Workshop (whose heat map records both cross-disciplinary agreement and points of ambiguity; Annex 3), and extended through the challenges and themes generated in the Map the Gap Hackathon. The result is a taxonomy of roughly eighty defined components distributed across the ten dimensions.

6.4.1. Structure of the matrix

Each component is positioned on three axes. The **dimension(s)** locate it among the ten Levesque dimensions (a component may belong to more than one). The **side**, supply (opportunity) or demand (capacity), is inherited from the dimension(s) and fixes how the component is assessed under the logic of Section 6.3. The **analytic level**, macro (policy, financing, governance), meso (the organisation and delivery of services), or micro (the immediate service–user encounter and lived context), records the vantage point from which the component is examined.

6.4.2. Care tiers

A further descriptor concerns the tier of the care system at which a component is assessed. The original framework already anticipates this: Levesque et al. (2013) note that indicators "may vary across the different levels of healthcare system (e.g., primary, secondary)", and the Task 1.2 specification likewise calls for sensitivity to care level. The EQUICARES framework therefore records, where relevant, the **care tier**, primary, secondary, or tertiary care, and, for mental health in particular, community-based and social-care provision, at which a component is expressed. The same component can take a different form across tiers: approachability operates in primary care largely through routine screening, frontline actors, and integrated entry points, whereas in secondary and tertiary settings it operates more through referral transparency and coordination across levels; affordability shifts from the cost of a primary-care contact to the cost and coverage of specialist or inpatient care. Recording the care tier allows the framework to reflect the distinctive role of primary care as the usual first point of contact and the locus of coordination and continuity (Starfield, Shi, & Macinko, 2005), and to

align with European efforts to strengthen and assess primary-care provision specifically (European Commission Expert Group on Health Systems Performance Assessment, 2018).

The care tier is distinct from the macro/meso/micro analytic level and the two should not be conflated: the analytic level concerns *whose vantage point* an assessment takes (policy, organisation, or encounter), whereas the care tier concerns *where in the delivery system* the service being assessed sits. A micro-level assessment of a person's encounter, for example, may concern primary, secondary, or tertiary care.

6.4.3. Cross-dimensional components and the conflation rule

A subset of components map to more than one dimension, for example, language and cultural responsiveness surfaces under Approachability, Acceptability, Ability to Perceive and Ability to Engage; service fragmentation surfaces across Availability and Accommodation, Affordability, Appropriateness and Ability to Engage; and social network and support recurs across several demand-side abilities. These cross-dimensional components are the sites where the conflation discussed in Section 6.3 is most likely to occur, and where the bidirectional reading of the pairings (6.1) is most visible. The framework therefore applies the validity rule at the component level: where a component spans both sides, its supply-side expression is specified as an *experienced opportunity* and its demand-side expression as a *capacity*, and the two are assessed as distinct items rather than collapsed into one. This preserves the relational pairing while keeping the two sides distinct.

6.4.4. From dimensions to components, indicators, and metrics

The framework uses four nested terms, worth distinguishing explicitly and aligning with the Grant Agreement:

1. a **dimension** is one of the ten Levesque dimensions, the broad conceptual areas of access;

2. a **component** is a defined, discrete facet of a dimension (the roughly eighty consolidated under Section 2.1.4 for example, *community-based outreach* under Approachability);

3. an **indicator**, used here interchangeably with the Grant Agreement's term **metric**, is the standardised quantity or qualitative judgement through which a component is assessed; each component yields one or more;

4. an **item** is the specific question or wording used to capture an indicator (Section 6.5), and may be adapted while the indicator it serves is held constant.

Components are therefore not themselves indicators: indicators (metrics) are derived from them, and the item bank operationalises them. On this definition the framework yields well in excess of the Grant Agreement's target of at least twenty new metrics for the adapted Levesque framework. Each indicator inherits the tags of its parent component (dimension, side, opportunity/capacity, analytic level, care tier) and additionally specifies a data source and, where relevant, a reference standard. Consistent with Section 6.3, supply-side indicators are framed as effective coverage (realised opportunity) rather than provision counts, and demand-side indicators as capacities; the set is thus weighted toward outcomes experienced by the person rather than inputs reported by the system.

6.5. The Assessment Question Set (Item Bank)

The architecture of dimensions, components and indicators (Section 6.4) is made operational as an **item bank**, the question set from which context-specific instruments are assembled. The bank is built bottom-up from the framework's structural unit: the component. Each of the ten Levesque dimensions (already defined by Levesque et al., 2013) is resolved into a set of components, each given an operational definition grounded in the scoping review (Section 2.1.4.1), approximately eighty components in total, and each carrying one or more candidate items. The bank consolidates the component-level items first drafted at M6, the questions developed and prioritised in the Map the Gap Hackathon (198 developed, 139 prioritised), and the instruments retrieved in the scoping review, all re-specified to the conventions below.

Status: a recommendation, not a mandatory instrument. The item bank is a resource, not a fixed scale or a set of compulsory questions. What users are expected to adopt is the assessment *strategy*, the component and its definition, the side on which it is assessed, and the distinctions of Section 6.3, while the items themselves may be used verbatim, adapted in wording to local language and context, or replaced, provided each continues to measure its assigned component on the correct side. Cross-context comparability is supported through the scoring approach of Section 6.6, not through identical wording. The bank is therefore best read as a calibrated starting point and a worked illustration of the strategy rather than as the EQUICARES questionnaire.

6.5.1. Structure: dimension → component → item

The fixed layer is the **dimension–component pair and its definition**; the flexible layer is the wording of the items beneath it. This allows a site in a given context to assess, for example, *Approachability → community-based outreach*, adapting the wording to local services and language, while the construct, and therefore the comparability, is preserved. The full bank is organised on this hierarchy and reported in the annexes (supply side and demand side); the main text below sets out the response and tagging conventions and gives worked examples (Annex 8 and 9).

6.5.2. Response format

To feed the scoring approach of Section 6.6, the default response format is a **graded ordinal (five-point Likert) scale with a defined polarity**, replacing the binary Yes/No format used in the M6 drafts. The graded format carries the gradations needed to locate failures (the provision–reach distinction) and satisfies the scoreable-format requirement of Section 6.6. Yes/No is retained only for genuine screening or routing items (for example, the use-status question that branches the demand instrument), which are diagnostic rather than scored.

6.5.3. Supply side: a two-source design (the provision–reach distinction)

Each supply component is given **two paralleled items**, an *individual* item phrased as experienced opportunity (the person's standpoint) and a *provider/system* item phrased as provision, so that the provision-versus-reach diagnosis is built into the instrument. For *Approachability → mental health awareness and promotion programmes*, for example:

1. *Individual (experienced opportunity):* "In the past 12 months, information or activities about mental health and how to get help reached me in my community." (1–5)

2. *Provider (provision):* "Our facility organises or supports mental-health awareness activities in the community." (1–5)

The individual item is the measure of accessibility; the provider item is the diagnostic comparator (never itself a measure of access, per Section 6.3).

6.5.4. Demand side: a journey-staged design (the capability–use distinction)

The demand instrument is organised as the person's **journey**, with stages mapping onto the demand dimensions, *Before you sought care* → Ability to Perceive; *Deciding to seek care* → Ability to Seek; *Reaching the service* → Ability to Reach; *After accessing care* → Ability to Pay and Ability to Engage. It opens with a **use-status screen** ("Have you ever used mental health services?") that routes respondents into one of two Likert versions, for those who have received care and those who have not, paired with open-ended reason questions. This branching operationalises the capability–use distinction, capturing autonomous versus constrained non-use at the point of data collection. A demand item is phrased as a capacity: for *Ability to Perceive → knowledge of available services*, "Before I sought care, I knew where to go and how to apply for mental-health support." (1–5)

6.5.5. Tagging

Every item carries the full tag set established in Sections 6.3 and 5.4: component; dimension(s); side; paired counterpart; opportunity/capacity type; analytic level; care tier; respondent (individual, or provider for the supply comparator); journey stage; and method. This turns a list of questions into an assessment instrument with explicit construct validity, and lets analysts verify, item by item, that a question assigned to a supply dimension measures an experienced opportunity and not a disguised demand-side capacity.

6.5.6. Worked re-wording

Re-specifying the M6 items to these conventions typically means two things: moving Yes/No to the graded scale, and restoring the person's standpoint. The *Approachability* item *"Can you easily find information about your specific needs?"*, which as written tests the person's ability, becomes *"When I looked for help, information about relevant services was easy for me to find."* (1–5), restoring it as a measure of the system's approachability as the person experienced it. A consolidated re-wording table accompanies the full bank in the Annex 8 and 9..

6.6. Toward a Comparable Scoring Approach (a direction for future work)

The framework's commitment to flexible wording (Section 6.5) raises a question it cannot yet fully answer: if two sites assess the same component with different items, how can their results

be compared? No data are available to validate a scoring method at this stage, so this section is offered not as a settled procedure but as a direction for future work, a sketch of how comparability *might* be built, and of the cautions any such effort should observe.

The minimal requirement is modest: that each item use an ordered-categorical (Likert-type) response with a defined polarity, so that responses are in principle convertible to a common metric. Beyond that, established tools could help build such an approach in future. A percent-of-maximum-possible transformation (Cohen et al., 1999) would place differently worded items on a common 0–100 metric without strong assumptions; and, where calibration data eventually exist, item-response-theory linking with anchor items, as in the PROMIS item-bank system (Cella et al., 2010), could support stronger equivalence across item sets. These are offered as building blocks for later development, not as claims the framework can presently substantiate.

Two cautions should guide any such work. First, supply- and demand-side scores should not be blended into a single index; reporting a paired *opportunity* and *capability* profile, with the gap between them, preserves the information that matters for access, and autonomous non-use, as a legitimate choice, should be excluded from any access-deficit score rather than counted as low access. Second, the Levesque dimensions behave as **formative composites (indices)** rather than reflective scales, a dimension such as Ability to Reach aggregates distinct, partly substitutable determinants that need not co-vary (Bollen & Lennox, 1991; Streiner, 2003), so internal-consistency reliability (e.g., Cronbach's alpha) is not the appropriate test at the dimension level. The low domain alphas reported in D1.5 (≈ .14–.54, against a 20-item total of ≈ .72) are expected for an index and were rightly treated there as descriptive; reliability and validity are better sought at the component level and through criterion or known-groups validity, with consistent item polarity. Comparable scoring is thus a worthwhile aim for future development, approached here with deliberate caution rather than assertion.

6.7. Assessment Methods and Equity in Practice

The framework specifies not only what to assess but how, and its commitments about method are consequences of the way it defines access rather than stylistic preferences. Two features of the framework make a **mixed-methods design**, combining quantitative and qualitative inquiry, close to unavoidable, with participatory methods a valuable complement.

The first is that access is a capability realised in the individual and assessed from the individual's standpoint (Sections 6.1, 5.3). If what is being assessed is whether a given person,

in their circumstances, had a real opportunity and the capacity to use it, then the categories, components, and items must be meaningful to the people being assessed. Instruments designed entirely by researchers risk measuring the wrong thing, or omitting barriers that matter, for groups whose experience differs from the designers', and, for a project concerned with equity, an instrument built without the affected people can reproduce the very exclusion it sets out to measure. This is a theoretical point as much as a practical one: Sen's capability approach treats the question of which functionings are valuable as a matter for the agency and public reasoning of those concerned (Sen, 1999), which implies that defining what counts as "access" should involve those whose access is in question.

The second is that several of the things the framework most needs to detect, constrained non-use and adaptive preferences (the capability–use distinction), and the compounded disadvantage that arises at intersections (Section 6.2), are often normalised or unspoken and do not surface through closed survey items alone. A mixed-methods design that pairs quantitative survey measurement with qualitative inquiry is therefore needed to capture both the distribution of access and the experience that explains it. Participatory methods, including community-based participatory research, can further strengthen this work, improving the relevance of items to the groups assessed and helping surface barriers external designers may miss (Huang et al., 2020; Wallerstein & Duran, 2010), and are a valuable complement where resources allow.

Three commitments follow:

The individual is the primary unit; mixed methods are required, not optional. Because the two sides of the framework assess different things, experienced opportunity and personal capacity, they call for different forms of evidence (López Barreda et al., 2019; Bollen & Lennox, 1991). Demand-side capacities and the lived experience of the access journey are best captured through end-user surveys and qualitative work, while supply-side realised opportunity is captured through person-centred survey items, contextualised, for diagnostic purposes only, by system and administrative data (the provision–reach distinction), consistent with the varied operationalisation approaches documented in the capability-in-health literature (Mitchell et al., 2016). This requirement is borne out in the project's own application of the framework rather than asserted in the abstract: the scoping review concluded that no single methodological approach captures access in full (Section 2.1.4.2); the meso-level study operationalised the framework through a mixed-methods design combining provider and stakeholder engagement with national survey data (T1.4; D1.4); and the micro-level study used a convergent design in which reflective diaries accompanied a structured survey, the

qualitative accounts serving to interpret the quantitative patterns (T1.5; D1.5). The low domain reliabilities reported in that micro-level study (Section 6.6) are a further sign that the dimensions cannot be carried by quantitative scoring alone.

A two-source diagnosis locates failures. Where feasible, pairing the person-centred measure with a supply-side comparator enables the provision/reach cross-tabulation of Section 6.3, and qualitative reason-capture enables the autonomous/constrained non-use distinction. Neither comparator displaces the person as the measure of accessibility; both serve to explain *where* and *why* access succeeds or fails.

Participation strengthens the design. Where feasible, involving people with relevant lived and professional experience in developing and interpreting the instrument improves the relevance and acceptability of items and helps surface constrained non-use and intersectional compounding (Wallerstein & Duran, 2010; Corus & Saatcioglu, 2015). The Map the Gap Hackathon in which such participants co-developed and prioritised the questions illustrates that this is feasible and offers a template for the pilots. Participation is recommended as a complement to, not a substitute for, the mixed-methods core.

Across the analytic levels, this maps onto the WP1 design: macro-level assessment draws chiefly on system data and the Delphi foresight of T1.3; meso-level assessment on stakeholder and provider engagement together with national surveys (T1.4); and micro-level assessment on end-user surveys and participatory fieldwork (T1.5).

6.7.1. Operationalising intersectionality in assessment

Equity is assessed within this same mixed-methods strategy. The intersectionality grounding of Section 6.2, intersecting positions as the interacting conversion factors that shape access is operationalised through four mechanisms. This operationalisation is the framework's own design, synthesising intersectionality methodology for the purposes of this assessment rather than drawn from any single source. The first two mechanisms *detect* intersectional inequity; the third and fourth guard against the two risks individual-level operationalisation is known to create assessing diversity without assessing whether services *respond* to it and reducing intersectionality to demographic categories while losing its structural meaning. Consistent with the strategy above, each mechanism has both a quantitative and a qualitative facet.

A bounded set of intersecting axes. Taken literally, intersectionality implies an unbounded number of category combinations; no assessment can examine them all, so a purposive, provisional selection of axes is required a point established in the methodological literature on

how intersectionality is studied empirically (McCall, 2005) and on how it is incorporated into population-health research (Bauer, 2014). The framework therefore fixes a priority axis set anchored to EQUICARES' target populations migration/refugee status, racialisation/ethnicity, gender identity, sexual orientation, disability, age, socioeconomic position, geography (rural/remote/left-behind), and homelessness each considered in intersection with *mental-health condition type*. These are not chosen arbitrarily: they are the populations whose barriers the scoping review repeatedly documented (among them refugees and asylum seekers, ethnic and sexual minorities, trans people, people experiencing homelessness, and older adults), that D1.1 catalogued, and that the WP1 field studies sampled (notably the national surveys of D1.4). The scoping review also shows why the bounding must preserve the intersectional sense rather than collapse back into single groups: the literature has tended to examine one vulnerable group at a time, and the studies that did look at specific intersections, Syrian refugee women, for example, surfaced barriers (such as needing a male relative's agreement to attend) that a single-axis lens would miss. Bounding the axes makes intersectional analysis tractable in the pilots while retaining its relational, non-additive character.

A disaggregated, mixed-methods data architecture. Selecting axes is of little use unless the assessment can examine access at their intersections, and doing so requires both quantitative and qualitative evidence. Quantitatively, every item carries a standard set of respondent characteristics so that access can be analysed across intersectional strata rather than one axis at a time (Bauer, 2014), supporting multilevel methods such as the multilevel analysis of individual heterogeneity and discriminatory accuracy (MAIHDA), which models outcomes across many small intersectional groups while guarding against over-interpreting small subgroups (Evans et al., 2018). Quantitative strata, however, show *where* inequity concentrates but not *how* disadvantages combine in lived experience; for that the framework relies on a qualitative, intracategorical reading (McCall, 2005), lived-experience accounts, narrative, and community-based participatory work (Huang et al., 2020; Wallerstein & Duran, 2010) which captures the texture of compounded disadvantage and surfaces the adaptive preferences and candidacy that closed items miss (the capability–use distinction). This architecture is already partly realised in WP1: the national surveys of D1.4 provide the disaggregated quantitative structure across multiple vulnerable groups, among them migrants, Roma communities, LGBTIQ+ people, older adults, unaccompanied children, people with disabilities, and earthquake survivors while the reflective-diary work of T1.5 provides the qualitative counterpart. The two interpretive distinctions function here as equity instruments: the provided-but-not-reached cell (the provision–reach distinction) and constrained non-use (the capability–use distinction) are read against intersectional position, since the scoping review indicates both concentrate among multiply-marginalised groups.

An intersectionality maturity rubric. The first two mechanisms detect whether multiply-marginalised people experience worse access; they do not, on their own, assess whether services do anything about it. This matters because a service can appear intersectionally aware merely by *recording* diversity, collecting demographic or equality-monitoring data without *responding* to it. Huang et al. (2020), appraising mental-health interventions for sexual-minority people, found exactly this pattern and captured it on a graded scale: *low* (homogeneous reach, diversity not captured), *medium* (additional identities recorded but compounded disadvantage not addressed), and *high* (provision genuinely adapted to intersecting positions). The framework adapts this scale into a service- and component-level rubric: each service or component is rated low, medium, or high through a qualitative review of how it is designed and delivered, examining concrete features such as interpreter availability, provider matching, culturally adapted materials, and flexible pathways, so that responsiveness becomes assessable rather than assumed. A graded rubric is preferred here to a fixed checklist by design. Because intersectional disadvantage is relational and non-additive, the features that make provision responsive are context- and intersection-specific and cannot be enumerated once for all groups (McCall, 2005; Bowleg, 2012): a universal checklist would be either too generic to be valid for the hardest, multiply-marginalised cases or too specific to travel across contexts, and, being tick-box, could be satisfied on paper without any change to the encounter (Bevan & Hood, 2006). Rating responsiveness by degree against anchored levels keeps the judgement portable, while leaving the concrete features to be evidenced locally; where a population and setting are well characterised, those features can be specified as a context-specific checklist that instantiates the rubric's "high" level rather than replacing it. The resulting rating is read alongside the disaggregated access scores, not on its own. The distinction it captures is one the scoping review itself documents: culturally and linguistically responsive provision same-language or same-gender providers, cultural adaptation, interpreter availability was frequently *absent* even where services formally existed and recorded their users, which is the gap between counting and responding in concrete form.

The rubric also operationalises the bidirectional reading of 6.1, since a “high” rating describes precisely a service that has reoriented provision around the intersectional needs that disaggregated assessment reveals. It should be noted that Huang et al. (2020) devised their coding as a research-appraisal tool; its use here as an assessment rubric is an adaptation rather than a direct application. A practical risk attends any such rubric: a service may score well through policy and documentation without changing the clinical encounter, the familiar problem of decoupling and of gaming what is measured (Bevan & Hood, 2006). The framework guards against this by scoring maturity *across levels* and requiring corroboration: a high rating is credible only where the person-centred evidence agrees with it, that is, where the relevant

intersectional group's experienced-access scores and the provision–reach distinction confirm that provision is actually reaching them and where users themselves, through the participatory work above, validate it. A macro- or policy-level claim not borne out in micro-level experience is treated as a flag for decoupling rather than as a pass.

What a rating means for the system is then clear. A low rating marks a service that cannot see whom it is failing, so the first task is to extend reach and put equity monitoring in place. A medium rating (the most common in the reviewed literature) is the most diagnostic: the service knows who its disadvantaged users are but has not changed what it offers them, so the deficit lies not in awareness or data but in translating recorded diversity into adapted provision. A medium rating therefore signals that equity monitoring, on its own, is inert and at risk of becoming performative; and, read together with the disaggregated scores and the structural-determinant lens, it locates the lever for change; where a real access gap persists and policy or commissioning does not require adaptation, the appropriate response is system-level (commissioning and policy that mandate and resource responsive provision) rather than an appeal to individual services. A high rating describes a service that has reoriented provision around the intersecting needs the assessment reveals and is credible only where the person-centred evidence confirms the adaptation reaches people in practice.

Structural determinants lens. A further risk of operationalising intersectionality through individual-level axes and disaggregation is that it can collapse into demographic categorisation describing *who* has worse access while leaving untouched *what produces it*. This runs against the core of intersectionality theory, for which the central construct is power and the structures that distribute it, not the attributes individuals carry (Crenshaw, 1991; Bowleg, 2012; Collins & Bilge, 2016), and against the social-determinants-of-health tradition, which locates the drivers of inequity at the structural level, the "causes of the causes", and which intersectionality extends by insisting that those structural positions interact rather than add (CSDH, 2008; Hankivsky & Christoffersen, 2008). The framework therefore requires at least one indicator directed at the system rather than the individual, typically assessed through qualitative analysis of policy and commissioning documents, concerning whether policy, commissioning, or service design explicitly recognises and provides for multiply-marginalised groups. This is not a free-standing addition: it connects to components the framework already contains at the macro level, such as *mental-health policies* and the political prioritisation of mental health, whose weakness the scoping review identified as a recurrent structural driver of inadequate access, and it aligns with the macro-level, forward-looking analysis of T1.3. Keeping a structural indicator in view allows the assessment to speak to whether systems are acting on intersectional disadvantage, not only to whether individuals report experiencing it, and it

guards against locating the “problem” in individuals rather than in the arrangements that disadvantage them.

6.8. Showcase: The Framework in a Single Assessment

To show the framework working as a whole, consider a pilot assessing access to community mental-health care, attending particularly to **refugee women**, an intersection of migration status, gender, language, and often low income that the scoping review repeatedly associated with compounded barriers. The assessment runs the full pathway set out across this chapter.

1. **Frame the assessment (person-centred logic; 5.1, 5.3).** Access is assessed from the standpoint of refugee women themselves. Supply-side dimensions are posed as experienced opportunity (“when you needed support, was information made available to you?”) and demand-side abilities as capacity (“are you able to recognise when you might need support?”), keeping the two sides distinct.

2. **Choose methods (mixed methods; 5.7).** A person-centred survey carries the scoreable items; reflective accounts and community-based participatory work with refugee women accompany it, both to confirm that the items are meaningful and to surface barriers the closed items miss. Where available, service and policy records are gathered as comparators.

3. **Select axes and disaggregate (6.7).** Migration status × gender × language, in intersection with the relevant condition, are foregrounded; every response is tagged with these characteristics, with the remaining axes still recorded.

4. **Score the two sides (6.6).** Responses are rescaled to the common metric and reported as paired opportunity/capability profiles. Suppose refugee women show markedly lower *Acceptability* (opportunity) and *Ability to Seek* (capacity) than other respondents, a wide gap on both sides of that pairing.

5. **Apply the distinctions (6.3).** On the supply-side comparator, the “provided but not reached” cell is concentrated among refugee women (the provision–reach distinction): acceptable services exist nominally but do not reach them. Among non-users, qualitative reason-capture shows non-use driven by anticipated discrimination and

prior harm rather than preference (the capability–use distinction): this is constrained, not autonomous, non-use.

6. **Read the equity mechanisms (6.7).** The maturity rubric rates the service "medium" (diversity recorded but provision not adapted), it records users' migration status and gender but offers no interpretation, no same-language or female provider, and no culturally adapted materials. The structural determinant lens finds national policy silent on refugee women's mental health. The qualitative accounts explain *how* language, gender norms, and fear of authorities combine, the compounded experience that the quantitative strata only point to.

Read together, these outputs do more than register that refugee women have poor access: they locate *where* and *why* it fails, and for whom. The paired scores show the inequity and place it on both the supply side (acceptability) and the demand side (ability to seek); the distinctions show that services exist but do not reach this group, and that their non-use is constrained rather than chosen; the rubric shows the service collects identities without adapting provision; the structural determinant lens shows the policy environment does not require it to; and the qualitative work explains the mechanism. The assessment therefore points to specific, level-appropriate actions, service-level adaptation (interpretation, provider matching, cultural adaptation) and policy-level recognition, rather than to a generic finding that "refugee women face barriers". This is the pathway the framework is intended to support: assess from the person, distinguish provision from reach and exclusion from declining, score the two sides as a profile, and read the result through the intersectional lens, quantitative and qualitative together.

6.9. Design Principles and the Status of the Framework

The preceding sections can be drawn together into four design principles and a statement of what the framework is and is not.

Design principles. The framework is *journey-informed*: it is organised around the person's pathway to and through care, recognition, seeking, reaching, paying, and engaging, rather than around discrete service episodes or institutional boundaries, which is what allows it to surface barriers that arise before and between formal contacts. It is *theory-driven*: anchored in the Levesque framework and the capability approach, so that every component and item has an explicit conceptual referent and can be read in terms of opportunity, capability, or

functioning rather than as a free-standing indicator. It is *equity-oriented*: built to detect differential access across intersecting positions of vulnerability rather than population averages (Section 6.2), reflecting the consistent finding that access is most fragile for those at the intersection of several disadvantages. And it is *adaptive*: applicable across analytic levels (macro, meso, micro), across care tiers (primary, secondary, tertiary, and community/social care), and across diverse pilot contexts, with components and item wording selected and adapted to the setting.

An assessment strategy, not a fixed instrument. The EQUICARES framework is an assessment *strategy*, not a scale or index. What it standardises is the conceptual layer, the component definitions, the side (supply/demand) and level of each, and the assessment logic and interpretive distinctions of Section 6.3, since this is what allows any two assessments to be comparable *in kind*. The item bank (Section 6.5) is a recommended, adaptable resource rather than a mandatory questionnaire: users may adopt items verbatim, adapt their wording to local language and context, or write their own, provided each item still measures its assigned component on the correct side. Comparability across contexts is sought not through identical wording but through the shared, still-to-be-developed scoring approach of Section 6.6. This separation of **fixed construct, flexible wording, and (in time) a common metric** is what is intended to let the framework be adopted across contexts while remaining locally valid.

7. Meso–Macro Level Assessment

7.1. Why a meso–macro level

The micro–meso framework establishes whether access is realised for people in vulnerable situations and locates where it fails. It does not, on its own, explain whether the *system* is configured to make access realisable in the first place whether there is a workforce, financing, governance, and service organisation capable of producing accessible care across a population. Those are questions of **system performance**, and they are the proper object of the second level of assessment.

Three considerations make this level necessary rather than optional. First, the Grant Agreement requires that the framework's metrics address not only equity but also **effectiveness, efficiency, and quality**, and that indicators **vary across the levels of the healthcare system** (primary, secondary, and so on); these are system-performance and care-tier questions that a person-centred instrument cannot fully carry. Second, the HSPA review

(Section 3) and the analysis underpinning this chapter show a mature body of system-level indicators that can be adapted to mental health and to vulnerability rather than invented anew. Third, and conceptually, the capability reading of Chapter 6 already points upward: the supply-side dimensions are the *opportunity structure*, and that structure is itself produced by the system's governance, resourcing, financing, and delivery arrangements. Assessing those arrangements is assessing the conditions under which capabilities can exist at all. Operationalising the Levesque framework at this system level is, moreover, not without precedent: it has been applied through administrative and system data (Leclair et al., 2022) and, more broadly, across varied levels and purposes (Cu et al., 2021), and the project's own meso-level study applied the adapted framework to organisational and structural factors (D1.4).

The two levels therefore divide the labour of the provision–reach distinction. The meso–macro level assesses **provision and the conditions for it** (is the system organised to provide accessible care?); the micro–meso level assesses **realised reach** (does it reach, and work for, the person?). Read together, and disaggregated by vulnerable group, a strong system-level score sitting above a weak person-level result for a particular group is the now-familiar signature of provision that does not reach: the meso–macro layer supplies the system-side comparator that §6.3 anticipated.

7.2. The HSPA functional spine

The chapter is organised on the established HSPA architecture (WHO, 2022), which assesses a health system through four functions:

1. **Governance**; strategic vision and policy, multisectoral collaboration, population and civil-society participation, information and knowledge systems, and legislation and regulation.

2. **Resource generation**; the health workforce (availability, mix, distribution, training), infrastructure and equipment, and pharmaceuticals.

3. **Financing**; revenue raising, pooling, and purchasing, together with the comprehensiveness of coverage.

4. **Service delivery**; assessed across **care tiers** (public health, primary care, and specialised care) on effectiveness, safety, user experience, access, equity, and efficiency.

This spine is well suited to EQUICARES because it is where the macro determinants of access are produced, and because it already carries the two requirements this chapter must meet: **efficiency** sits within Financing and within the Service-delivery performance criteria, and **care tiers** are the organising axis of Service delivery. The mental-health adaptation draws on the OECD mental-health system benchmark (OECD, 2021a) and, for the primary-care tier, on the European primary-care performance framework (European Commission Expert Group on Health Systems Performance Assessment, 2018), both reviewed in Section 3.

This chapter builds directly on the HSPA review of Section 3 rather than departing from it. That review surveyed the same corpus; in its narrative it organised the mental-health-specific evidence around the OECD benchmark's six performance dimensions, but it also reviewed the WHO taxonomy of functions, subfunctions, and indicative measures, and it mapped the (predominantly supply-side) indicators it found onto the Levesque dimensions. The present chapter takes that mapped evidence and re-organises it onto the WHO functional spine for assessment, retaining the OECD benchmark as the source of mental-health-specific content and the Levesque mapping as the link to the micro–meso level. The two are therefore continuous: Section 3 reviews and maps the indicators; this chapter structures them for system-level assessment.

7.3. Mapping system indicators to the Levesque supply side and to components

The meso–macro indicators are not a parallel taxonomy; they are mapped onto the **same components** used at the micro–meso level, and through them onto the five supply-side Levesque dimensions. This is what makes the two levels one framework: a single component is assessed from the system side here and from the person's side in Chapter 6. The crosswalk produced by the HSPA review (Section 3) the operational definitions consolidated in the project's HSPA analysis, which pair each Levesque component with its corresponding HSPA indicators provides the basis for this mapping.

The predominant correspondences are as follows (HSPA function → supply-side dimension, via components):

Table 11. Mapping HSPA functions to supply-side dimensions

HSPA function / content	Maps chiefly to (supply-side dimension)	Illustrative shared components

Financing; coverage; out-of-pocket protection	**Affordability**	financial protection mechanisms; direct/indirect cost of care
Resource generation (workforce, infrastructure, beds); waiting times; geographic distribution	**Availability and Accommodation**	workforce availability and distribution; proximity of services; waiting times
Governance (policy, vision, information systems, outreach, legislation)	**Approachability** (and the structural determinant lens, §6.7)	mental-health policies; visibility and information channels; community-based outreach
Service-delivery quality, continuity, integration, evidence base	**Appropriateness**	clinical quality of care; continuity of care; integration across services
Person-centred care; cultural responsiveness; involuntary-treatment safeguards	**Acceptability**	interpersonal quality of care; confidentiality and privacy regulations; freedom from coercive practices

Because HSPA is, by construction, an assessment of provision and its conditions, the meso–macro indicators map almost entirely to the **supply side**. This is the very concentration the HSPA review reported Section 3 found the indicators in the corpus to be predominantly supply-side, with demand-side measures markedly underrepresented and it is exactly what the two-level design predicts: the system level describes the opportunity structure, while the demand-side abilities remain the province of the person-centred level, which draws on the scoping review to cover them. The full system-indicator set, tagged by *HSPA function · subfunction · indicator · care tier · supply-side dimension · component · GA aspect (effectiveness / efficiency / quality / equity)*, is provided as an annex and built directly from the project's HSPA analysis (Annex 10).

7.4. Care-tier-adjusted assessment

Service delivery is assessed across **care tiers**; public health and prevention, primary care, and specialised (secondary and tertiary) care, together with community-based provision, in keeping with the Grant Agreement's requirement that indicators vary across the levels of the healthcare system, and with the care-tier descriptor introduced for components in §6.4. The same component is expressed differently by tier: approachability operates in primary care through routine screening, frontline actors, and integrated entry points, and in specialised care through referral transparency and coordination across levels; affordability shifts from the cost of a primary-care contact to the cost and coverage of specialist or inpatient care. The primary-care tier in particular draws on the European primary-care performance set (universal access, integration, person-centredness, comprehensiveness, continuity, coordination, and gate-keeping/referral arrangements; European Commission Expert Group on Health Systems Performance Assessment, 2018), and indicators of **coordination and continuity across tiers** (referral, information transfer, follow-up after discharge) are assessed as features of the system rather than of any single tier.

7.5. Efficiency as equity-anchored utilisation

The Grant Agreement asks the framework to consider **efficiency**. Rather than import a separate set of resource-accounting metrics, which can be equity-blind, or even regressive, since a system may appear efficient precisely by under-serving the costly-to-reach (Cylus, Papanicolas, & Smith, 2016), the framework reads efficiency through the same Levesque and equity lens as the rest of the assessment. The approach is to take **standard, already-collected utilisation metrics and disaggregate them by vulnerable group against a general-population comparator in the same catchment** (district or centre), and to interpret the *gap* as the system-level signature of an upstream access failure.

The logic is that of avoidable, ambulatory-care-sensitive use: where earlier access fails, need is displaced into later, costlier, more acute care, so a higher rate of avoidable acute use among a vulnerable group is at once **inefficient and inequitable**, and it points to the specific dimension where access failed upstream (van Loenen et al., 2014). Illustrative indicators, each reported as a ratio of the vulnerable group to the general population in the same area, and each read through a Levesque dimension include:

1. **psychiatric hospitalisation rate** (general acute use); upstream Approachability/Availability;

2. **involuntary/compulsory admission rate**; a documented disparity for migrant and minority groups; signals Acceptability and Approachability failure, and engages the coercion concern of Section 6.3;

3. **crisis or emergency contact as first point of contact**, against **community/outpatient contacts per capita**; high acute and low community use indicates people reaching care only in crisis (Approachability/Availability);

4. **30-day readmission** and **follow-up after discharge within the recommended period**; continuity and Appropriateness (and Ability to Engage);

5. **"did-not-attend" / drop-out rate**; Acceptability and engagement.

Efficiency in this framework is therefore not a separate criterion in tension with equity but the **resource-side expression of unrealised access**, made visible by intersectional disaggregation and interpreted through the same dimensions. It connects directly to the effective-coverage logic of §6.3: an avoidable admission is the cost of an opportunity that was not realised earlier in the journey. The one caution is that these metrics are informative *only* when disaggregated; read as population aggregates, they revert to the equity-blind accounting the framework is trying to avoid.

7.6. Enabling condition and policy recommendation: intersectional registries

The disaggregated reading of efficiency in Section7.5 and, more broadly, the disaggregated data architecture of Section.7 at system level, depends on a condition that most health information systems do not currently meet, as the targeted HSPA review found (Section 3; see also Bauer, 2014): that registries and administrative datasets capture intersectional, equity-relevant identifiers (for example migration or refugee status, ethnicity, disability, and, where appropriate and safe, sexual orientation and gender identity), linked to utilisation records. Without this, the vulnerable-group-versus-general-population ratios cannot be computed, and system-level equity remains invisible.

This is not an addition outside the framework: it falls squarely within the HSPA **Governance** function, under information and knowledge systems. The framework therefore makes it a **policy recommendation**, that mental-health information systems and registries be developed to support equity-disaggregated, intersectional monitoring, to be carried into the Discussion

and Conclusion as a forward-looking measure and aligned with the project's macro-level foresight (T1.3).

The recommendation carries an essential safeguard. Collecting sensitive intersectional data about people in vulnerable situations creates real risks of privacy breach, misuse, and stigma, risks borne by the very groups the data are meant to serve. The recommendation must therefore be paired with **strong data governance and protection, clear purpose limitation, and participatory oversight** by the communities concerned, consistent with the project's ethics requirements. Intersectional data should expand people's standing in the system, never their exposure.

Taken together, the two levels set out in this Part adapt and extend the Levesque framework in several connected ways, rather than as isolated additions. The framework first reframes access from a patient-centred process into a person-centred journey, and grounds it in Sen's capability approach, so that access is understood as a real opportunity to obtain care, distinct from both provision and use, that is mediated by conversion factors. On that basis, intersectionality is incorporated as the conversion factors that differentiate access across overlapping positions of disadvantage, and a person-centred assessment logic, with its two interpretive distinctions, addresses the supply–demand conflation observed in earlier applications. These conceptual moves are made operational through a defined set of components, their indicators, and an adaptable item bank. Finally, the framework extends Levesque from the person to the system: a meso–macro level, built on the architecture of Health System Performance Assessment, assesses whether the system is organised to produce access, adds sensitivity to care tiers, reframes efficiency as equity-anchored utilisation, and identifies intersectional registries as an enabling condition with the two levels joined throughout by the shared components and a common capability spine. Table 12 consolidates these adaptations against the original framework, indicating for each what has changed and why.

Table 12. A summary of the framework's adaptations and additions

Original Levesque framework (2013)	EQUICARES adaptation / addition	Purpose and grounding
Access framed as a patient-centred process.	Reframed as a person-centred journey, organised around the individual's pathway to and through care.	Centres the person rather than the service episode; aligns with candidacy (Dixon-Woods et al., 2006).

A structural map of access, five supply-side dimensions and five paired demand-side abilities meeting at the system–population interface, but without a unifying theory of what access is or why it varies.	Grounded in Sen's capability approach: access is a capability (a real opportunity), distinct from provision (resources) and use (functioning), and mediated by conversion factors.	Gives “access” a single, theory-based meaning and explains unequal access under equal provision (Sen, 1992, 1999; López Barreda et al., 2019).
A general framework for access to health care.	Adapted specifically for mental health and care services and for people in vulnerable situations.	Sensitises the framework to mental-health-specific and equity-relevant barriers (scoping review; hackathon).
Concerned with equity and attentive to vulnerable and disadvantaged populations, but with no explicit mechanism for intersecting (multiple, overlapping) disadvantage.	Intersectionality applied as conversion factors, a cross-cutting lens across all ten dimensions, not an eleventh dimension, and linked to the social determinants of health.	Detects differential access across intersecting positions of vulnerability (CSDH, 2008; intersectionality literature).
Supply dimensions and demand abilities are paired and meant to be assessed together; in subsequent applications the two sides have frequently been conflated in instruments.	A person-centred assessment logic: supply measured as experienced opportunity, demand as capacity to act, with a wording convention, a validity rule, and two interpretive distinctions (provision–reach; capability–use).	Resolves the documented supply/demand conflation and respects agency in non-use (Cu et al., 2021).
Five dimensions and five abilities, defined conceptually.	Each dimension resolved into defined components (~80 in total), from which indicators (≥20 metrics) and an adaptable item bank are derived (supply two-source; demand journey-staged).	Turns the concepts into an operational, assessable instrument (scoping review → workshop → hackathon).
A multilevel account of determinants (system, institution, organisation, provider; individual, household, community, population) but centred on access as realised at the person–system interface, with no system-performance assessment layer.	Two complementary levels of one design: a micro–meso (person) level and a meso–macro (HSPA system) level, joined by shared components and the capability spine.	Adds a system-performance assessment layer (HSPA) and links it to the person level, extending assessment to whether the system is organised to produce access.
Not differentiated by care tier.	Care-tier-adjusted assessment across primary, secondary, specialised, and community/social care.	Makes assessment sensitive to where in the system access succeeds or fails (Grant Agreement requirement).
No treatment of efficiency.	Efficiency reframed as equity-anchored utilisation disaggregated metrics such as avoidable or involuntary admissions by vulnerable group rather than resource accounting.	Meets the Grant Agreement's efficiency requirement while keeping equity central (van Loenen et al., 2014).
No information-systems component.	Policy recommendation: registries and information systems that capture intersectional identifiers, with data-governance and participatory safeguards.	An enabling condition for equity-disaggregated, system-level monitoring (HSPA governance function).

Part III

Integrated Interpretation

8. Integration with WP1 Tasks

Task 1.2 does not stand alone. Its purpose within Work Package 1 is to provide the **common analytical spine** on which the other WP1 tasks collect and interpret their data, and to hand a calibrated framework forward to the rest of the project. This chapter sets out how the framework connects backward to the evidence that shaped it, sideways to the tasks that applied it, and forward to the work that depends on it.

8.1. A two-way relationship: the M6 → M18 calibration

The framework was designed to be used before it was finalised. A draft version was delivered at M6 so that the subsequent WP1 tasks could build their data collection on its dimensions and components. Those tasks then applied the draft in the field, and their application experience has fed back into the consolidation presented in this deliverable. D1.2 may therefore be understood as the M18 stage of a calibration process: the draft framework shaped T1.3–T1.5, and what those tasks learned in using it has shaped the final framework.

8.2. Backward: the evidence base (T1.1)

The systematic review of prevalent mental health conditions and access barriers (T1.1; D1.1) supplied much of the raw material from which the framework's components were derived. The barriers and enablers it catalogued across vulnerable populations and conditions informed both the component definitions consolidated in §2.1.4.1 and the equity orientation that runs through the framework. In capability terms, D1.1 mapped the conversion factors that the framework must be sensitive to. In parallel, the targeted HSPA review (Section 3) supplied the system-level indicators that the meso–macro level of the framework (Chapter 7) organises on the HSPA functional spine and maps back onto the same components, so both the micro–meso and the meso–macro levels are grounded in the deliverable's own evidence base.

8.3. Lateral: the framework in application (T1.3, T1.4, T1.5)

The framework provided the shared structure across all three empirical WP1 tasks, each operating at a different system level:

1. **Macro level - T1.3 (D1.3).** The pan-European Delphi foresight exercise on mega-trends used the framework's dimensions to structure expert anticipation of how current and future trends will affect equitable access. This situates the framework's components against forward-looking, system-level pressures, illustrates its application beyond cross-sectional assessment, and aligns with the system-level orientation of the meso–macro layer (Chapter 7).

2. **Meso level - T1.4 (D1.4).** The meso-level study explicitly operationalised "the adapted Levesque framework (Work Package 1.2)" through a mixed-methods design across the eight pilot sites, structuring its national surveys around the five supply-side dimensions and its stakeholder interviews around organisational and structural factors, in effect bridging the person and system levels. Its findings, barriers varying across pilot countries and across vulnerable groups are consistent with the framework's emphasis on intersectional disaggregation (Chapter 6) rather than population averages.

3. **Micro level - T1.5 (D1.5).** The micro-level study applied the demand-side abilities, complemented by the Patient Health Engagement Model, to the lived journey of help-seeking among people in vulnerable situations (survey, n ≈ 202, with reflective diaries). Its findings are broadly consistent with the framework's person-centred, capability-based logic: it foregrounds the *work* individuals must do to access care, repeated help-seeking attempts while navigating system barriers and life responsibilities, alongside the importance of mental health literacy (Ability to Perceive), the deterrent effect of stigma (Ability to Seek), the ability to pay as a leading barrier (Ability to Pay), and trusting, validating relationships as facilitators (Ability to Engage). These accounts illustrate the access *journey* that the framework aims to assess.

What these applications returned to T1.2 is concrete. D1.5's account of the burden of access strengthened the framing of demand-side dimensions as *capacities and means to act* rather than behaviours; D1.4's cross-group variation underscored the disaggregated data

architecture, and the experience of fielding instruments at meso and micro levels informed the response and interpretation conventions now specified in Chapter 6.

8.4. Forward: use across the project

The framework is an input across the project, and in two modes as a tool for *assessing* access and as a guide for *planning* accessible solutions. As an assessment tool, its components and indicators give **WP2** a structured lens for appraising existing innovative solutions, and they support the pilot-site profiling of **T3.1**. As a planning and design guide, the same components supply criteria for building accessibility into the solutions the project creates rather than judging it only after the fact: in **WP3**, where the Smart Health Labs co-design, implement, and assess innovative solutions with people in vulnerable situations, the framework can structure the accessibility design and evaluation of those solutions including the project's **AI assistant (T3.5)**, whose own accessibility for vulnerable groups can be assessed component by component, and in **WP4**, where innovative and community-based solutions are co-designed and piloted, it can inform accessibility planning at the pilot sites from the outset. The same logic extends to community-based services more broadly: the dimensions and components offer pilot teams a shared checklist for anticipating where a new service might fail to reach or to suit the people it is meant to serve. Feeding **T5.1**, the supply/demand, opportunity/capability structure and the comparable scoring approach support the economic analysis; here the meso–macro level is particularly relevant, since its effective-coverage logic (provision versus realised opportunity) and its equity-anchored efficiency metrics (avoidable and involuntary admissions, readmission) translate directly into the costing of access gaps. Realising those metrics also surfaces a cross-cutting recommendation that connects to the project's information infrastructure that registries capture intersectional identifiers (Chapter 7).

9. Discussion

Task 1.2 set out to develop a framework for assessing the accessibility of mental health and care services for people in vulnerable situations by adapting the Levesque framework rather than building a new one, and the work yields several claims worth foregrounding. Conceptually, it reframes access as a person-centred *journey* grounded in the capability approach, so that access is understood as a real opportunity, a capability, realised by an individual, distinct from both the nominal provision of a service and its actual use. Methodologically, it identifies and addresses a conflation that recurs in the applied Levesque literature, in which instruments intended to assess a service characteristic in fact capture an individual ability, or the reverse, and resolves it with a single rule: assess always from the

person, but treat the supply side as experienced opportunity and the demand side as capacity to act. Structurally, it organises assessment at two complementary levels, a micro–meso, person-centred level and a meso–macro, health-system level joined by a shared set of components, and it reframes efficiency as equity-anchored utilisation rather than resource accounting. These are the highlights against which the framework should be judged, and each invites scrutiny.

The empirical material assembled across the five development activities and the three WP1 field applications is broadly consistent and locates the framework within an established literature. Access for people in vulnerable situations emerges as shaped simultaneously by structural barriers, insufficient or absent services, geographic inequity, cost, low political prioritisation and by relational and experiential ones, stigma, discrimination, mistrust, and the absence of culturally and linguistically responsive care with several determinants, notably language, trust, social support, and service fragmentation, recurring across dimensions and levels (D1.1; Lowther-Payne et al., 2023; Cu et al., 2021; D1.4; D1.5). This picture is consonant with the access scholarship that the Levesque framework itself synthesised (Penchansky & Thomas, 1981; Aday & Andersen, 1974) and with reviews of its application (Cu et al., 2021), and it supports reading the dimensions relationally rather than in isolation. The framework's principal departure from that literature is to give "access" a single referent, the capability, drawn from a now-substantial body of work applying the capability approach in health (Mitchell et al., 2016; López Barreda et al., 2019) and to people in vulnerable situations specifically (Gadsby, 2013; Kerman & Sylvestre, 2020; Lavie-Ajayi et al., 2018). Its second departure, the two-level design, retains the architecture of Health System Performance Assessment (WHO, 2022) while shifting the emphasis from inputs and provision toward effective coverage whether opportunities are realised for the person (Tanahashi, 1978; Shengelia et al., 2005; Ng et al., 2014); it is intended to complement, rather than replace, HSPA dashboards, supplying the person-centred and equity-disaggregated reading they typically lack.

Several of these features represent advances rather than restatements, and the most concrete is methodological. The applied access literature has long lacked a consistent rule for what its instruments measure: Cu et al. (2021) found that items drawn from the same framework variously captured service characteristics and individual abilities, and the WP1 user-side study reported that no validated measure of the demand-side dimensions specific to mental health yet existed (D1.5). By anchoring every item in the person while distinguishing experienced opportunity from capacity, and by making that rule auditable through the two interpretive distinctions, the framework offers a corrective that is transferable to any use of the Levesque

model. It responds to a documented difficulty in the field rather than a hypothetical one, and it does so with a device, the provision–reach and capability–use distinctions that, to our knowledge, has not previously been articulated together in the access-measurement literature.

A second contribution is integrative. Capability scholars have called for the approach to be made operational in health while noting how rarely this is achieved (Mitchell et al., 2016; López Barreda et al., 2019); intersectionality scholars have argued that equity analysis must move beyond single-axis categories and stay tied to structures of power (Bowleg, 2012; Hankivsky & Christoffersen, 2008); and the health-system-performance tradition has been faulted for stopping at provision rather than effective coverage (Tanahashi, 1978; Shengelia et al., 2005). The EQUICARES framework brings these otherwise separate strands into one structure: a capability-based, person-centred core; an intersectional, social-determinants-aware equity lens; and a health-system level that reads provision against realised access. The value of this integration is practical as much as theoretical, since it allows a single assessment to ask, of the same components, whether a service exists, whether it reaches and is usable by people in vulnerable situations, and whether the system is organised to sustain it, a combination that instruments addressing one of these at a time do not provide.

A first challenge concerns the choice of capability over functioning. Capability is notoriously difficult to operationalise; the absence of agreed empirical tools has been a long-standing criticism of the approach, and its applications in health remain methodologically heterogeneous (Mitchell et al., 2016; López Barreda et al., 2019). Functionings, what people actually do or achieve, are by contrast easier to observe, and it might reasonably be held that an access framework should measure utilisation and outcomes rather than a contested notion of opportunity. The response is twofold. First, the framework does not attempt to measure capability in the abstract; it measures *realised opportunity* from the person's standpoint whether a service reached them and could be used which is tractable through ordinary survey and interview items. This stays close to Levesque et al.'s (2013) own definition, in which access is the *opportunity* to identify needs and to seek, reach, and obtain or use care, held distinct from *utilisation*, the realised use of services that the field has often taken as a proxy for access (Aday & Andersen, 1974). Measuring the opportunity as the person experienced it, rather than substituting utilisation for it, is therefore faithful to the source framework as much as to the capability reading. Second, the very difficulty this challenge raises is the reason the distinction matters: collapsing capability into functioning is what allows non-use to be misread as inaccessibility, and a service that merely exists to be counted as one that works. Measuring achievement alone would reproduce precisely the conflation the framework is designed to

prevent, and in mental health it risks the paternalism of treating utilisation as the goal (López Barreda et al., 2019).

A second challenge concerns the operationalisation of intersectionality. Intersectionality is, at its core, a theory of interacting structures of power, and its translation into measurable axes and strata has been criticised for reducing a relational concept to demographic categorisation, and for the related problem of category proliferation, the impossibility of measuring every intersection (McCall, 2005; Bowleg, 2012). Fixing a bounded set of axes, as the framework does, could be read as exactly such a reduction. The framework accepts the force of this concern and addresses it in three ways: the axis set is bounded purposively and anchored to the project's own populations rather than chosen for convenience; a qualitative arm is retained alongside the quantitative strata, so that *how* disadvantages combine is examined and not only *where* they concentrate; and a structural indicator keeps the analysis attached to the policies and arrangements that produce disadvantage rather than to the attributes individuals carry (Crenshaw, 1991; Hankivsky & Christoffersen, 2008). Multilevel methods such as MAIHDA further guard against over-interpreting small intersectional subgroups (Evans et al., 2018). The result is not a claim to have resolved the tension between quantification and the relational core of intersectionality, but a design that holds the two in view.

Two further challenges concern measurement and efficiency. The first is that leaving item wording free, while standardising only the construct, threatens the comparability the framework seeks, since differently worded items may not be psychometrically equivalent across contexts (Bollen & Lennox, 1991; Streiner, 2003). This is a genuine limit, and the response is deliberately modest: comparable scoring is presented as a direction for future work rather than a validated procedure, anchor items and tests of measurement invariance are recommended, and the dimensions are treated as formative indices for which internal-consistency reliability is the wrong criterion. The second is that recasting efficiency as equity-anchored utilisation risks understating efficiency in its ordinary sense of cost containment (Cylus, Papanicolas, & Smith, 2016), and that efficiency and equity can genuinely conflict. The framework does not deny the tension; it argues that, for an access framework, the more informative reading of standard utilisation metrics is the equity-disaggregated one, in which an avoidable or involuntary admission among a vulnerable group is read as the resource-side signature of an upstream access failure (van Loenen et al., 2014) rather than as a neutral efficiency datum. Efficiency so understood complements, but does not replace, conventional cost analysis.

The most practical challenge is feasibility. A framework with roughly eighty components, two assessment levels, a mixed-methods design, intersectional disaggregation, and a reliance on registry data that many systems do not yet hold is demanding, and the burden on both services and respondents is non-trivial, a concern borne out by the WP1 micro-level study, which documented the work that accessing care already imposes on people in vulnerable situations (D1.5). This concern is met by the framework's status as a strategy rather than an instrument: components, items, levels, and care tiers are selected and adapted to the assessment at hand rather than applied in their entirety, and the more data-intensive elements, the system comparator and the equity-disaggregated metrics, are presented as aspirations supported by a clear recommendation (intersectional registries) rather than as preconditions. Adoption can therefore be partial and phased, with the person-centred core usable on its own and the system level added where data and resources allow.

Several overarching messages follow from the work as a whole. The first is that the same determinants recur across the dimensions and levels of access rather than belonging to any one of them: stigma and discrimination, language, trust, social support and isolation, and service fragmentation shape perception, seeking, reaching, paying and engaging alike, on both sides of the supply–demand relationship. This is why the framework reads the dimensions relationally, each supply-side dimension together with the demand-side ability it is meant to support, and why an assessment that examined dimensions in isolation would miss the cross-cutting barriers that fall hardest on people at the intersection of several disadvantages.

The implications follow from these positions. For measurement, the conflation finding and the person-centred logic are transferable beyond this project to any application of the Levesque framework, and the two interpretive distinctions offer a general grammar for reading access data. For policy and practice, the framework directs attention to whether systems *respond* to, not merely record, the needs of multiply-marginalised groups, and its recommendation on intersectional registries identifies a concrete enabling condition for equitable monitoring. More broadly, for equitable access across Europe the central implication is that the gap is less often the simple absence of services than the failure of services to reach and suit the people who most need them, so that improving equity depends on building accessibility into how systems are organised, not only on expanding provision; because the decisive barriers are relational and intersectional, comparable improvement across European systems will require the equity-disaggregated, intersectional monitoring that the framework's system level describes. For EQUICARES, it supplies a common spine across the project: a structured lens for WP2's appraisal of existing solutions and the pilot-site profiling of T3.1; criteria for the co-design,

implementation and evaluation of solutions in WP3's Smart Health Labs (including the project's AI assistant, T3.5) and the community-based piloting of WP4; and a basis for the economic analysis of T5.1, to which the equity-anchored efficiency metrics speak directly. The same component–indicator structure can also underpin a monitoring dashboard, giving such a tool a person-centred, equity-disaggregated reading to complement conventional HSPA indicators.

In practical terms, the framework is meant to support implementation and decision-making, not description alone. It can be used to decide what to assess and to locate where, and for whom, access is failing; to set criteria for designing accessible solutions from the outset rather than judging them afterwards; and to prioritise action and resources toward the dimensions and groups where the access gap is widest. Because it is a strategy rather than a fixed instrument, teams can adopt it partially and in phases starting with the person-centred core and adding the system level where data allow which keeps it usable for real decisions within the time and resources of the project's pilots.

Several limitations qualify these contributions. The framework has been developed but not yet empirically or psychometrically validated: the item bank is a recommendation rather than a tested scale, and the scoring approach is a direction for future work whose comparability claims await evidence. The micro–meso level relies primarily on self-report, with the attendant risks of recall and social-desirability bias, while the meso–macro indicator set is exemplary rather than validated and its equity-anchored efficiency metrics depend on registries capturing intersectional identifiers, data not yet routinely available, which the framework can recommend but not assume. The scoping review, though broad, reflects the published applications of a single framework and the populations those studies happened to cover, so gaps in that literature are inherited here. One such gap concerns exclusion mechanisms. In particular, risk-based gatekeeping, notably the exclusion or onward diversion of people at acute suicide risk away from first-line primary and community services, and their frequent exclusion from mental-health research on safety grounds, did not feature in the included studies, despite being a salient driver of unmet need in practice; the framework's eligibility-criteria component is well positioned to capture such criteria, and their absence from the literature is itself worth flagging as a priority for future assessment. Finally, the framework’s breadth, a strength conceptually, is a constraint practically: full application will be feasible only for well-resourced assessments, and lighter adaptations will trade comprehensiveness for usability. Taken together, these are genuine and acknowledged limits; the Conclusion that follows sets out how they might be addressed as the framework moves from development into application.

10. Conclusion and Next Steps

Task 1.2 set out to deliver a solid monitoring, evaluation, and assessment framework for the accessibility of mental health and care services, tailored to people in vulnerable situations through an adaptation of the Levesque framework. This deliverable presents that framework in its consolidated form: the ten Levesque dimensions resolved into roughly eighty defined components; a person-centred, capability-based assessment logic that measures supply as experienced opportunity and demand as capacity; two interpretive distinctions; a recommended, adaptable item bank; and a comparable scoring approach that seeks cross-context comparability without imposing a single instrument. Equity, via intersectionality understood as conversion factors, is threaded throughout.

The framework is delivered at **two complementary levels**: a micro–meso, person-centred level (Chapter 6) and a meso–macro, health-system-performance level (Chapter 7) built on the HSPA functional spine and mapped back to the same dimensions and components. The second level carries the system-performance requirements of the task, **efficiency**, reframed as equity-anchored utilisation, and **care-tier-adjusted** metrics, so that the deliverable addresses effectiveness, efficiency, quality, and equity across the levels of the care system, as the Grant Agreement requires, while keeping the person as the reference point throughout.

The framework has already been applied in practice. Its draft version structured the macro-, meso-, and micro-level studies of T1.3, T1.4, and T1.5, and their application has informed the calibration of the final version presented here.

Several next steps follow. First, **validation and refinement**: the item bank should be piloted and, where data allow, psychometrically calibrated to strengthen cross-context comparability, with anchor items retained and adaptations documented; the meso–macro indicator set should likewise be validated in use. **Second, application across the project:** the framework feeds WP2's assessment of existing solutions, the pilot-site profiling of T3.1, the co-design, implementation and evaluation of solutions in WP3's Smart Health Labs (including the AI assistant, T3.5) and the community-based piloting of WP4, and the economic analysis of T5.1, where its effective-coverage logic and equity-anchored efficiency metrics support the costing of access gaps; its component–indicator structure can also underpin a monitoring dashboard. Third, **information infrastructure**: realising the system-level and equity-disaggregated assessment depends on health information systems and registries that capture intersectional identifiers; the deliverable recommends their development, paired with strong data governance and participatory oversight. Fourth, **participatory continuation**: the lived-

experience involvement that shaped the framework should continue through its application, both to keep items meaningful in each context and to surface the intersectional compounding that fixed measurement misses. In this way the assessment framework may function less as a static instrument than as an adaptable strategy for examining inequitable access to mental health care across Europe.

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12. Annex 1. Characteristics and Summary of the Studies Included in the Scoping Review

No	Study	Authors	Study objectives	Country / Setting	Target Group	Study design	Mental Health Condition	Mental Health Context	Use of Framework	Addressed Dimensions	Availability of Measurement Tool
1	Factors influencing multiple non-utilised healthcare appointments from patients' and healthcare providers' perspectives: a qualitative systematic review of the global literature	Aldadi et al. (2024)	To explore patients' and providers' perspectives on factors contributing to multiple non-utilised appointments	Canada Denmark UK USA South Africa	Healthcare providers and healthcare users	Systematic review	Not exclusively mental health-focused; mental, emotional, and psychological factors including PTSD, fear, distress, humiliation were identified as one of six analytical themes influencing appointment non-utilisation.	Primary and secondary care	A posteriori	Only a distinction between supply side and demand side was made, supply side dimensions were grouped as "healthcare system determinants", demand side dimensions were grouped as "patient experience and decision making".	Not applicable
2	Barriers and Facilitators to Accessing Mental Health Supports Among Black Perinatal Women: Application of the Patient-centered Access Framework	Ash et al. (2025)	To understand Black perinatal women's experiences accessing mental health supports	USA	Black/African American perinatal women (being pregnant or giving birth within the past 12 months)	Qualitative, thematic analysis	Perinatal mental health conditions, specifically depression, anxiety, and PTSD/traumatic stress disorders	Primary and secondary care, community-based care, NGO-based care, social care	A priori	All dimensions were mentioned, but supply and demand side dimensions were discussed together.	Not publicly available

3	Towards the development of actionable recommendations for improving mental healthcare access for migrants: a qualitative study in Munich, Germany	Baierl et al. (2026)	To explore the determinants influencing migrants' access to mental healthcare from the perspectives of migrants and health professionals in Munich, Bavaria, and to provide the foundation for developing comprehensive recommendations for action to improve migrants' mental healthcare access.	Germany	Migrants, refugees, international students, and mental health professionals	Qualitative study, iterative content analysis	General mental health and mental healthcare access including depression, PTSD, anxiety, psychotic disorders, and migration-related mental distress	Primary, secondary and tertiary level	A priori with framework adaption	All dimensions were addressed, but adapted a posteriori by schematizing and modifying it based on their findings	Not publicly available
4	Improving access to social farms for people with dementia, including people from India, Bangladesh, and Pakistan.	Bartlett et al. (2025)	To find out how accessible social farms (care farms/farm-based services) in England are for people living with dementia, including people from India, Bangladesh, and Pakistan; and to identify barriers and facilitators to access across diverse populations	UK	Social farm managers social farm users (100) and their care givers (46) (users were from from UK-British India, Bangladesh, Pakistan)	Mixed method; quantitative component applying cross-sectional study and qualitative component applying content analysis	Dementia and mental and physical health support interventions in social farms	Community-based care	A priori	All dimensions were mentioned, but supply and demand side dimensions were discussed together.	Not publicly available
5	Perinatal mental health care from the user and	Berger et al. (2020)	To gain basic insights into the strengths, gaps and	Switzerland	Perinatal women with diagnosed mental health	Study protocol, qualitative	Perinatal mental disorders (PMD): mood	Primary and secondary care	A priori	NA	Publicly available semi-structured interview guide for women and focus

	provider perspective: protocol for a qualitative study in Switzerland		requirements for adequate mental health care in the perinatal phase in a high-income country		condition healthcare providers social care providers	explorati ve design	and affective disorders (F30-F39), anxiety disorders (F41), adjustment disorders (F43), OCD (F42), personality disorders (F60-F69), substance use disorders (F10-F19), and psychotic disorders (F20-F29);				group guide for providers
6	Living with cystic fibrosis during the COVID-19 pandemic: An interpretive description of healthcare access from patients with cystic fibrosis and their providers in Alberta, Canada	Brehon et al. (2025)	To explore patient and provider perspectives of the impact of the pandemic on cystic fibrosis healthcare access and service delivery	Canada	Patients with cystic fibrosis and healthcare providers	Qualitati ve, thematic analysis	It addresses healthcare access and service delivery for cystic fibrosis, though mental health needs of patients are raised as a secondary concern within the findings	Secondary and tertiary level	A priori	The framework's dimensions were used a priori to structure data generation but results were not reported dimension-by-dimension. Instead, findings were grouped into three thematically constructed themes that cut across and blend multiple Levesque dimensions together	Publicly available semi-structured interview guide for CF patients and providers
7	Where are services regarding sexual minorities and psychological therapies post-COVID in 2024? A mixed-method	Broadwa y-Horner (2024)	To evaluate the effectiveness of psychological therapies for sexual minorities in the post-COVID context, and to explore their experiences	UK, Australia, USA, Canada	Sexual minorities	Mixed-method systemat ised review	Mental health broadly including depression, anxiety, minority stress, internalised homophobia/b iphobia, trauma, and common mental health	Primarily NHS primary care and Improving Access to Psychological Therapies, Secondary care, community based care, NGO-based	A posteriori with framework adaption	The author adapted the framework into a "6A's of health equity" checklist, operationalising six dimensions and applying them to each included study as an audit rather than reporting findings per dimension.	Not applicable

		systematised review	with such services				problems among sexual minorities.	care, private care		Availability: Does the service exist at all? Accessibility: Physical and practical access (example given: a mother with small children blamed for being late) Awareness: Service exists but people do not know it is there Affordability: Known service but priced too high Appropriateness: Care offered but low quality or unable to incorporate diversity Acceptability:Culturally needs to be addressed; cultural frame for help-seeking may differ	
8	Where's the help when you need it? Examining accessibility to mental health resources among law enforcement	Clifton & Hancock (2025)	To examine the applicability of the Levesque Framework of health care access to law enforcement officers and to identify which dimension poses the most significant barrier to accessing mental health care, with a focus on the role of police	USA	Law enforcement	Quantitative, cross-sectional study	All mental health conditions, focus is on access barriers rather than a specific diagnosed condition	Workplace-based care	A priori	All demand- side dimensions were addressed individually and reported separately	Publicly available. Mental Health Literacy Scale; Medical Mistrust Index; author-developed Likert-scale items

			culture and stigma.								
9	Barriers to accessing mental health care for refugees and asylum seekers in high-income countries: A scoping review of reviews mapping demand and supply-side factors onto a conceptual framework	Dumke et al. (2024)	To map and synthesize the existing literature on barriers to accessing mental health care for refugees and asylum seekers in high-income countries	High income countries with a focus on Europe, North America, and Australia	Refugees and asylum seekers in high-income countries	Scoping umbrella review	Mental health broadly, with particular emphasis on depression, PTSD, anxiety, and severe mental illness; no single condition targeted exclusively	Primary and secondary care, community-based and NGO-based care	A posteriori	Main focus was on barriers to accessing mental health care, and barriers were mapped onto its stages rather than reported dimension by dimension.	Not applicable
10	Breaking barriers: a qualitative exploration of healthcare access for crack cocaine users in Limerick	Duopah et al. (2024)	To fill the gap in knowledge by examining barriers to service access for crack cocaine users from the perspective of both persons who use crack cocaine and service providers	Ireland	Crack cocaine users healthcare providers	Qualitative, phenomenological approach	Not a mental health-specific study; focused on substance use disorder and associated co-occurring issues including dual diagnosis such as depression, PTSD, anxiety, psychosis, and personality disorder	Community-based and primary care	A priori	Each supply side dimension was addressed, but themes that could be related to demand side were grouped under supply side dimensions	Not publicly available
11	Barriers to health care access among transgender	Fernandez & Gaitonde (2026)	To identify the barriers to healthcare access experienced by transgender and	India	Self-identified transgender and gender-	Mixed methods; quantitative component	Mental health was not a primary focus, but mental health is explicitly	Primary and secondary public care, private sector; NGO and community-	A priori and a posteriori	All dimensions were addressed. Supply and demand sides were	Not publicly available

	people in Kerala		gender-diverse individuals in Kerala, India.		diverse individuals	applying cross-sectional survey qualitative, thematic analysis	identified as a key concern	based organizations		kept together within each domain.	
12	Qualitative study of the perspectives of women with lived experience of domestic and family violence on accessing healthcare	Hollingdrake et al. (2023)	To explore the perceptions of women with lived experience of domestic and family violence on accessing healthcare and to identify how nurses can facilitate and support women experiencing domestic and family violence to receive the care they need	Australia	Women with lived experience of domestic and family violence	Qualitative	Not a mental health-specific study; focused on healthcare access broadly for women experiencing domestic and family violence. Mental health needs including psychological support, trauma, anxiety, mental health assessments emerged as a secondary but prominent theme within the findings	Primary and secondary care, community based and NGO-based care	A priori and a posteriori	Each supply side dimension was addressed, but themes that could be related to demand side were grouped under supply side dimensions.	Publicly available focus group interview guide for women with lived experience of domestic and family violence
13	Assessing Virtual Mental Health Access for Refugees during the COVID-19 Pandemic Using the Levesque Client-Centered Framework: What Have We Learned	Hynie et al. (2022)	To document the perceptions of refugee newcomers, as well as those of key actors involved in the referral and delivery of virtual mental health (VMH) services, to understand how virtual	Canada	Refugee newcomers	Qualitative, deductive qualitative analysis	General mental health and psychosocial well-being	Virtual mental health services, primary and secondary level, community-based and NGO-based care	A priori	All dimensions were addressed.	Not publicly available

	and How Will We Plan for the Future?		modalities can impact access to mental health services for vulnerable groups.								
14	Access to Virtual Mental Healthcare and Support for Refugee and Immigrant Groups: A Scoping Review	Hynie et al. (2023)	To apply a multidimensional framework in identifying factors that affect the accessibility of virtual mental health services for immigrants, refugees and asylum seekers globally, across multiple countries and settings	Multi-country; included studies from Australia, Canada, Denmark, Germany, Lebanon, Mexico, Netherlands, Norway, South Africa, Spain, Sweden, Switzerland, Turkey, UK, USA	Immigrants, refugees, and asylum seekers	Scoping review	Mental health and well-being broadly including depression, anxiety, PTSD/trauma, substance use, caregiver burden, general mental well-being, perinatal depression, suicidal ideation, acculturation stress, cognitive functioning	Virtual mental health services, primary and secondary level, NGO and community-based care	A posteriori	Only four supply-side dimensions were addressed, Approachability was not addressed. Appropriateness and acceptability were grouped together. The demand-side dimensions were not examined.	Not applicable
15	Access to mental health and addiction services for youth and their families in Ontario: perspectives of parents, youth, and service providers	Kourgiantakis et al. (2023)	To explore access to mental health and addiction services for youth aged 16–24	Canada	16-24 aged youngsters with substance use disorder, their parents, and service providers	Qualitative using thematic analysis	Mental health concerns broadly including depression, anxiety, concurrent disorders, substance use/behavioural addictions, and co-occurring mental health and addiction disorders	Mental health and addiction services, primary and secondary level and private practice	A priori and posteriori	Main focus was on barriers to access youth addiction services. Results and discussion were organized under the emerging themes, and dimensions were discussed under related themes.	Not publicly available; but thematic categories of questions were reported in manuscript

16	The Right to Rehabilitation for People With Dementia: A Codesign Approach to Barriers and Solutions	Layton et al. (2024)	To explore barriers to access to dementia rehabilitation to identify solutions that improve access to rehabilitation	Australia	People living with dementia, their care providers, and health care providers	Qualitative codesign study using experience-based codesign methodology	Dementia and co-occurring mental health conditions	Rehabilitation, primary and secondary care, community-based care level	A posteriori	All five supply-side dimensions were addressed, and the corresponding demand-side dimensions were integrated within each supply-side dimension rather than reported separately.	Not publicly available
17	Barriers and facilitators of access and utilization of mental health services among forensic service users along the care pathway	Leclair et al. (2022)	To identify individual and contextual barriers and facilitators of access to mental health services during the period preceding an offense leading to a verdict of NCRMD (Not Criminally Responsible on account of a Mental Disorder)	Canada	People found NCRMD	Quantitative, retrospective cohort	Severe mental illness; primarily psychotic spectrum disorders and mood disorders with concurrent personality disorder and concurrent substance use disorder	Community-based care, primary and secondary care, emergency mental health services	A priori	Three demand-side dimensions were addressed, each operationalised as a distinct outcome variable and analyzed separately. Supply-side dimensions were embedded within contextual predictors rather than reported as separate framework categories. Ability to seek: Operationalised as having at least one mental health service contact prior to the index offense Ability to reach: Operationalised as having at least one contact with a psychiatrist Ability to engage (receiving care): Operationalised as two outcomes; volume of psychiatric visits (intensity) and continuity of care	No survey or interview instrument used; access operationalised through administrative records; variables used to operationalise Levesque framework dimensions reported in full

										(Bice-Boxerman index).	
18	Understanding inequalities in access to adult mental health services in the UK: a systematic mapping review	Lowther-Payne et al. (2023)	To address the inequalities in access to mental health care by identifying which population groups continue to be poorly served by access to adult mental health services in the UK, how access has been measured, and what research methods have been applied	UK	Adult populations (aged 18+) at risk of experiencing inequalities in access to NHS mental health services, including groups defined by age, gender, ethnicity, disability, socioeconomic status, sexual orientation, religion, place of residence, occupation, pregnancy/maternity, contact with criminal justice system, refugee/asylum seeker status, and trafficked people/street sex workers	Systematic mapping review	Adult mental health broadly; no restriction to a specific condition;	Primary, secondary and tertiary care	A priori	All dimensions were addressed.	Not applicable
19	LGBTQ+ experiences of accessing NHS adult mental health services during COVID-19 in an area of North West England: a qualitative interview study	Lowther-Payne et al. (2026)	To understand LGBTQ+ people's experiences of mental health and accessing NHS mental health services during the COVID-19 pandemic, and to explore how their LGBTQ+ identity	UK	LGBTQ+ adults aged 18 and over who accessed or tried to access NHS adult mental health services between March 2020 and February 2022	Qualitative, reflexive thematic analysis	General mental health conditions	Secondary level, community-based care, crisis lines, private sector, NGO-based care, school-based and work-based care.	A priori and a posteriori	All dimensions were addressed. Supply and demand sides were discussed together under emerged themes.	Publicly available interview guide for LGBTQ+ adults

			influenced these experiences.								
20	Navigating Mental Health Frontiers: A Scoping Review of Accessibility for Rural LGBTIQA+ Communities	Maria et al. (2025)	To contribute to ongoing efforts by addressing accessibility disparities for LGBTIQA+ communities in rural and remote areas, specifically focusing on mental healthcare	Australia Brazil Canada Thailand USA	LGBTIQA+ individuals residing outside metropolitan or larger regional centres	Scoping review	General mental health conditions; no single condition specified	Primary and secondary care, community-based and NGO-based care, private sector	A posteriori	All dimensions were addressed.	Not applicable
21	Access to early diagnosis for attention deficit/hyperactivity disorder among children and adolescents in Mexico City at specialized mental health services	Martínez-Jaime et al. (2024)	To evaluate the accessibility of mental health services among children and adolescents that are tailored to specific needs of attention deficit and hyperactivity disorder profiting Levesque's conceptual model	Mexico	Children and adolescents with attention deficit and hyperactivity disorder and their primary caregivers	Quantitative, retrospective cohort	Attention deficit and hyperactivity disorder	Secondary and tertiary care level	A priori	The study primarily examined delays in ADHD diagnosis by analysing the age at which individuals perceived the need for care, sought help, contacted a mental health provider, arrived at the host hospital, and ultimately received a diagnosis.	Instrument not publicly available; access operationalised through age-based measurement of five sequential pathway stages derived from the Levesque Framework; pathway stages and sociodemographic variables used in analyses reported in full.
22	Barriers and Enablers to Health-Seeking for People Affected by Severe Stigmatising Skin Diseases (SSSDs): A Scoping Review	McCollum et al. (2022)	To identify enablers and barriers to health-seeking in relation to SSSDs (Severe Stigmatising Skin Diseases)	Low middle income countries	People affected by Severe Stigmatising Skin Diseases (SSSDs)	Scoping review	Not a mental health-specific study; focused on Neglected Tropical Diseases with severe stigmatising skin manifestations however, mental health and psychosocial	Not specified for mental healthcare	A posteriori	Mental healthcare accessibility was discussed under Appropriateness.	Not applicable

							consequences of these diseases were acknowledged as critical gaps				
23	Access to healthcare for people experiencing homelessness in the UK and Ireland: a scoping review	McNeill et al. (2022)	To assess the evidence from the published literature addressing access to healthcare for people experiencing homelessness in the UK and Ireland.	UK Ireland	Adults aged 16 and older experiencing homelessness, defined using FEANTSA ETHOS typology categories	Scoping review	Not a mental health-specific study; focused broadly on access to healthcare mental health was repeatedly identified as a significant co-occurring need for PEH, mental health issues described as part of complex health needs, specific mention of mental health services access barriers	Any level and any type of mental healthcare services	A posteriori	Mental health care accessibility was discussed under all dimensions.	Not applicable
24	Improving access to healthcare services for people experiencing homelessness : evidence from a scoping review of interventions	Meda et al. (2025)	To provide a comprehensive overview of interventions supporting equitable and needs-based healthcare access for people experiencing homelessness	Multi-country (predominantly English-speaking countries	People experiencing homelessness as defined by the ETHOS framework including roofless, houseless, insecure housing, and inadequate housing; with sub-groups including youth, veterans, HIV-	Scoping review	Not exclusively mental health-focused; mental health conditions are among the conditions addressed (including substance use, mental illness)	Primary, secondary, tertiary care and community-based care	A priori and a posteriori	All dimensions were addressed but supply and demand side dimensions were discussed together.	Not applicable

					positive individuals, and racially marginalised groups						
25	Protocol for integrating mental health services into primary healthcare facilities: a qualitative study of the perspectives of patients, family members and healthcare providers in rural Bangladesh	Naheed et al. (2022)	To explore the perceptions, beliefs, and experiences of NCD patients, their family members, healthcare providers, and community health workers regarding mental health problems and the feasibility/acceptability of integrating mental health services into primary healthcare settings	Bangladesh	People with NCDs (hypertension and/or diabetes)	Qualitative study study protocol	General mental health conditions; no single condition specified	Primary care level, integration of mental health care into primary care setting	A priori	NA	Publicly available semi-structured and focus group interview guides
26	Access, Inequalities and Annual Health Checks (AHCs) for Adults Living with Severe Mental Illness in the UK: A Mixed-Methods Systematic Review	Owens et al. (2025)	To identify and explore factors, including access inequalities, related to annual health checks (AHCs) for people living with SMI sharing protected characteristics in the UK, as identified in Core20PLUS5; and to examine what features, interventions or models of	UK	Adults aged ≥18 years living with severe mental illness (SMI), defined as schizophrenia, bipolar affective disorder, and other psychoses (including patients on lithium therapy); including marginalised subgroups as identified in	Mixed-Methods Systematic Review	Severe Mental Illness, specifically schizophrenia, bipolar affective disorder, and other psychoses.	Primary care, secondary care and community-based care	A priori	All dimensions were addressed, but findings were not presented as separate sections per dimension. Results were reported under thematic categories including structural barriers, financial barriers, cognitive barriers, reasonable adjustments.	Not applicable

			service provision improve uptake and access to AHCs.		Core20PLUS5 (e.g., people from ethnic minority backgrounds, those experiencing deprivation, people with learning disabilities, sex workers, homeless individuals)						
27	Perceived barriers to care for migrant children and young people with mental health problems and/or neurodevelopmental differences in high- income countries: a meta-ethnography	Place et al. (2021)	To develop conceptual understanding of perceived barriers to seeking care for migrant children and young people (aged 0–25 years) with mental health problems and/or neurodevelopmental differences in high-income countries.	High income countries	Migrant children and young people (aged 0–25 years) with mental health problems and/or neurodevelopmental differences	Meta-ethnography	General mental health conditions; no single condition specified	Any level and any type of mental healthcare services	A posteriori	All dimensions were addressed.	Not applicable
28	Access to Acute Medical and Forensic Care for Adolescents and Adults Who Have Experienced Sexual Assault: A Systematic Scoping Review	Rogers et al. (2026)	To map the current state of knowledge and identify gaps in the literature regarding access to acute medical and forensic care following sexual assault, using Levesque's framework to provide a holistic picture of supply and	UK, Australia, Ireland	Adolescents and adults aged ≥14 years who have experienced sexual assault	Systematic scoping review	Mental health conditions were not the primary focus; however, mental health screening, acute mental health crisis care, and psychosocial assessment were addressed as components of the broader	Primary care, secondary care, outreach	A priori and posteriori	All dimensions were addressed.	Not applicable

			demand-side factors influencing help-seeking.				acute care response. Substance use was also addressed.				
29	Syrian refugee women's experiences of barriers to mental health services for postpartum depression	Salameh et al. (2025)	To describe Syrian refugee women's experiences of the barriers to access mental health services for postpartum depression	Turkey	Syrian refugee women	Qualitative, descriptive thematic analysis	Postpartum depression	Primary and secondary care	A priori and posteriori	All dimensions were mentioned, but supply and demand side dimensions were discussed together.	Publicly available semi-structured interview guide
30	Barriers to accessing health care for people with chronic conditions: a qualitative interview study	Schwarz et al. (2022)	To identify barriers to accessing healthcare services faced by children with chronic bronchial asthma, adults with non-specific chronic back pain, and older people with pre-existing mental illness/es	Austria	Children with chronic bronchial asthma, adults with non-specific chronic back pain, older people with pre-existing mental illness/es	Qualitative, thematic analysis by using the framework analysis approach	General mental health conditions (older people with pre-existing mental illness/es)	Any level and any type of mental healthcare services	A priori	Main focus was on barriers to access health and mental health care across defined target groups. All dimensions were addressed but supply and demand side dimensions were grouped together.	Publicly available semi-structured interview guide
31	Access to Mental Health Services for People Living with Heart Failure: A Qualitative Study	Shah et al. (2025)	To identify factors affecting access to mental health services for people living with heart failure (PLWHF), from both patient and health system perspectives, as part of a multiphase investigation aimed at	Canada	People living with heart failure, clinicians (nurses, cardiologists, psychologists, psychiatrists) and researchers with expertise in heart failure	Qualitative study, inductive reflexive thematic analysis	Depression, anxiety	Primary care, secondary care, community-based care	A posteriori	All dimensions were addressed. each as a distinct section with its own sub-themes. However, Acceptability and Ability to engage had no themes generated from the data, noted as likely related to the demographic homogeneity of the sample.	Publicly available semi-structured interview guide for people living with heart failure, clinicians and researchers

			designing and evaluating a mental health service for this population.		and/or mental healthcare						
32	Access to Technology-Mediated Community Mental Health Care Among Low-Socioeconomic Status Consumers With Serious Mental Illness: Qualitative Study	Stone & Veinot (2026)	To examine the applicability of Levesque et al.'s access framework to technology-mediated care for SMI among low-SES consumers, to analyze how low-SES consumers use technology to facilitate care access across multiple points in the access process, and to extend the Levesque et al. framework where necessary to better reflect this population and care context	USA	Low-socioeconomic status adults with serious mental illness and health and service provider key informants	Qualitative, ethnography	Serious mental illness including schizophrenia, bipolar disorder, and other severe psychiatric conditions	Community-based care	A priori and a posteriori	Operationalised the Levesque framework through its process/stage dimensions. Supply and demand-side dimensions were not reported separately.	Not publicly available
33	Perceptions of barriers to accessing perinatal mental health care in midwifery: A scoping review	Viveiros & Darling (2019)	To explore midwives and midwifery clients perceptions of factors that impede access to perinatal mental health care in high resource settings	High income countries	Midwives and midwifery clients	Scoping review	Perinatal mental health conditions	Not specified but mainly primary care	A posteriori	All dimensions were addressed.	Not applicable

34	Barriers and Facilitators to Mental Health Care Access Among Asylum Seekers: A Narrative Review Using the Levesque Framework	Wehbe et al. (2026)	To synthesize peer-reviewed literature on barriers and facilitators to mental health care access among asylum seekers in high-income host countries, organized through the Levesque patient-centered access framework, and to identify evidence-based models of care that may address these barriers.	High-income host countries; SA, UK, Germany, Switzerland, Canada, Chile, Greece, Sweden, Ireland, Jordan, and Australia.	Asylum seekers	Narrative review	PTSD, depression, anxiety, psychosomatic disorders (no restriction applied)	Primary care, secondary care, community-based care, NGO-based care	A posteriori	All dimensions were addressed, but not separately as standalone sections. Instead, they were embedded within three thematic domains, with explicit mapping including: “Structural and system-level barriers”, “Cultural and linguistic barriers”, and “Socioeconomic barriers”	Not applicable
35	Healthcare professionals' perspectives on minoritised ethnic young people's access to eating disorder services in the West Midlands, United Kingdom: a qualitative study	Williams-Ridgway et al. (2026)	To understand healthcare professionals' perspectives on minoritised ethnic youth's access to specialist eating disorder services, barriers and facilitators to help-seeking for eating disorders among this population, and HCPs' experiences working with these patients and their families.	UK	Healthcare professionals	Qualitative, reflexive thematic analysis	Eating disorders including anorexia nervosa, bulimia nervosa, binge eating disorder, ARFID among minoritised ethnic young people aged 10–25.	Secondary care	A priori and a posteriori	The dimensions are not reported as separate labelled sections. Instead, findings are organised under two overarching levels as service level and service user level with six themes.	Publicly available semi-structured interview guidelines for healthcare providers

36	Service-level barriers to and facilitators of accessibility to treatment for problematic alcohol use: a scoping review	Wolfe et al. (2023)	To map characteristics of services for the treatment of PAU that have been reported in the literature to be barriers to or facilitators of access to treatment from the perspective of individuals with PA	Global	Individuals with problematic alcohol use	Scoping review	Main focus is on Problematic Alcohol use, but concurrent mental health conditions were also addressed	Primary, secondary and tertiary care, community-based care, workplace-based care	A priori and posteriori	All supple side dimensions were addressed. Main focus was on barriers to access to treatment for problematic alcohol use.	Not applicable
37	Accessing mental health services for a child living with anxiety: Parents' lived experience and recommendations	Woodgate et al. (2023)	To identify factors that influence parents' perceptions of youth mental health service approachability, acceptability, and appropriateness	Canada	Parents of youth living with an anxiety disorder	Qualitative, hermeneutic phenomenology	Paediatric population anxiety disorders	Secondary level, child and adolescent mental healthcare services	A priori and posteriori	All dimensions were mentioned, but supply and demand side dimensions were discessed together.	Not publicly available; but thematic categories of questions were reported in manuscript
38	Examining Factors Influencing Forcibly Displaced Children and Youth's Access to Mental Health Support: An Overview of Reviews	Yılmaz et al. (2025)	To synthesize evidence from existing reviews on barriers and facilitators affecting forcibly displaced children and youth's access to and engagement with mental health services, in order to inform policy, service delivery, and future research.	USA, UK, Canada, Norway, Netherlands, Australia, Sweden, Denmark, Ireland, Belgium, Bosnia, France, Israel, Germany, Austria, Italy, Greece, and countries within the Middle East and North	Forcibly displaced children and youth (including refugees, asylum seekers, unaccompanied minors, and undocumented children); broadly aged 10–24 years.	Umbrella review, narrative synthesis	General mental health (no restriction applied); PTSD, depression, anxiety, behavioural problems, and suicidality were the most frequently addressed	Primary care, secondary care, community-based care, school-based care, NGO-based care	A priori and posteriori	All dimensions were mentioned each as a distinct stage such as Approachability and Ability to perceive as "Opportunity to identify healthcare needs".	Not applicable

				Africa (MENA) region, Southeast Asia and Thailand.							

13. Annex 2. Measurement of the Levesque Framework Dimensions in Studies Included in the Scoping Review

No	Authors	Tool	Study Type	Addressed Dimensions	Questions
1	Berger et al. (2020)	Semi-structured in-depth interview form and focus group interview form	**Qualitative Study Protocol**	**Approachability and Ability to Perceive**	**Questions for Services Users:** Could you tell me about your experiences during that time? (Optional: How did you feel as an expectant mother or as a mother? Did you have any specific concerns about the baby, your husband/partner, or your family? What were your main thoughts about the pregnancy or your baby after birth?) Could you tell us about the circumstances of realizing that you became unwell? (Optional: When did you notice that you became unwell? How did you recognize you were ill? What was it like to be ill? What kind of symptoms did you have? At what point did you recognize that you needed help?) Before feeling unwell or seeking help, how did healthcare professionals obtain information from you about your mental wellbeing? (Optional: Did healthcare professionals ask you about your feelings/your mood? How was the communication about mental health with your healthcare professional? What aspects were helpful for the communication, what hindering? Did you feel confident about talking openly and honestly about your feelings and mood? Is there a reason why you didn't feel comfortable talking to your health professional about how you were feeling? Were you afraid of something? In general, how was the relationship with your healthcare professional?) At the beginning of your pregnancy – before you became unwell – what did you think or know about perinatal mental illness? (Optional: Did a healthcare professional inform you about perinatal mental illness? How did you receive the information about perinatal mental illness? Do you think it is important that women are informed about perinatal mental illness at the beginning of their pregnancy? Why?) **Questions for Service Providers:** The following questions focus on speaking with perinatal women about their general mental wellbeing. How do you gather information about perinatal women's mental health when you don't know if there are signs of a perinatal mental health disorder? Are there some factors, like previous history of mental illness, or traumatic birth, that may influence how often you ask women about their emotional wellbeing? Do you think and ask about social circumstances that could influence maternal mental health, like previous history of mental disorders, poor partner relationship, or a difficult mother-infant interaction? Could you describe some barriers to discussing mental health and wellbeing with your patients? Do the women speak about perinatal mental disorder on their own? What do they ask? Do the women receive some psychoeducation about perinatal mental disorders?
				Acceptability and Ability to seek	**Questions for Services Users:** How did you seek help? (Optional: Who did you talk to or seek help from? Were there any barriers to seeking help? How did you feel when you talked to a healthcare professional about your feelings? Did you think they understood? Were you comfortable talking to healthcare professional about your feelings? Were there any concerns or anxieties?)
				Availability and Accommodation and Ability to Reach	**Questions for Services Users:** After talking to a health care professional or seeking help, what happened? (Optional: Which service/s were you referred to? What treatment did you receive? How did you feel and think about this referral? Did you have any concerns? How long did it take to be seen once you have been referred to a specialist?)

					Questions for Providers: Please tell us how you proceed when a woman is seeking help or when you recognize that a woman has some signs of a perinatal mental disorder. Is the process difficult in any way? Are there any differences between the procedures for women with pre-existing mental disorders and women with a first case of emerging perinatal mental disorder? Does the specific diagnosis (for example, depression, anxiety disorder, psychosis) make a difference when you work with women with perinatal mental health disorder? What is your experience of collaboration with different health care professionals? Can you describe support and information sharing between different disciplines of health care professionals? How should collaboration between different services be organized and improved to prevent disconnected care?
				Affordability Ability to Pay	Not addressed
				Appropriateness and Ability to Engage	**Questions for Services Users:** How did you experience the treatments or services? (Optional: Which person, what kind of support or treatment helped you most? What would you have liked to be different related to the experienced healthcare provision? Are there any appointments? Do you think the healthcare professionals were competent? Did you experience an excessive demand of the healthcare professionals?)
				Crosscutting questions	**Questions for Services Users:** What advice would you give to a woman beginning her pregnancy who is also experiencing mental illness? What advice would you give to a health care professional about caring for a woman who is also experiencing mental illness during pregnancy or after the baby is born? What gaps, if any, do you feel there are in the mental health support given to women before, during and after pregnancy? What strategies would be helpful to optimize maternal mental health care? If you look back, what would you do differently today? Is there anything else you would like to share? **Questions for Providers:** Please tell us your experiences in working with women suffering from perinatal mental disorder. What made working with these mothers more challenging than working with mentally healthy mothers? How did you handle that issue/situation? Could you give us an example where maternal mental health care proceeded well / proceeded poorly? In general, do you feel confident, competent, or uncertain when working with women with perinatal mental disorders? What kind of resource or support would help you better serve affected women and their families? Where do you detect gaps in health care provision for affected women in the perinatal phase? If you had the opportunity to change or improve something in caring for mothers with perinatal mental disorders during the perinatal period, what would it be? How do you suggest the change(s) be implemented? What do you think would most help mothers-to-be or mothers with mental health disorder during the perinatal period?

					What do you think about the education programs that cover maternal mental health care? Do you have any recommendations to improve basic and ongoing education?
2	Naheed et al. (2022)	Semi-structured in-depth interview form and focus group interview form	**Qualitative Study Protocol**	**Approachability and Ability to Perceive**	**Questions for service users:** Do you think that Noncommunicable disease (such as- hypertension, diabetes) are related to mental health problems (such as mental stress, depression, anxiety)? How? Do you have any mental stress/depression/anxiety? Why do you think you have mental stress/depression anxiety? Since when are you suffering from this problem? What are the reasons behind taking these treatments? Who made the decision to take these treatments (yourself or a family member)? Please elaborate on your experience with these treatments. If you have not taken any treatment for these mental health problems, what are the reasons for doing so? Where can you go to seek care for this problem? Do Upazilla health complexes offer any services for mental health problems? What treatments are offered? Do you think for patients with a physical problem such as diabetes, hypertension, cardiovascular disease, etc., mental health problem (such as mental stress/ depression/ anxiety) is an important issue? Why? Do you think your physical problem (diabetes or hypertension) requires mental health services? Why? How can you or others get benefit from this? What do you understand by mental health problem / when is an individual considered as having mental problem? (Probe such as mental stress, depression, anxiety) What do you think are the reasons for people having mental health problems (probe such as mental stress, depression, anxiety)? **Questions for caregivers:** Do you think that Noncommunicable disease (such as- hypertension, diabetes) are related to mental health problems (such as mental stress, depression, anxiety)? How? Does your patient have any mental stress/depression/anxiety? Why do you think he/she has mental stress/depression anxiety? Since when is he/she suffering from this problem? What are the reasons behind taking these treatments? Who made the decision to take these treatments? Please elaborate on your experience with these treatments. If your patient has not taken any treatment for these mental health problems, what are the reasons for doing so? Where you he/she go to seek care for this problem? Do Upazilla health complexes offer any services for mental health problems? What treatments are offered? Do you think for patients with a physical problem such as diabetes, hypertension, cardiovascular disease, etc., mental health problem (such as mental stress/ depression/ anxiety) is an important issue? Why? Do you think your patient's physical problem (diabetes or hypertension) requires mental health services? Why? How can you or others get benefit from this? What do you understand by mental health problem / when is an individual considered as having mental problem? (Probe such as mental stress, depression, anxiety) What do you think are the reasons for people having mental health problems (probe such as mental stress, depression, anxiety)? **Questions for providers:** Detailed about the referral system of the primary health care centre. For example, screening for NCD (Who did it? How?)

					Have you seen any patient visited at your service centre to seek care for mental health? What is their perception and belief regarding depression, stress and anxiety? In your opinion, what they normally do when they get depressed or upset? **Focus group questions for providers:** What is your role regarding NCD prevention and control at the community? How NCD patients are identified at the community? Do you maintain and referral system for NCD patients? How do you maintain the referral system? Please describe briefly. What types of NCD patients received after referral (if any)? Please tell about medicine supply, diagnosis test etc). What types of NCD patients are commonly seen at the community? What do you understand by mental health problems or mental disorders? What do you think about mental stress, depression and anxiety? What do you know about mental health? Why do you think mental disorders happen? (probe: depression, stress and anxiety) What are the common terms used for mental health problems in your community? How mental disorders are considered at the society? What types of problems a person with a mental disorder has usual face? Why? According to you, what type of patients suffer from mental health problem? Does NCD patient suffer from common mental disorder? Why?
				Acceptability and Ability to seek	**Questions for service users:** Do you think mental health services should start being offered in the Upazilla health complexes? Why? Please elaborate on how patients will get benefit from this? Will you take treatment if mental health services are offered at the Upazilla health complexes? Who do you think are the most appropriate people for administering mental health services in the hospital? Probe about doctor, psychiatrist, nurse, community health worker. How can mental health services be administered to hypertension or diabetes patients? (Probe about individually or separately.) Why do you think this method is appropriate? What is your preferable way to seek care for mental health service (Face to face, Over phone, Separately)? **Questions for caregivers:** Do you think mental health services should start being offered in the Upazilla health complexes? Why? Please elaborate on how patients will get benefit from this? Will your patient take treatment if mental health services are offered at the Upazilla health complexes? Who do you think are the most appropriate people for administering mental health services in the hospital? Probe about doctor, psychiatrist, nurse, community health worker. How can mental health services be administered to hypertension or diabetes patients? (Probe about individually or separately.) Why do you think this method is appropriate? What is your preferable way to seek care for mental health service for your patient? (Face to face, Over phone, Separately) **Questions for providers:** According to you, what type of patient suffer from mental health problem? Does NCD patient suffer from common mental disorder? Why? Please describe Do you think mental health service is important for patient with NCD? Why ? Do you think mental health service should be functional in the primary health care centre? What type of resources is necessary for this purpose? (Probe: manpower, place, auxiliary service provider?) **Focus group questions for providers:** Do you think mental health service is important for patient with NCD? Why?

					Do you think mental health service should be functional in the primary health care centre? What type of resources is necessary for this purpose? (manpower, place, auxiliary service provider?)
				Availability and Accommodation and Ability to Reach	**Questions for service users:** What treatments have you taken/are taking for this/these mental problems (such as-mental stress/depression/anxiety)? **Questions for caregivers:** What treatments have you taken/are taking for this/these mental problems (such as-mental stress/depression/anxiety)? Please elaborate. **Questions for providers:** In the primary health care centre, How NCD services are managed? To prevent NCD, what programs are in progress? Describe In the primary health care centre, what are the services for NCD? Who provides the service? Detailed about the referral system of the primary health care centre. For example, screening for NCD (Who did it? How?) Is there any system for screening of NCD? Please describe? What are the medicines available for NCD services? Is this enough? In your primary health care centre, what type of mental health services is available? If not available what are the reasons? Is there any screening system for mental health service? Describe it. How mental health service can be detected? What are the tools? How many times monthly? Are there any guidelines to detect mental health problems (such as depression/ anxiety)? If possible, can you share the guidelines? **Focus group questions for providers:** What types of services are available regarding NCD prevention and control in your area? Please describe briefly. Do you get any remuneration for performing NCD services at the community? Please describe your remuneration details. What types of training did you received regarding NCD control and prevention? Please describe about training details (Topic, duration, participants, organizer, and facilitator). In your primary health care centre, is there any service available for mental health problem? If not available, what are the reasons? Where do people in your area usually go for treatment of mental disorders (like, Depression, Anxiety and Stress)?
				Affordability and Ability to Pay	**Questions for service users:** Do you agree to pay for the mental health services? If yes how much? **Questions for caregivers:** Do you agree to pay for the mental health services? If yes how much? **Questions for providers:** Do you think patient will bear any cost of mental health service?
				Appropriateness and Ability to Engage	**Questions for service users:** What can be done for these mental health problems? Do you think, mental health problems should be treated? **Questions for caregiver:** What can be done for these mental health problems? Do you think, mental health problems should be treated?
				Crosscutting questions	**Questions for service users:** What do you think are the challenges to take mental health services (Individual stage, familial stage and societal stage)? **Questions for caregivers:** What do you think are the challenges to take mental health services (Individual stage, familial stage and societal stage)? **Questions for providers:** For NCD services, what are the challenges? How it can be solved?

					What will be the challenges to execute mental health service into the primary health care centre? According to you, what type of challenges a patient has to face if he/she wants to seek care for mental health service? (Individual stage, familial stage and societal stage) What are the possible ways to integrate mental health into the primary health care systems? What do you think will work? What will it take to deliver the model? What potential risks must be mitigated? What recommendations can be pulled out on actors, settings, equipment/supplies, other health system considerations for the policymakers? **Focus group questions for providers:** For NCD services, what are the challenges of the CWs? How it can be solved? What will be the challenges to execute mental health service into the primary health care centre? What are the possible ways to integrate mental health into the primary health care systems? What do you think will work? What will it take to deliver the model? What potential risks must be mitigated? What recommendations can be pulled out on actors, settings, equipment/supplies, other health system considerations for the policymakers?
3	Hollingdrake et al. (2023)	Focus group interview guide for women with lived experience of domestic and family violence	**Qualitative**	**Approachability and Ability to Perceive**	What services are out there for women and families experiencing violence? What health services do women access? How do women find out where to get help?
				Acceptability and Ability to seek	What health services do women access?
				Availability and Accommodation and Ability to Reach	What services are out there for women and families experiencing violence? Which services are connected to each other?
				Affordability and Ability to Pay	-
				Appropriateness and Ability to Engage	What are the ways that women connect with health services?
				Crosscutting questions	What makes it easier for women and families to access healthcare? What makes it harder for women and families to access healthcare? If you could design a pathway for women and families from healthcare services to DV services (and vice versa) what would it be?

4	Lowther-Payne et al. (2026)	Semi-structured interview guide for LGBTQ+ adults	**Qualitative**	**Perception of mental health needs and desire for care**	Can you tell me about how your mental health was during the COVID-19 pandemic. How did this differ to pre-pandemic? Did the pandemic and associated restrictions (e.g., lockdowns) specifically affect your experience of mental health, if so how? What help did you feel you needed at this time? What sort of help were you hoping for? What help did you access?
				Healthcare seeking	Can you tell me about your experience of seeking help for your mental health during the pandemic. What did you do? Where did you go first for help with your mental health (e.g., GP, A&E, LGBTQ+ organisation, direct to mental health services, online resources)? Why did you go here first? How did you contact them? Did the pandemic affect your choice in where you went to for help, if so how? If you have sought help before, how did your choice differ from pre-pandemic? Did your LGBTQ+ identity affect your choice in where you went to for help, if so how? Was there anything else that affected your choice in where you went to for help?
				Healthcare reaching	Can you tell me about what happened after seeking help for your mental health during the pandemic. What was it like when you tried to get help for your mental health? Were you referred to mental health services (e.g., IAPT, CMHTs, CRHTs EIS)? What contact did you receive from this service/s? What form did this contact take (e.g., face-to-face, telephone, video)? Did the pandemic impact on what happened after seeking help for your mental health, if so how? Did your LGBTQ+ identity impact what happened after seeking help for your mental health, if so how? During contact with services, were you asked about your sexual orientation and/or gender identity? If so, what was your experience of this? Was there anything else you feel impacted what happened after seeking help for your mental health?
				Healthcare utilisation	(if referred to/accepted by mental health services) Can you tell me about your experience of using mental health services during the pandemic. Did you have regular contact with the service/s? What form did this contact take (e.g., face-to-face, telephone, video)? Were you already in contact with this service or other mental health services before the pandemic? If so, how did your experience differ before and during the pandemic? Did the pandemic affect how you used this service/s, if so how? Did your LGBTQ+ identity affect how you used this service/s, if so how? Were you asked about your sexual orientation and/or gender identity? If so, what was your experience of this? Was there anything else you feel impacted how you used mental health services? (if not referred to/accepted by mental health services) Did you use any other sources of support during the pandemic (e.g., LGBTQ+ organisations, third sector organisations, online forums, friends, and family)? What were these sources of support like?
				Healthcare consequences	Can you tell me about your overall experience of accessing or trying to access mental health services during the pandemic. Were you satisfied with the contact you had with services? How did it help (or not help) your mental health? Were there any particularly positive or negative experiences? Are there any changes you would recommend to improve access to services from your experience of using mental health services during a pandemic? Are there any changes you would recommend to improve access specifically for LGBTQ+ people? If you had to access services again (either during a pandemic or not), would you do anything differently next time? If so, what?
				Crosscutting questions	Is there anything further we haven't talked about that you would to add?

5	Salameh et al. (2025)	Semi-structured interview guide	**Qualitative**	Approachability and Ability to Perceive	What's your thinking regarding PPD? How can you define PPD? What's your feeling after your infant's birth? If you are experiencing emotional problems, such as worry or sadness after the birth of your infant, what do you do to make yourself feel much better? How do you describe your need for mental health services? Do you know where to go to get support/treatment? What's your experience with your health care providers during pregnancy and postpartum? What type of assessment for your mental health status did your receive? What type of discussion/conversation did you have with your health care providers about mental health support and treatment services available for you? What's your understanding about available mental health treatment options for PPD? What's your understanding about available mental health services for PPD in Turkey?
				Acceptability and Ability to seek	If you received any treatment in Turkey, how do describe your personal experience?
				Availability and Accommodation and Ability to Reach	What's your understanding about available mental health treatment options for PPD? What's your understanding about available mental health services for PPD in Turkey?
				Affordability and Ability to Pay	-
				Appropriateness and Ability to Engage	If you received any treatment in Turkey, how do describe your personal experience?
				Crosscutting questions	What do you think are some of the important barriers for refugee mothers affecting their access to mental health services in Turkey? Approachability (health beliefs, trust, expectation) Acceptability (culture, gender, autonomy) Availability and accommodation (living environment, transportation, time, social support) Affordability (income, health insurance) Appropriateness (care giver support, engagement) Have you ever asked or tried to get mental health support but could not for some reasons? What were these reasons? Is there anything else you would like to tell me?
6	Schwarz et al. (2022)	Semi-structured interview guide	**Qualitative**	**Crosscutting questions**	After introducing the model of Levesque et al.: From your point of view, where do barriers exist in the context of health care for children with bronchial asthma/ working people with non-specific chronic low back pain (LBP) / older people with pre-existing mental illness (excluding dementia) living independently? Where do you see barriers specifically in the area you work in? Can you think of barriers that are particularly common in a specific area of care (e.g. outpatient practices)? Can you think of barriers particularly relevant for individuals with certain symptoms, medical conditions, diagnoses? Can you imagine that barriers exist also outside your area of work/perception/activity? What could these be? From your point of view, what are possible reasons/ causes for barriers you have mentioned?

					Are there specific subgroups of children with bronchial asthma/ working people with non-specific chronic low back pain (LBP) / older people with pre-existing mental illness (excluding dementia) living independently that are particularly affected by these barriers? If so, why? Why do you think barriers occur particularly often with this group? Are the reasons related rather to the design of the system, or do barriers occur because of certain characteristics of these patients? What would need to happen to reduce, eliminate, or make it easier to overcome the barriers you mentioned? Who could contribute to this? Where do you see opportunities specifically in the area in which you work? Can you think of measures, recommendations related to selected symptoms, clinical pictures, diagnoses?
7	Shah et al. (2025)	Semi-structured interview guide	**Qualitative**	**Approachability**	**Questions for Clinicians:** How do you typically identify when a Medly patient's mental health has been negatively affected? For example, do you conduct any screening, formally or informally? Where, when, by who, and what is this information used for? Can you recall an example of when a patient discussed their mental health with you? How do these conversations typically go? **Questions for Researchers:** What are some common or best practices to identify when a patient living with heart failure is experiencing negative impacts on their mental health? Ideally, how should these conversations typically go?
				Ability to Perceive	**Questions for Patients:** How has your journey with heart failure impacted your mental health? For example, are there times that you have felt stressed, or where it has impacted your emotions, behaviour, or relationships with others? During these times, what helped you know that your mental health was affected?
				Acceptability	**Questions for Clinicians:** What approaches, formal or informal, do people living with heart failure use to manage their mental health, based on your clinical practice? What role do you play in this, if any? If you suspected that a Medly patient's mental health has been negatively affected, what are the current approaches to managing this? Have you referred patients to mental health services? If so, which ones? If not, what are some of the contributing factors to this? Can you recall any particular examples where you referred a Medly patient to a mental health service? How do these conversations typically unfold? What do you find helpful or challenging about these conversations or processes? **Questions for Researchers:** What approaches, formal or informal, do people living with heart failure use to manage their mental health, based on your research? From your perspective, what role do clinicians play in this, if any? If a clinician suspected that a Medly patient's mental health has been negatively affected, what are the current approaches to managing this?
				Ability to Seek	**Questions for Patients:** How do you generally manage your mental health, if at all? Who have you talked to about your mental health, if anyone (professional or informal)? Have you ever talked with a healthcare provider about your mental health? Are there any mental health services or support you are aware of? How did you come to learn about them? What role has your heart failure clinicians played in helping you find mental health care services? If they have not played a role, what role would you have wanted them to play in helping you find mental health services?
				Availability and Accommodation	**Questions for Clinicians:** Can you describe the booking process for Medly patients to access mental health services?

					From your perspective/understanding how accessible is it for patients to make appointments (if applicable), and how long does it typically take for them to connect with a mental health professional once an appointment is booked? Based on your clinical practice, are there specific aspects of the mental health services you refer to that help or hinder access to these services. For example, what are your thoughts on their location, format, and hours of operation, etc.? Can you recall any examples of Medly patients accessing mental health services and what their experience was like? **Questions for Researchers:** Can you describe the booking process for Medly patients to access mental health services? From your perspective/understanding how accessible is it for patients to make appointments (if applicable), and how long does it typically take for them to connect with a mental health professional once an appointment is booked? Based on your research, are there specific aspects of the mental health servicesvyou refer to that help or hinder access to these services. For example, what arevyour thoughts on their location, format, and hours of operation, etc.?
				Ability to Reach	**Questions for Patients:** If you have accessed mental health services, what has been your experience trying to access mental health care services? What was your experience like… Traveling to the service? Location/format of these services? Booking an appointment (if applicable)? Once you booked an appointment, how long did it take for you to connect with a mental health professional (if applicable)? Hours of operation/support of the service?
				Affordability	**Questions for Clinicians:** How affordable do you believe mental health services are to Medly patients? **Questions for Researchers:** How affordable do you believe mental health services are to Medly patients?
				Ability to Pay	**Questions for Patients:** Were there any financial costs involved in any of the mental health services you accessed? If so, how did this affect your journey of seeking mental health care?
				Appropriatenes s	**Questions for Clinicians:** From your perspective, what constitutes quality mental health services for people living with heart failure? To what degree do you feel these elements are present or not present in the mental health care available to patients in the Medly program? Can you describe an example of when a patient received high or low quality mental health care? Do you feel that patients in the Medly program are having their mental health needs met? If not, what improvements do you see are needed? **Questions for Researchers:** From your perspective, what constitutes quality mental health services for people living with heart failure? To what degree do you feel these elements are present or not present in the mental health care available to patients in the Medly program?
				Ability to Engage	**Questions for Patients:** What has been the quality of care you received from mental health professionals? Do you feel your mental health needs were met through this care? If not, what do you feel was missing to improve your experience?
				Crosscutting questions	**Questions for Clinicians:** Is there anything else you would like to share about your observations or experiences supporting the mental health impacts people living with heart failure face, and their journey accessing mental health services? **Questions for Researchers:**

					Is there anything else you would like to share about your observations or experiences supporting the mental health impacts people living with heart failure face, and their journey accessing mental health services? **Questions for Patients:** Is there anything else you would like to share about your journey with your mental health when living with heart failure that we haven't touched upon today?
8	Williams-Ridgway et al. (2026)	Semi-structured interview guide	**Qualitative**	**Crosscutting questions**	**Help-Seeking:** In your opinion are there any differences in help-seeking patterns and behaviours between ethnic groups? If so, could you elaborate on these differences? Why do you think these differences might occur? What do you perceive to be barriers for help-seeking for minority ethnic individuals? (And why?) What do you perceive to be facilitators for help-seeking for minority ethnic individuals (And why?) **Accessing Treatment:** Do you think minority ethnic groups face any difficulties accessing eating disorder services? If so, what do you think these difficulties are? In your opinion are there any differences in the type of referrals or patterns of referrals between ethnic groups? If so, could you elaborate on these differences? Why do you think these differences might occur? Given you work in a diverse and multicultural area do you think the ethnicity of the service users you see is reflective of this? Can you tell me a bit more about your experiences at the point of initial assessment with individuals and families from minority ethnic groups? **Treatment Experience:** Can you tell me a bit more about your experiences of delivering eating disorder treatment to individuals and families from minority ethnic groups? What type of treatment do you deliver? Can you tell me more about your experiences of engaging individuals and families from minority ethnic groups in [individual/group/family based] interventions? Have you experienced any challenges in care planning and delivering treatment to individuals from minority ethnic backgrounds? If so, what were these challenges? How, if so, did you overcome these challenges? How confident do you feel delivering treatment for individuals from minority ethnic backgrounds? Have you received specific training? What is your understanding and experiences of culturally adapted/sensitive treatment? **Future Provision:** If you could change anything about the treatment offered in your service for minority ethnic groups, what would it be? (And why?) In your opinion what do you think service providers and healthcare professionals could do to make services more accessible and improve treatment for people from different ethnic backgrounds?
10	Kourgiantakis et al. (2023)	Thematic categories of questions reported within the manuscript	**Qualitative**	**Thematic categories of questions**	Experiences of youth, parents/caregivers, and service providers Mental health and addiction services used currently or in the past Concerns that prompted requests for navigation support Barriers and facilitators to accessing mental health and addiction services The role of families and the impact of family involvement Experiences of discrimination, racism, and stigma.

11	Woodgate et al. (2023)	Thematic categories of questions reported within the manuscript	**Qualitative**	**Thematic categories of questions**	What it is like for the child to live with anxiety How living with anxiety shapes daily life What hinders and what helps the child to live satisfying, hopeful, and productive lives
12	Clifton & Hancock (2025)	Mental Health Literacy Scale; Medical Mistrust Index; author-developed Likert-scale items	**Quantitative**	**Ability to Perceive**	**Perceive as illness:** MHLS (1 = strong disagree to 5 = strongly agree) People with a mental illness could snap out of it if they wanted A mental illness is a sign of personal weakness A mental illness is not a real medical illness It is best to avoid people with a mental illness so that you don't develop this problem Seeing a mental health professional means you are not strong enough to manage your own difficulties **Associate:** MHLS (1 = definitely unwilling to 5 = definitely willing) Move next door to someone with a mental illness Spend an evening socializing with someone with a mental illness Make friends with someone with a mental illness Have someone with a mental illness start working closely with you on a job Have someone with a mental illness marry into your family Vote for a politician if you knew they had suffered a mental illness Employ someone if you knew they had a mental illness
				Ability to Seek	**Not seek help:** MHLS (1 = definitely unwilling to 5 = definitely willing) If I had a mental illness, I would not seek help from a mental health professional. **Keep from work:** 4 author-developed items and 1 MHLS item (1 = strong disagree to 5 = strongly agree) If I had a mental illness I would not tell anyone (MHLS) Seeing a mental health professional would have negative ramifications for my career (author-developed) People who see a mental health professional should keep their coworkers from finding out (author-developed) People who see a mental health professional should keep their bosses/supervisors from finding out (author-developed) People who see a mental health professional may be mistreated at work (e.g., shunned, avoided) (author-developed)
				Ability to Reach	**Knowledge of treatment:** MHLS (1 = strong disagree to 5 = strongly agree) I am confident that I know where to seek information about mental illness I am confident using the computer or telephone to seek information about mental illness I am confident attending face to face appointments to seek information about mental illness (e.g., seeing a General Practitioner) I am confident I have access to resources (e.g., General Practitioner, internet, friends) that I can use to seek information about mental illness **Agency trust:** Author-developed items (1 = strongly disagree to 5 = strongly agree)

					My immediate supervisor treats me with respect I trust my immediate supervisor's decisions My immediate supervisor clearly explains the reasons for his/her decisions My immediate supervisor considers his/her subordinates' viewpoints
				Ability to Pay	1 author-developed item (1 = strongly disagree to 5 = strongly agree) Seeing a mental health professional is affordable
				Ability to Engage	Medical Mistrust Index (1 = strongly disagree to 5 = strongly agree) You'd better be cautious when dealing with health care organizations Patients have sometimes been deceived or misled by health care organizations When health care organizations make mistakes they usually cover it up Health care organizations have sometimes done harmful experiments on patients without their knowledge Health care organizations don't always keep your information totally private Sometimes I wonder if health care organizations really know what they are doing Mistakes are common in health care organizations
13	Leclair et al. (2022)	Variables from administrative records used to operationalise Levesque's framework dimensions		**Approachability**	-
				Ability to Perceive	-
				Acceptability	-
				Ability to Seek	**Dependent variables:** Seeking mental healthcare: at least one contact with any type of services for mental health reasons (dichotomous)
				Availability and Accommodation	**Independent variables:** Number of physicians per 1,000 population in regional health district Community resources within 15-minute drive radius

					Hospital centres offering outreach services within 30-minute drive radius Hospital centres offering referral services within 60-minute drive radius
				Ability to Reach	**Dependent variables:** Reaching psychiatric care: at least one contact with a psychiatrist on an outpatient or inpatient basis (dichotomous) **Independent variables:** Residency outside of major urban centres
				Ability to Pay	**Independent variables:** Material disadvantage of residency area (quintiles) Social disadvantage of residency area (quintiles)
				Ability to Engage	**Dependent variables:** Volume of psychiatric care: sum of psychiatric visits (consultations and follow-up) as inpatient or outpatient (intensity) Continuity of psychiatric care: Bice-Boxerman continuity of care index (0–1), reflecting extent to which regular psychiatric care is provided by a single psychiatrist outside of hospitalization and emergency room visits
				Exploratory variables	Volume of emergency mental health services: sum of emergency room visits for mental health reasons
				Crosscutting variables	Age at start of observation period Gender Living with a partner, family or friends (proxy for social support) Having a criminal record Significant connection to a primary care physician (Usual Provider Care index >75% or complete medical examination by same provider at least once every 2 years)
				Mental health needs	History of prior NCRMD verdict Primary diagnosis at verdict (psychotic disorder, mood disorder, other)

					Concurrent personality disorder Concurrent substance use disorder
14	Martínez-Jaime et al. (2024)	Levesque's Framework dimensions operationalised age-based measurement of five sequential pathway stages	**Quantitative**	**Ability to Perceive**	**Dependent variables:** Age of first perception of the problem **Independent variables:** PC education level (primary school / middle school / high school or college)
				Ability to Seek	**Dependent variables:** Age of search for a mental health professional
				Ability to Reach	**Dependent variables:** Age of first contact with a mental health professional Age of arrival at the host hospital
				Ability to Pay	**Independent variables:** Health insurance status (partial / total / none) Primary caregiver occupation (formal employment vs. housewife/informal employment)
				Ability to Engage	**Dependent variables:** Age of diagnosis
				Crosscutting independent variables	Gender (girl vs. boy) Number of siblings (has siblings vs. no siblings) Primary caregiver age (>40 vs. ≤40)

14. Annex 3. Heat Map and Summary of Workshop Results

Components	Supply Side					Demand Side					Level		
	Approachability	Acceptability	Availability	Affordability	Appropriateness	Ability to perceive	Ability to seek	Ability to reach	Ability to pay	Ability to engage	Macro-level	Meso-level	Micro-level
Community-based outreach	X												
Comprehensibility of information about services	X												
Confidence-building and transparency mechanisms	X												
Integrated mental health entry point	X												
Mental health awareness and promotion programs	X												
Mental health policies	X												
Prevention and screening programs	X												

Components	Supply Side					Demand Side					Level		
	Approachability	Acceptability	Availability	Affordability	Appropriateness	Ability to perceive	Ability to seek	Ability to reach	Ability to pay	Ability to engage	Macro-level	Meso-level	Micro-level
Research on Mental Health	X												
Routine collection and publication of PREMs and PROMs	X				X								
Transparent and accessible information channels	X												
Visibility of services	X												
Adaptability of services across subgroups		X											
Cultural appropriateness of services		X											
Institutional history and systemic discrimination		X					X						
Patient involvement and shared decision-making		X			X								
Provider characteristics and match		X											
Representation and inclusion of different subgroups		X											
Respectfulness and interpersonal quality		X			X								

Components	Supply Side					Demand Side					Level		
	Approachability	Acceptability	Availability	Affordability	Appropriateness	Ability to perceive	Ability to seek	Ability to reach	Ability to pay	Ability to engage	Macro-level	Meso-level	Micro-level
Stigma-sensitivity and safety		X											
Adaptation to diverse needs			X										
Alignment with everyday realities			X										
Facility accessibility			X										
Flexible modes of contact and appointment mechanisms			X										
Geographic distribution			X										
Physical presence of services			X										
Remote and virtual service delivery			X										
Staff availability and capacity			X										
Suitable opening hours			X										
Timeliness			X		X								

Components	Supply Side					Demand Side					Level		
	Approachability	Acceptability	Availability	Affordability	Appropriateness	Ability to perceive	Ability to seek	Ability to reach	Ability to pay	Ability to engage	Macro-level	Meso-level	Micro-level
Breadth and depth of insurance coverage				X									
Direct cost of care				X									
Equity in cost burden				X									
Financial protection mechanisms for vulnerable groups				X									
Indirect and opportunity costs of care				X									
Public financing and investment in health services				X									
Risk of catastrophic or impoverishing expenditure				X									
Acceptability of care					X								
Adequacy of clinical effort					X								
Coordination and continuity of care					X								
Co-production of policies and services					X								

Components	Supply Side					Demand Side					Level		
	Approachability	Acceptability	Availability	Affordability	Appropriateness	Ability to perceive	Ability to seek	Ability to reach	Ability to pay	Ability to engage	Macro-level	Meso-level	Micro-level
Effectiveness and positive outcomes					X								
Integration and coordination between healthcare services					X								
Integration between disciplines					X								
Responsive and tailored care					X								
Technical quality of care					X								
Awareness of available health services						X							
Belief in the validity of the condition						X							
Cultural and social framing of illness						X							
Health literacy level						X				X			
Perceived responsiveness to care and expectation of positive outcomes						X							

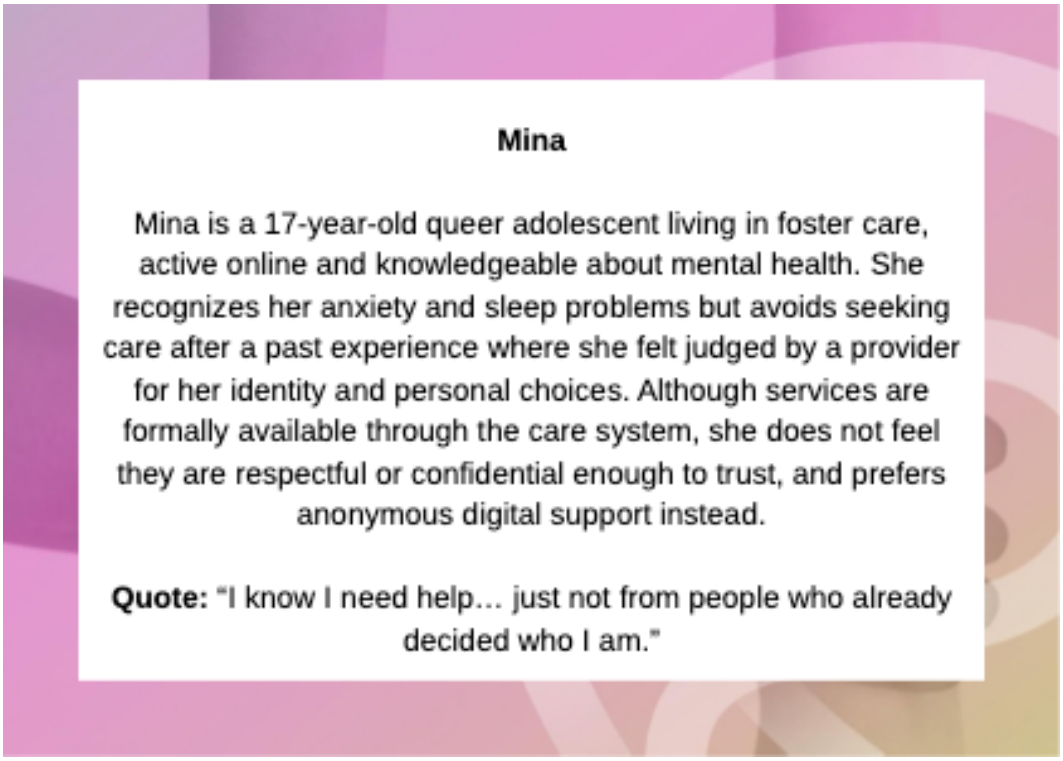
Components	Supply Side					Demand Side					Level		
	Approachability	Acceptability	Availability	Affordability	Appropriateness	Ability to perceive	Ability to seek	Ability to reach	Ability to pay	Ability to engage	Macro-level	Meso-level	Micro-level
Perceived trustworthiness of services						X							
Symptom awareness and interpretation						X							
Anticipated stigma among marginalised/vulnerable groups							X						
Community-level stigma of seeking care							X						
Cultural and social norms and judged appropriateness of seeking care							X						
Judged acceptability of services							X						
Lack of trust in institution							X						
Legal, political, and power structures							X						
Motivation and emotional readiness							X			X			
Personal autonomy, agency and social support							X						
Digital access and technological infrastructure								X					

Components	Supply Side					Demand Side					Level		
	Approachability	Acceptability	Availability	Affordability	Appropriateness	Ability to perceive	Ability to seek	Ability to reach	Ability to pay	Ability to engage	Macro-level	Meso-level	Micro-level
Geographic proximity of residence to services								X					
Individual mobility								X					
Occupational and time flexibility								X					
Physical ability								X					
Public transportation systems								X					
Safety, accessibility, and inclusiveness of the living environment of individuals								X					
Social capital and social support networks								X	X				
Access to health insurance or public coverage and risk of catastrophic expenditure									X				
Income, earnings stability and economic vulnerability									X				

Components	Supply Side					Demand Side					Level		
	Approachability	Acceptability	Availability	Affordability	Appropriateness	Ability to perceive	Ability to seek	Ability to reach	Ability to pay	Ability to engage	Macro-level	Meso-level	Micro-level
Communication skills										X			
Empowerment, self-efficacy and self-management										X			
Support to caregivers										X			

* X" indicates the dimension assigned to each concept in the preliminary framework. Cell shading reflects workshop participants' mapping decisions across the five inter-disciplinary groups: the darker the shade, the greater the number of groups that mapped the concept to that dimensions

15. Annex 4. Personas Used in Hackathon



Anna

Anna (35) is a widowed single mother of two, financially strained but highly resourceful, managing aid systems and daily survival after the earthquake. She understands her distress but prioritizes her children's needs, struggling to find time, childcare, or flexible services. Although free services exist; long waits, rigid appointment systems and impersonal care make them hard to use.

Quote: "If I stop, everything falls apart—there's no space for me to fall apart."

Fatma

Fatma (76) is an older woman living alone in a village with limited mobility. She has been feeling low, tired and withdrawn but assumes this is simply normal part of aging. She doesn't know anyone getting mental health support and is not aware of available mental health services. Although some services exist in nearby areas, information does not effectively reach her.

Quote: "I am good, I feel great! Let's talk positively, so that we turn out to be positive."

Robi

Robi (52) is a Roma man experiencing homelessness, with strong street networks but limited literacy and deep mistrust of institutions due to repeated exclusion. He rarely seeks care unless in crisis, and although outreach services exist, they often feel inconsistent and disrespectful. His past experiences make him doubt that services are for people like him.

Quote: "They come and go. Why should I believe this time is different?"

Alex

Alex is a 40-year-old man with a physical disability who uses a wheelchair and lives in the city. He has a job with minimal insurance coverage and is having some financial problems. He recognizes his increasing stress and low mood due to economic problems. However, the costs of transportation, co-payments, and taking time off work make it difficult to regularly attend care, especially for services that require frequent visits.

Quote: "Getting help shouldn't cost this much—by the time I can get there, I'm already exhausted."

Ahmad

Ahmad is a 29-year-old refugee with limited French, working irregular hours as a seasonal worker. He feels anxious and irritable for sometime and his recent sleep problems make these worse. He has some access to services through informal networks. Although he got few appointments, interpreter support wasn't available and care feelt rushed, fragmented, and hard to follow. He left unsure of what was said or what to do next.

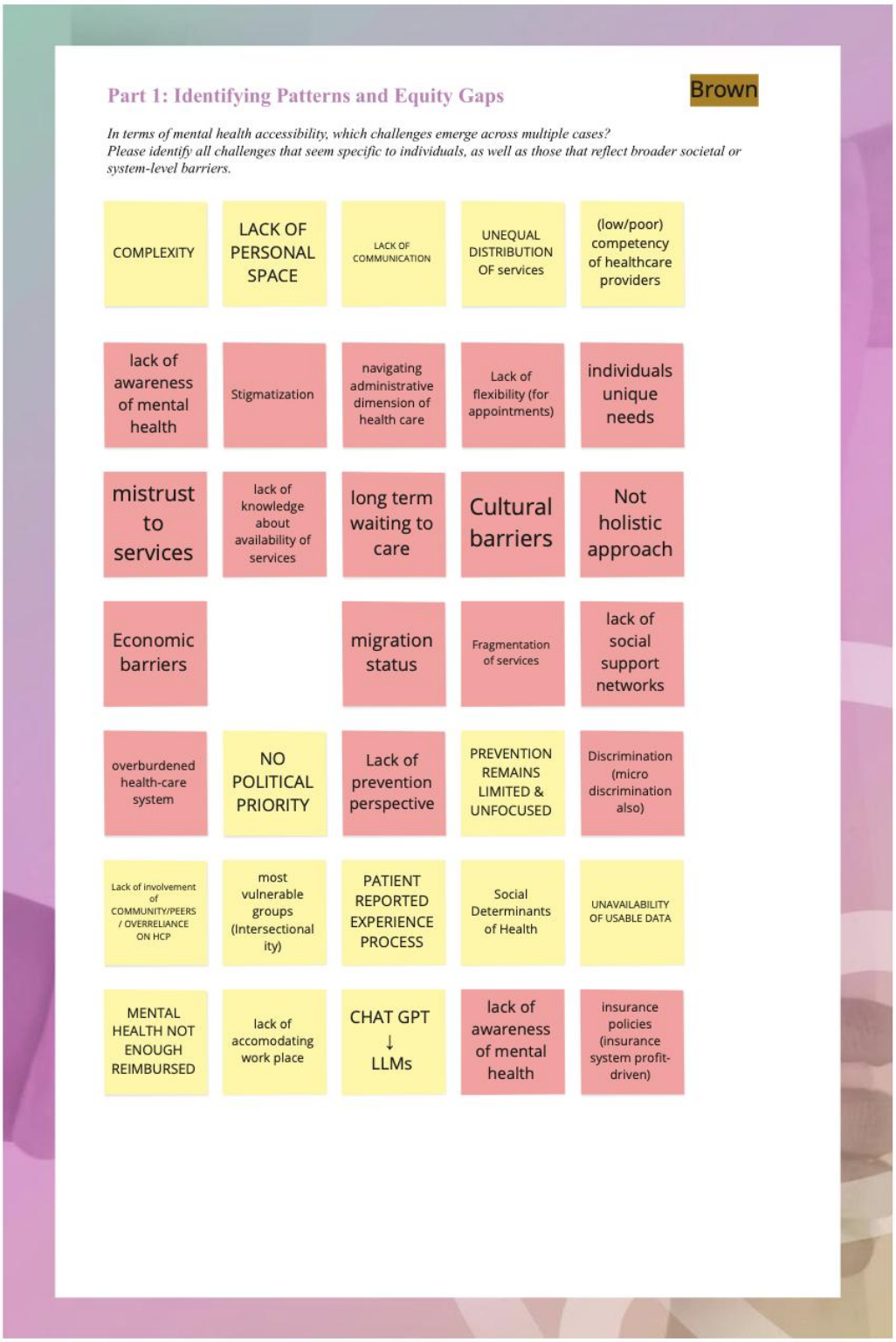
Quote: "I go, I sit, I nod… but I don't really understand what is happening."

Celine

Celine is a 42-year-old professional woman with a long-standing bipolar diagnosis, financially stable and highly familiar with mental health services. She actively seeks care and follows treatment, but finds that services often feel fragmented, with poor coordination between providers and limited personalization beyond medication management. Although she continues to attend appointments, she feels her broader needs are not fully understood or addressed.

Quote: "I've been in the system for years… but it still feels like no one sees the whole picture."

16. Annex 5. Challenge Mapping Boards



Part 1: Identifying Patterns and Equity Gaps

Orange

In terms of mental health accessibility, which challenges emerge across multiple cases?
Please identify all challenges that seem specific to individuals, as well as those that reflect broader societal or system-level barriers.

Green

Part 1: Identifying Patterns and Equity Gaps

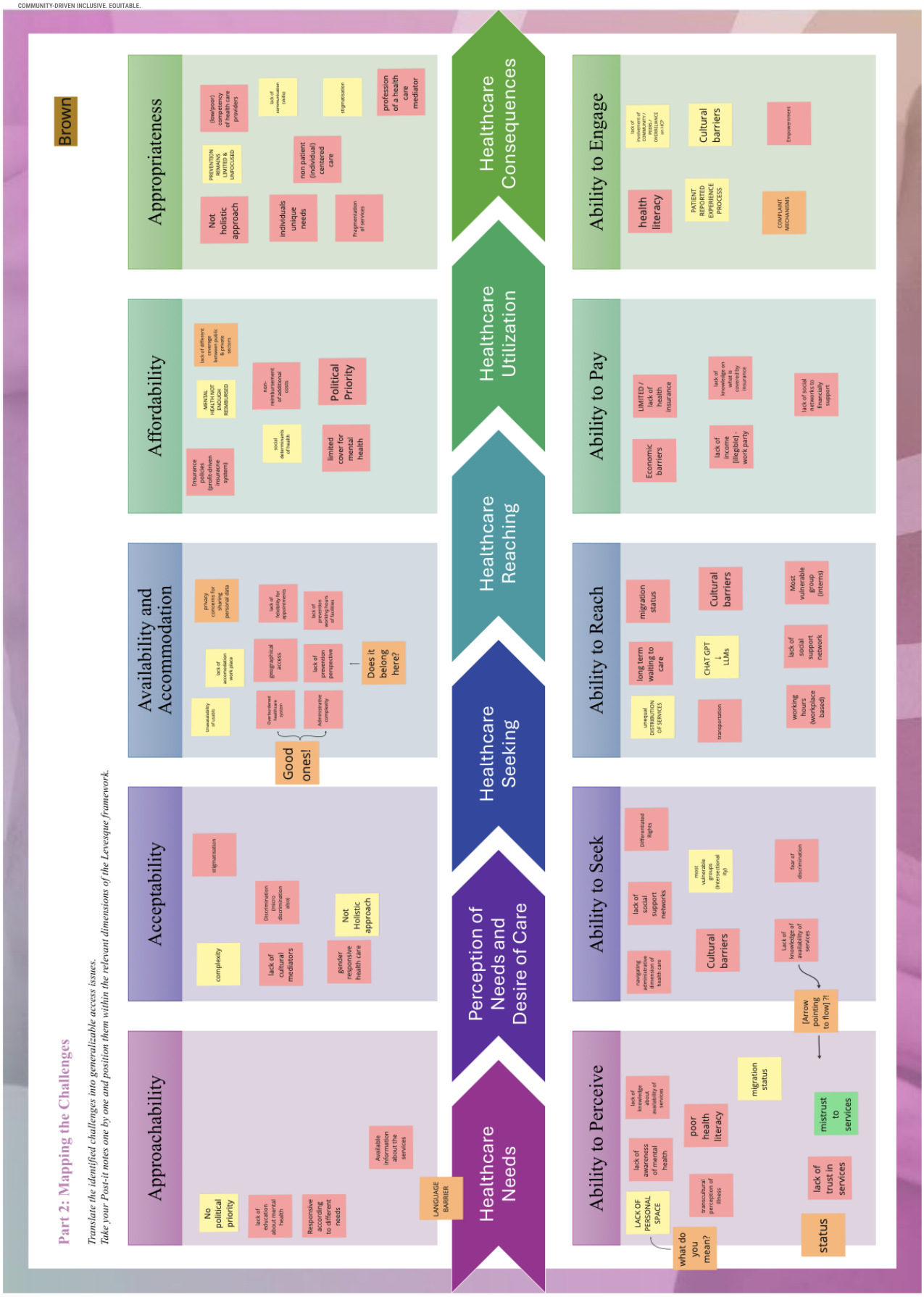
In terms of mental health accessibility, which challenges emerge across multiple cases?
Please identify all challenges that seem specific to individuals, as well as those that reflect broader societal or system-level barriers.

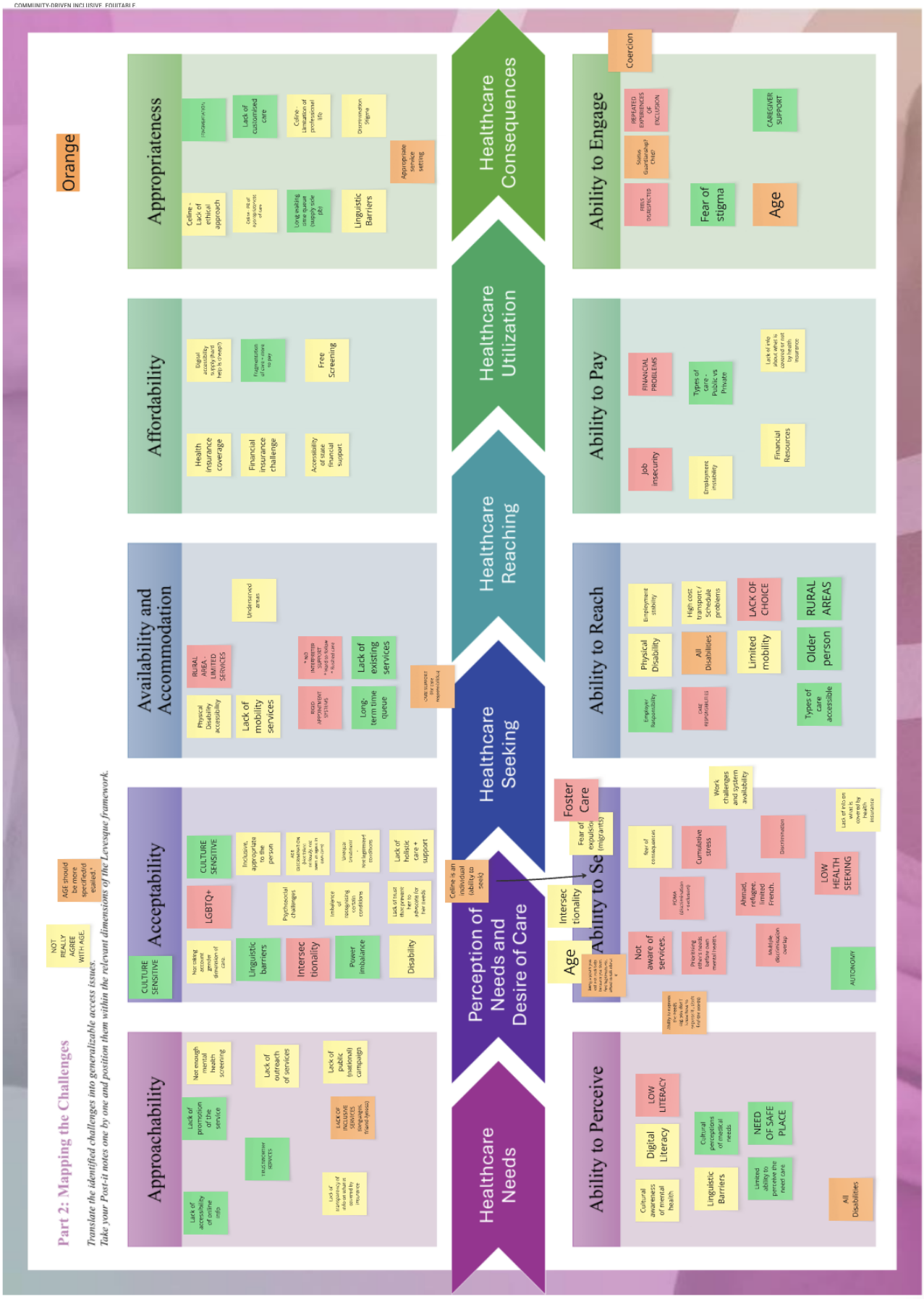
Part 1: Identifying Patterns and Equity Gaps

Red

In terms of mental health accessibility, which challenges emerge across multiple cases?
Please identify all challenges that seem specific to individuals, as well as those that reflect broader societal or system-level barriers.

FRAGMENTED SERVICES - FATIGUE	Lack of Trust - Confidentiality	LACK OF SKILLS OF CARE PROVIDERS ON APPROACHING/HANDLING DIVERSITY	Financial Barriers	
LACK OF SKILLS OF CARE PROVIDERS ON APPROACHING/HANDLING DIVERSITY	LACK OF RESPONSIBILITY OF MAKING A CONNECTION WITH PATIENTS (SEEN AS A NUMBER)	MAINSTREAM SERVICES ARE NOT FOR EVERYBODY	INFORMATION POVERTY	
LANGUAGE BARRIERS	LACK OF LOW HEALTH LITERACY	SOCIAL SUPPORT NETWORK	PERCEPTION OF NOTHING IS WRONG (STIGMA)	
REPETITIVENESS OF NEGATIVE ENCOUNTERS	AVAILABILITY B/ACCESSIBILITY of transportation to/from services	LACK OF RESPECT	LONG WAIT TIMES	
LACK OF MOBILE SERVICES	COMPLEXITY OF TREATMENT (Cultural barriers?)	NO PERSONALISED SERVICES	CK OF AFFORDABLE TIMELY AND INTERCONNECTED SERVICES	
LACK OF PREVENTATIVE CARE (SCREENINGS)	LACK OF ONE-SIDED DECISION-MAKING	NO CLEAR ROAD MAP NO CLEAR EXPLANATION OR EXPECTATIONS	LACK OF ACCESSIBILITY FOR ALL	
LACK OF TRUST / THERE IS NO UNDERSTANDING FROM PROVIDERS	ADAPTING TREATMENT / PERSONALISED FOLLOW-UP	CONNECTION PHYSICIAN & PHARMACIST	INSURANCE CONCERNS	LEGAL STATUS - FEAR TO ACCESS SERVICES
FEELING UNWELCOME WHEN APPROACHING A PROVIDER	STIGMA AND PREJUDICE	LACK OF A HOLISTIC APPROACH	POVERTY AND SOCIAL EXCLUSION	UNDERFUNDING OF SERVICES
Gender Norms	EMPLOYMENT vs. HEALTHCARE	LACK OF EDUCATION	LACK OF SPECIALISED PROFESSIONALS	HEALTHCARE WORKERS BURNOUT


Brown
Part 2: Mapping the Challenges
Translate the identified challenges into generalizable access issues.
Take your Post-it notes one by one and position them within the relevant dimensions of the Levesque framework.
Healthcare Needs
Perception of Needs and Desire of Care
Healthcare Seeking
Healthcare Reaching
Healthcare Utilization
Healthcare Consequences
Approachability
Acceptability
Availability and Accommodation
Affordability
Appropriateness
Ability to Perceive
Ability to Seek
Ability to Reach
Ability to Pay
Ability to Engage
Good ones!
Does it belong here?
what do you mean?
[Arrow pointing to flow] ?!
Status


Orange
Part 2: Mapping the Challenges
Translate the identified challenges into generalizable access issues.
Take your Post-it notes one by one and position them within the relevant dimensions of the Levesque framework.
NOT REALLY AGREE WITH AGE.
AGE should be more specified/ detailed.
Healthcare Needs
Perception of Needs and Desire of Care
Healthcare Seeking
Healthcare Reaching
Healthcare Utilization
Healthcare Consequences
Approachability
Acceptability
Availability and Accommodation
Affordability
Appropriateness
Ability to Perceive
Ability to Se
Ability to Reach
Ability to Pay
Ability to Engage
Age
Intersectionality
Foster Care
Fear of expulsion (migrants)
Celine is an individual (ability to seek)
Coercion
Fear of stigma
Age
CAREGIVER SUPPORT
Linguistic Barriers
Appropriate service setting
Lack of customized care
Celine - Limitation of professional life
Discrimination Stigma
Celine - Lack of ethical approach
Long waiting time queue (happy side pb)
Digital accessibility (apply, fluent help is enough)
Fragmentation of care = more to pay
Free Screening
Health insurance coverage
Financial insurance challenge
Accessibility of state financial support
Undiscovered issues
RURAL AREA - LIMITED SERVICES
Physical Disability Accessibility
Lack of mobility services
Lack of existing services
Long-term time queue
Job insecurity
FINANCIAL PROBLEMS
Types of care - Public vs Private
Employment instability
Financial Resources
Employer Responsability
Physical Disability
All Disabilities
Limited mobility
Older person
Types of care accessible
Employment stability
High cost transport / Schedule problems
LACK OF CHOICE
RURAL AREAS
Disability
Power imbalance
Intersectionality
Linguistic barriers
LGBTQ+
CULTURE SENSITIVE
Lack of holistic care + support
Lack of public (national) campaign
Lack of outreach of services
Lack of promotion of the service
Not enough mental health screening
Lack of accessibility of online info
Cultural awareness of mental health
Digital Literacy
LOW LITERACY
Linguistic Barriers
Cultural perceptions of medical needs
NEED OF SAFE PLACE
All Disabilities
Not aware of services.
Cumulative stress
Fear of consequences
Work challenges and system availability
Discrimination
LOW HEALTH SEEKING
AUTONOMY

Part 2: Mapping the Challenges

Translate the identified challenges into generalizable access issues.
Take your Post-it notes one by one and position them within the relevant dimensions of the Levesque framework.

Green
Part 2: Mapping the Challenges
Translate the identified challenges into generalizable access issues.
Take your Post-it notes one by one and position them within the relevant dimensions of the Levesque framework.
services quality
Approachability
Acceptability
Availability and Accommodation
Affordability
Appropriateness
Healthcare Needs
Perception of Needs and Desire of Care
Healthcare Seeking
Healthcare Reaching
Healthcare Utilization
Healthcare Consequences
Ability to Perceive
Ability to Seek
Ability to Reach
Ability to Pay
Ability to Engage
digital accessibility
lack of appropriate communication services for all needs
importance / objectives / awareness of mental health
transparent information (digital and personal)
services outreach (info approach community campaigns)
PERCEPTION OF MENTAL HEALTH
increase health education (improvement w/ other sectors
digital AI improvement inclusive & accessible & efficient
LANGUAGE interpreter translator etc.
loss of rights and/or privileges
Lack of cultural mediators
Gender intersectional sensitive care
stigma external (service provider)
PRIVACY & confidentiality (honor, shame) ESP. security cyber security
accessibility in building environment
services outreach (mobility needs)
Lack of flexibility of services (location, times)
All urgent appointments
PROPS CULTURAL SOCIAL-ECON VALUES TRAINED
lack of budget
Political Motivation -- Drivers of all not considered
health insurance affordable free
lack of budget
financial and support services
FLEXIBILITY of appointments (transport, childcare)
no payment plans and no sharing of costs
fragmented care
Integrated service care taking into account
lack of personalized services
privacy confidentiality
Cultural appropriateness
COERCION - FORCED TREATMENT and CARE
Services quality - Professional behavior
(digital) information of accessibility
belongs to a minority group
relying on illegitimate forms of mental health support
self-diagnosing online
lack of awareness of formal services
social isolation
AI speed
Not clear
language barrier
Belongs to a minority group
afraid of losing custody parental rights
fear of discrimination
stigma internal in family
You're privileged more cultural barriers
rural far areas
urban barriers mobility transport
life constraints (childcare/hou sework/work)
limited behavior in rural areas
someone to accompany a long-term service
mama solo life without caregiver
no health insurance
financial constraints
low income and work instability
no transparency of financial cost
increased cost for services + disability specific costs
ability from work to secure SICK LEAVE
Be more specific on equity, affordability / Economic barriers
context suitability / adequate referrals
lack of trust (including historical experiences)
Consent
actual harm of negative care
Taboo
LANGUAGE BARRIERS
COMPLAINT MECHANISMS

17. Annex 6. Prioritised Questions for Supply-Side Dimensions

Dimension	Questions
Approachability	**Access to information channels:** 1. Can you easily find information about your specific needs? 2. Can you find the information you need online? 3. Is the information online up to date? **Information about services:** 1. Are you aware of your rights, insurance coverage, and available mental health resources and services? 2. Do you think there are health services available to you? 3. Can I have an overview of the availability of the services I need and when they are available? 4. Are you aware of all the services available? If yes, please tell us which ones. **Outreach, screening, preventive services:** 1. Have you been informed through specific communication campaigns that are directly focused on your needs? 2. Have you seen mental health services being promoted? 3. Have you ever been reached out to by mental health services for a screening? 4. Have you ever been contacted by a healthcare provider about preventive measures for mental health?
	Mapped under approachability but potentially relevant to other dimensions: <u>Acceptability:</u> **Cultural and language inclusiveness** 1. Have you been offered language interpreters or cultural mediators? **Opportunity to choose provider** 1. Were you able to express a preference for a provider with a certain gender, religion, or age? <u>Availability and accommodation:</u> **Availability of translation services** 1. Is there an official translation service available? 2. Is there a translator available to assist you during your appointment? **Barriers to digital health service access** 1. Have you encountered accessibility barriers in accessing digital health services and tools? <u>Appropriateness:</u> **Need responsiveness** 1. Do you have a care plan? Were you able to contribute to it? Did it meet your expectations?
Acceptability	**Stigma and discrimination:** 1. How can I be sure that I will not be stigmatised? 2. Do you feel that your [characteristic] status has influenced how you are treated within the healthcare system?

3. Do you think you could face discrimination in healthcare?
4. Do you think you have ever been treated differently by a provider due to mental health problems?
5. Did you feel you were treated with respect and dignity?
6. Have you ever felt judged by a provider for your experiences or identity?

Privacy and confidentiality

1. Do I have the possibility to control who has access to the data related to my mental health status or condition?
2. Do you know what your provider does with your information or who they can share it with?

Cultural-responsive care

1. Is there an official cultural mediation service available?
2. Can you find services that are tailored to your specific needs?
3. Did they interact with you in a culturally sensitive way?

Acceptability of care process

1. Is there a process to capture my story that prevents me from having to repeat myself over and over again?

Mapped under acceptability but potentially relevant to other dimensions:

Ability to seek:

Self-efficacy in care-seeking

1. Do you feel empowered to seek help?

Fear of anticipated consequences

1. Do you feel safe sharing your mental health concerns without consequence?

Past experiences

1. Does your previous experience, or that of others, affect the way you seek help?

Availability and Accommodation

Proximity of services:

1. Are there any available resources close to you? Do you have access to free services? What support do you need? Do you know of any resources?

Physical accessibility of services:

1. Do you feel mental health facilities are accessible to people with disabilities?

Timeliness of care

1. Do you have easy access to the help and support you are seeking when you need it within an acceptable time frame and according to your schedule?

Alignment of opening hours with users' needs:

1. Does your provider offer appointments outside of working hours or weekends?
2. Can you access services when you are available?
3. Do healthcare service hours accommodate your work schedule or personal responsibilities?

Childcare support:

1. Have you ever received childcare support from or while receiving services?

Questions assessing overall availability and accommodation

1. How convenient is it for you to attend your appointments? (considering time options, proximity, distance, and ease of transport). Are you able to reach services? Do you receive funding to reach mental healthcare services?
2. Do you have easy access to the help and support you are seeking? (in your own language, in your area, with easy transportation)

Mapped under acceptability dimension but potentially relevant to other dimensions:

Acceptability:

Privacy and confidentiality

1. Is there anyone you would not want us to share your data with? Do providers ask for permission before sharing your information?

Affordability:

Financial protection mechanisms

1. How convenient is it for you to attend your appointments? (considering time options, proximity, distance, and ease of transport). Are you able to reach services? Do you receive funding to reach mental healthcare services?

Availability of low-cost/free services

1. Are there any available resources close to you? Do you have access to free services? What support do you need? Do you know of any resources?

Appropriateness

Need-responsiveness

1. Do these services meet your needs?

Continuity of care

1. Have you ever been unable to receive appropriate care due to missing, incomplete, or inaccessible health records or data?
2. How does the lack of accessible or usable health data affect the quality and continuity of care in your community?

Ability to perceive

Awareness of available health services

1. Do you know who to call for help in times of crisis?
2. Are you aware of the mental health services in your area?

Questions developed under availability and accommodation dimension but not prioritized for accessibility assessment tool

Availability and Accommodation

Appointment mechanisms

1. Is it easy to schedule and/or rebook an appointment when needed?

Alternative care delivery models

1. Are there alternative service options available (home services, telehealth, etc.)?

Fragmentation of services

1. Do you find yourself having to repeat your story at each visit or when seeing a different provider?
2. Do you feel that communication between services and with you is adequate or fragmented?

Affordability	**Insurance coverage** 1. Does your health insurance plan cover your healthcare expenses? 2. Are there any services you needed but could not access because of your health insurance plan? 3. Do you have health insurance?

4. Does your health insurance cover all your mental health services? If not, can you afford them?

Cost transparency
1. Do you know the cost of the appointment before the service?
2. Have you been informed of the costs? Are there any payment plans available?

Financial impact of fragmentation
1. Can you find the care you need within a small network of providers (combining a therapist, psychiatrist, and gp)? Does this fragmentation affect you financially?

Mapped under affordability but potentially relevant to other dimensions:

Ability to pay
Financial independence
1. Are you dependent on someone else to afford healthcare?

Questions developed under affordability dimension but not prioritized for accessibility assessment tool

Insurance coverage:
1. Have you used your insurance for mental health services?
2. Do you have insurance? Who is your insurance provider? Are you aware of what your insurance provider covers?
3. Does your insurance cover the amount of care that you need?

Low-cost or free of charge care
1. Are you aware of low-cost or free services? Have you ever been offered a payment plan for a service?

Financial support schemes
1. Do you receive any social benefits that help cover health costs?

Appropriateness

Need-responsive care
1. Do you believe that the healthcare system adequately meets the needs of people like you?
2. Do you feel that your needs are fully met, socially and psychologically, beyond medical treatment?
3. Were you met at your own level and supported at your own pace?

Involvement in decisions about care
1. Have you been informed by your provider about the treatment and/or medications you are receiving prior to service?
2. Was the information (about your care) provided in an accessible manner?
3. Do you feel like you are shaping the care you are receiving?
4. Do you feel like you are taking part in the care you are receiving?

Perceived quality of care
1. Do you receive quality care?

Adequacy of consultation time
1. Was there enough time for you to express your needs?

PREM
1. Is there a channel through which I can report my personal experiences while dealing with healthcare services?

Discrimination

1. Have you ever been discriminated against based on your gender, sexual orientation, or ethnicity?

Compulsory treatment and coercive practices

1. Have you ever been treated, restrained, or institutionalised against your will? If so, were you aware of your rights, including complaint mechanisms and the right to appeal?
2. Do you have legal capacity to make decisions about your care? If not, have you been offered supported decision-making services?

Cross-cutting macro-level questions

1. Based on your experience, do you think that mental health services receive enough attention and priority from policymakers?

Mapped under appropriateness but potentially relevant to other dimensions:

Ability to engage:

Satisfaction with care

1. Are you satisfied with the care provided?

Questions developed under appropriateness dimension but not prioritized for accessibility assessment tool

Need responsiveness-cultural responsiveness

1. Do you feel that the services offered are appropriate to your needs and reflect or acknowledge your culture and identity?

Adequacy of consultation time:

1. Were you given adequate time to make decisions? Are you aware of your rights to restrict data sharing (communication with other providers, insurance reporting of services on taxes)?

Coordination and continuity:

1. Do you have a network of providers? If so, do they work together to coordinate your care?
2. How many times have you had to explain yourself to providers?
3. Do you know what happens next? What are the next steps of your treatment?

Interpersonal quality and respect

1. Do you feel heard?

Involvement in care:

1. Do you feel like you have an influence on your treatment process?

Cross-cutting questions:
Prior negative experiences:

1. Have you had a negative experience during mental health care? How many times did it occur? How did it impact your engagement with services?

18. Annex 7. Prioritised Questions for Demand-Side Dimensions

Dimension	Questions

Interpretation and perception of mental health needs

1. When is the last time you have taken the time to reflect on your mental status?
2. Do you feel like you have the capability to know whether you have mental health challenges or issues?
3. Do you have the words to describe how you feel?
4. How do you feel? Is there something that worries you? If not, why not? What is stopping you from asking for help?

Stigma around mental health conditions

1. Do you feel that your mental health needs are recognised by your community? Are you comfortable expressing them?

Access to trustworthy information channels

1. Do you have internet, Wi-Fi, or devices?
2. Are you able to find information online regarding mental health? Can you understand it? (easy to read, translated in your own language, culturally adapted)
3. Can I rely on the information from ChatGPT?

Language barriers

1. What languages can you speak? Which language would you prefer to engage with providers?
2. Can you find information in your own language?

Mental health wellbeing

1. Where do you see yourself on the OECD well-being scale?

Ability to Perceive

Mapped under ability to perceive dimension but potentially relevant to other dimensions:

Cross-cutting questions:

1. Is there anything you were worried about that you didn't seek help for or didn't mention? If yes, what are those issues?
2. What stops you from communicating with these services?

Questions developed under ability to perceive dimension but not prioritized for accessibility assessment tool:

Language barriers

1. Do you speak the language of the services?
2. What language do you understand or want to be communicated with?

Mental health literacy

1. Did you ever learn about mental health in schools?
2. Is it easy for you to understand the information provided? How do you access information? Do you have the means to access mental health related information? Do you need help with accessing information?

Educational background:

1. What is your educational background?

Social support

1. Do you have someone to rely on?

<u>Acceptability:</u>

Respectfulness:

1. How was the welcoming of the service providers?

	Availability and Accommodation: **Availability of translation services** 1. Have you had to bring a translator with you to services?
Ability to Seek	**Stigma around mental health and care seeking** 1. Have you ever avoided seeking care due to concerns about being judged, stigmatised, or treated unfairly? 2. Do your friends and family discuss mental health or know others who go to therapy? 3. Are there attitudes in your immediate environment that affect the way you seek mental health care? **Fear of discrimination:** 1. Have you ever experienced fear of discrimination when seeking medical help? 2. Have you ever avoided seeking care due to concerns about being judged, stigmatised, or treated unfairly? **Social support:** 1. Do you have anyone you can talk to at home? **Trust in services** 1. Do you trust that you can share with your provider without your parents, caregiver, or guardian finding out? 2. Do you trust mental health services? 3. How confident are you that the system or provider will help you? **Past experiences** 1. Have you had good experiences? **Autonomy:** 1. Can you seek care on your own, without the need or obligation to be supported by someone else? **Anticipated negative consequences:** 1. Do potential negative consequences prevent you from seeking care? 2. Do you have any concerns about accessing the service? **Mapped under ability to seek dimension but potentially relevant to other dimensions:** Acceptability: **Cultural responsiveness:** 1. How is your culture taken into account during your appointment? Appropriateness **Quality of care-need responsiveness** 1. Have you ever felt that health services did not act in your best interest? **Interpersonal quality:** 1. Did the providers' approach make you feel uncomfortable at any time during your visit? Did you feel safe? If not, how would you expect to be treated? **Cross-cutting questions:** 1. Have you used services? Why or why not? 2. Does your legal status affect the way you receive help? 3. What could hinder you from seeking care?

Questions developed under ability to seek dimension but not prioritized for accessibility assessment tool:

Ability to seek:

Stigma around mental health and care seeking:

1. Have you ever felt shame sharing your mental health problems with your family or community?
2. Have you ever stopped seeking mental health care due to fear of judgement?

Social support

1. Do you have a social network that supports you? (formal or informal, close friends, relatives)

Self-advocacy:

1. Do you think you can speak up when you face a discriminatory approach?

Autonomy:

1. Are you able to seek help without your caregiver's consent?

Approachability:

Availability of information channels:

1. Is information regarding mental healthcare services available? How comfortable are you with using digital resources or making online appointments?

Acceptability:

Privacy and confidentiality:

1. Do you think the information you provided will remain confidential?
2. Are you aware of how we use the information you provided?

Opportunity to choose provider:

1. Are you able to choose the gender of your provider?

Availability and Accommodation:

1. Is information regarding mental healthcare services available? How comfortable are you with using digital resources or making online appointments?

Ability to pay:

Insurance status:

1. Do you have insurance? Who is your insurance provider? Are you aware of what your insurance provider covers?

Ability to engage:

Self-advocacy:

1. Do you think you can speak up when you face a discriminatory approach?

Autonomy-mobility

1. Are you independent? Do you depend on someone to access mental health services?

Ability to Reach

Time flexibility/everyday responsibilities

1. Do you have other responsibilities that limit your ability to attend medical sessions?
2. Do your responsibilities (such as childcare, elderly care, or work) prevent you from accessing services?

2. Do you have other responsibilities during the time of your appointment (such as care or work)?

Questions assessing overall ability to reach

1. How difficult or easy is it for you to get to the mental healthcare facility?
2. Can you access the services available? What are your accessibility needs?

Mapped under ability to reach dimension but potentially relevant to other dimensions:

Acceptability

Opportunity to choose services and providers

1. Are you able to choose the gender of your provider? Are you able to choose your provider? Are you able to choose the service?

Availability and accommodation

Remote provision of care:

1. Can I access priority services remotely?

Flexibility and diversity of service delivery options

1. Do you have different options to choose from when you want to reach certain services?

Outreach

1. Are there any available mobile services? Would you be more likely to use services if mobile services were available?

Proximity of services

1. Can you get all the help you need nearby?
2. Does the location or structure of services ever prevent you from going?

Ability to seek

Stigma around mental health and care seeking

1. Have you ever stopped seeking mental health care due to fear of judgement?

Questions developed under ability to reach dimension but not prioritized for accessibility assessment tool:

Ability to reach:

Mode of transportation

1. How do you normally travel to appointments?

Everyday responsibilities

1. Are you concerned about seeking care because of your caretaking duties?

Work-related responsibilities

1. Do you have to take sick leave to attend appointments, or are you limited in how much time you can take off for appointments?

Availability and accommodation

Proximity of services

1. Do you have a hospital or clinic nearby?
2. How long does it take you to travel to appointments?

Ability to Pay	**Financial capacity for mental healthcare cost** 1. During the last 12 months, how many times have you avoided seeking medical help due to economic constraints? 2. Do you have enough income to pay for health insurance? 3. If your insurance does not cover your health expenses, can you afford to pay out of pocket? 4. Has receiving healthcare ever caused financial issues? 5. Would the cost of mental health services be a burden to you? **Financial concerns regarding indirect and opportunity cost of care** 1. Have you ever foregone care due to financial concerns, including lost wages? **Mapped under ability to pay dimension but potentially relevant to other dimensions:** <u>Affordability</u> **Indirect and opportunity cost of care** 1. Do you have additional costs to seek care beyond the cost of the service itself (such as transport or childcare)? <u>Ability to perceive</u> **Awareness of financial rights and coverage** 1. Are you aware of your rights, insurance coverage, and available mental health resources and services? <u>Ability to reach</u> **Work-related responsibilities** 1. Has receiving healthcare ever interfered with your job? **Questions developed under ability to pay dimension but not prioritized for accessibility assessment tool:** **Financial capacity for mental healthcare** 1. Can you afford your medications? 2. How comfortable do you feel spending money on accessing mental healthcare services? **Financial independence** 1. Do you financially depend on someone else to cover your service costs? **Payment preferences** 1. What is your payment preference? How would you like to pay? <u>Affordability</u> **Burden of direct cost of care** 1. How much of your income do you spend on mental healthcare? **Availability of affordable medications** 1. Is there subsidised or low-cost medication available? **Direct cost of care** 1. Have you ever hesitated to get medication because of the cost? 2. Would the cost of accessing services prevent you from reaching them? **Indirect and opportunity cost of care** 1. What are other costs, beyond financial, that challenge you in accessing mental healthcare services?
Ability to Engage	**Trust in non-judgemental provider attitude**

1. Do you trust that your provider will help you without judgement?

Health system navigation skills
1. Do you have difficulty navigating different services?

Privacy concerns
1. Do you trust that your provider will not share your information without your consent?

Questions assessing overall ability to engage
1. What factors make it difficult for you to follow your treatment or care plan?
2. Are you able to finish your treatment? If not, why?

Autonomy-independence
1. Can you receive the care you need on your own?

Mapped under ability to engage dimension but potentially relevant to other dimensions:

Appropriateness

Support groups
1. Am I aware of the existence of any support groups I could connect with?

Involvement in care
1. To what extent do you feel actively involved in decisions about your healthcare?

Access to information for informed decision-making
1. Is there a mechanism or process to inform me about clinical trials related to my condition?

Informed consent mechanisms
1. Have you actively consented to receiving services or medication?

Coercion and involuntary treatment
1. Have you ever been treated, restrained, or institutionalised against your will? If so, how did it impact your mental health? As a result, are you willing to seek care again?

Need-responsiveness
1. Do your mental health services help address your other concerns or needs (such as housing or food insecurity)?
2. Did mental health services help you with your mental wellbeing?

Patent-centeredness
1. Do you feel heard?

Ability to seek

Fear of negative experiences
1. Do you feel safe seeking care without any negative consequences or repercussions?

Questions developed under ability to engage dimension but not prioritized for accessibility assessment tool:

Satisfaction with treatment
1. Are you satisfied with your treatment? If yes, what did you like from the beginning? If no, what would you change?

Autonomy-independence
1. Do you need consent for care?

Appropriateness

Respectfulness-Interpersonal quality

1. Were you understood by your provider? Were you treated with dignity and respect? Did you feel understood and safe?

Involvement in care

1. Are you able to choose on your own whether to get treatment or not? Do you feel like you have the right to stop?
2. Do you feel like you are able to make decisions about your treatment freely?

Ability to seek

Prior negative experiences

1. How would you evaluate your past experiences with mental health services?

Perceive safety of care seeking

1. Do you feel safe seeking mental healthcare services?

19. Annex 8. Item Bank: Supply-Side Dimensions

Recommended item bank, not a mandatory instrument. Adopt the assessment strategy, the component and its definition, the side it is measured on, and the safeguards (Section5.2) then use these items verbatim, adapt their wording to local language and context, or replace them, provided each continues to measure its assigned component on the correct side. Comparability across contexts is preserved through the scoring approach (Section 5.5), not through identical wording.

How to read these tables. Dimensions follow Levesque et al. (2013); components and definitions are from Section 2.1.4.1. All items use a five-point Likert scale (1 = Strongly disagree to 5 = Strongly agree) worded so that a higher score means better access; reverse-construct components (e.g., stigma, coercion, bureaucratic or fear-based barriers) are phrased positively to keep this polarity. Supply-side components carry two paralleled items an individual item (experienced opportunity, the measure of accessibility) and a provider/system item (provision, a diagnostic comparator only). Demand-side components carry one capacity item and are grouped by the journey stage that maps to each ability. The demand instrument is preceded by a Yes/No use-status screen that routes respondents and is paired with open-ended reason questions (Safeguard 2).

19.1. Approachability

Supply-side dimension · paired demand ability: Ability to Perceive · 10 components.

Component	Component definition	Individual item — experienced opportunity (1–5)	Provider / system item — provision (1–5)
Mental health prevention and screening programmes	*Proactive efforts by services to identify mental-health needs early through routine screening or preventive assessment in non-specialist settings.*	In the past 12 months, a health worker asked me about my mental health, mood or stress — even during a visit for another reason.	We routinely offer mental-health screening or preventive conversations at primary-care or other contact points.
Transparency	*Clear communication to users about what follows contact with services — referral, monitoring, rights and possible*	It was made clear to me what would happen after I reached out for	We clearly explain what happens after initial contact, including referral

	consequences — so that engaging feels predictable and safe.	support (e.g., referral, follow-up, who would know).	pathways, confidentiality and users' rights.
Integration across health and non-health services	*The extent to which mental-health support and referral are embedded within other health, social, educational and community services.*	I was offered mental-health support or a referral while using another service (e.g., GP, school, social or community service).	We provide mental-health support or referral through integration with general health care, social services, schools or other entry points.
Providers' awareness and knowledge	*Frontline providers' knowledge of what services exist, how to connect people to them, and of mental-health conditions themselves.*	The professionals I first contacted seemed to know what services were available and how to direct me to them.	Our frontline staff are equipped to recognise mental-health needs and know how to connect people to appropriate services.
Provider workload and patient contact time	*Whether provider capacity and appointment time are sufficient to notice and respond to mental-health needs.*	The professional I saw had enough time to pay attention to my mental-health concerns.	Staff workloads and appointment lengths allow enough time to identify and respond to mental-health needs.
Cultural responsiveness of care and providers	*Providers' capacity to recognise and respond to concerns in ways that fit people's cultural backgrounds, so they feel understood and appropriately directed.*	When I first sought help, staff understood my background well enough to point me in the right direction.	Our staff are supported to recognise and respond to needs across the cultural backgrounds of the people we serve.
Community-based outreach	*Active strategies that extend services beyond formal settings — mobile teams, home or community visits, embedded*	I have seen or met a mental-health worker outside a clinic — for example at home, a school, a shelter or a community event.	Our services include community-based outreach (e.g., home visits, school sessions, mobile units) targeting underserved populations.

	services — especially for underserved groups.		
Frontline actors	*Non-clinical frontline people (teachers, social and community workers) who help identify needs and open pathways to care.*	Someone outside the health system (e.g., a teacher, social or community worker) helped me realise I could get support.	We work with non-clinical frontline actors to identify needs and open pathways to care.
Mental health awareness programmes	*Public campaigns and education that build the literacy and confidence to recognise needs and seek help, including in underserved communities.*	In the past 12 months, I encountered information or activities in my community that helped me understand mental health and how to get help.	Our facility organises or supports mental-health awareness activities in the communities we serve, including underserved groups.
Visibility of services and accessible information channels	*Whether clear, updated, usable information about services and how to access them is publicly visible across channels.*	Clear, up-to-date information about services was visible and available to me (e.g., signage, leaflets, hotline, website).	We maintain visible, up-to-date information about our services across accessible channels (signage, leaflets, phone, online).

19.2. Acceptability

Supply-side dimension · paired demand ability: Ability to Seek · 6 components.

Component	Component definition	Individual item — experienced opportunity (1–5)	Provider / system item — provision (1–5)

Confidentiality and privacy regulations	*Practices and safeguards that protect users' information, crucial where disclosure carries social or material risk.*	I felt confident that what I shared with services would be kept confidential.	We have, and clearly communicate, confidentiality and privacy safeguards for service users.
Interpersonal quality of care	*Whether encounters are respectful and non-judgmental, free of hostility or stereotyping.*	Mental-health staff treated me with respect and without judgment.	We train and support staff to provide respectful, non-judgmental interpersonal care.
Cultural inclusivity	*Alignment of services with users' language, cultural beliefs and values, including language support.*	Services were offered in a way that fit my language and cultural background (e.g., interpretation, cultural understanding).	We adapt services to the languages and cultural values of the populations we serve (e.g., interpreters, cultural adaptation).
Availability of different types of service provision	*Whether services are offered in formats and modalities that match users' preferences and circumstances.*	I could access support in a format that suited me (e.g., in person, online, group, individual).	We offer a range of service modalities so users can choose options that fit their preferences and circumstances.
Shared decision-making practices	*The degree to which users are involved in decisions about their own care.*	I was involved in decisions about my own care.	We involve service users in decisions about their care and respect their treatment preferences.
Freedom from compulsory treatment and coercive practices	*The absence of involuntary or coercive interventions that undermine trust and acceptability (higher = less coercion).*	My experience with services was free from coercion or pressure (e.g., involuntary or forced interventions).	We minimise coercive practices and have safeguards to protect users

			from involuntary or forceful interventions.

19.3. Availability and Accommodation

Supply-side dimension · paired demand ability: Ability to Reach · 8 components.

Component	Component definition	Individual item — experienced opportunity (1–5)	Provider / system item — provision (1–5)
Service availability and capacity	*Whether enough services exist, with capacity to meet population need.*	When I needed care, a service was available to take me without being turned away for lack of capacity.	Our services have sufficient capacity to meet demand in the population we serve.
Proximity of services	*Geographic closeness of services to the populations they serve.*	Services were located close enough for me to use them.	Services are distributed to be geographically accessible to the communities we serve.
Workforce availability and distribution	*Sufficiency and distribution of staff, specialists and interpreters.*	When I needed care, the right staff (including specialists or interpreters) were available to me.	We have adequate staffing — including specialists and interpreters — distributed to meet need.
Waiting times	*Timeliness of access; waits short enough that people do not disengage.*	I was able to get care within a reasonable time.	Our waiting times are short enough to avoid disengagement.

Referral and coordination mechanisms	*Effective pathways that move people through the system without undue burden.*	Moving between services or getting a referral was handled smoothly for me.	We have effective referral and coordination mechanisms so users are not left to navigate fragmented care alone.
Low bureaucratic barriers to utilising care	*The absence of administrative or legal requirements that block access even where services exist (higher = fewer barriers).*	Administrative or paperwork requirements did not stop me from getting care.	We minimise administrative and eligibility barriers that could prevent people from utilising care.
Alternative care delivery models	*Delivery options (telehealth, mobile, home visits, flexible scheduling) that fit everyday realities.*	Care was offered in ways that fit my daily life (e.g., telehealth, home or mobile visits, flexible times).	We offer alternative delivery models (telehealth, mobile units, home visits, flexible scheduling) to fit users' lives.
Physical accessibility of health facilities	*Whether facilities are adapted for people with mobility or other limitations and afford privacy.*	The facilities I used were physically accessible to me and offered adequate privacy.	Our facilities are physically accessible (e.g., for mobility limitations) and provide adequate privacy.

19.4. Affordability

Supply-side dimension · paired demand ability: Ability to Pay · 4 components.

Component	Component definition	Individual item — experienced opportunity (1–5)	Provider / system item — provision (1–5)

Direct cost of care	*Out-of-pocket fees and charges for services and medication, shaped by financing and coverage.*	I could afford the direct costs of care (e.g., fees, medication) when I needed it.	Direct costs to users for our services are kept low or covered.
Indirect cost of care	*Costs of accessing care (transport, communication and similar) rather than of the care itself.*	The extra costs of getting to and using care (e.g., transport) were manageable for me.	We take steps to reduce indirect costs of accessing care (e.g., transport support).
Opportunity costs of care	*Economic trade-offs such as lost income or time away from work to attend care.*	Attending care did not cost me unaffordable time or income (e.g., time off work).	We schedule and deliver care in ways that reduce users' lost time and income (e.g., flexible or after-hours options).
Financial protection mechanisms	*Aid, subsidies, exemptions or coverage that protect people from cost barriers.*	Financial support or coverage was available to help me afford care.	Financial protection mechanisms (e.g., subsidies, exemptions, aid) are available to users who need them.

19.5. Appropriateness

Supply-side dimension · paired demand ability: Ability to Engage · 13 components.

Component	Component definition	Individual item — experienced opportunity (1–5)	Provider / system item — provision (1–5)

Need responsiveness of care	*Whether care is designed and delivered to address people's actual needs.*	The care I received addressed my actual needs.	We design and adapt care to respond to the actual needs of the people we serve.
Clinical quality of care	*Competence, evidence base and accountability of care delivery.*	The care I received was competent and based on good practice.	Our care is evidence-based, safe and subject to quality accountability.
Provider workload and patient contact time	*Sufficient appointment time to deliver tailored, adequate care, especially for complex needs.*	There was enough time in my appointments to address my needs properly.	Appointment lengths and workloads allow staff to provide adequate, tailored care.
Continuity of care	*Sustained therapeutic relationships and care without disruptive discontinuity.*	I was able to continue with the same care or provider over time without disruptive interruptions.	We support continuity of care and stable therapeutic relationships over time.
Integration across services	*Coordination across sectors and care domains so care is coherent across the journey.*	My care was well coordinated with my other health or social care.	We coordinate care across sectors and domains to deliver coherent, integrated support.
Consent, privacy and confidentiality regulations	*Regulatory frameworks protecting autonomy without introducing timeliness or access barriers.*	Consent and confidentiality procedures protected me without getting in the way of timely care.	Our consent and confidentiality procedures protect users without creating undue barriers to timely care.

Care setting and service environment	*Whether the physical or virtual environment supports the therapeutic process (e.g., privacy).*	The setting where I received care (in person or online) felt private and supportive.	Our care settings (physical and virtual) are designed to support privacy and the therapeutic process.
Freedom from stigma and discrimination	*Freedom from stigmatising or discriminatory treatment within care (higher = less stigma).*	I was not treated with stigma or discrimination because of who I am during my care.	We have protocols to prevent stigma and discrimination toward people in vulnerable situations.
Interpersonal quality of care	*Whether treatment encounters feel responsive, respectful and tailored.*	During treatment, I felt listened to and that care was tailored to me.	We support staff to deliver responsive, respectful, individually tailored treatment.
Cultural responsiveness of care	*Whether care is experienced as relevant and aligned with diverse backgrounds.*	The care I received was relevant to and respectful of my cultural background.	We deliver care that is culturally relevant and trustworthy for diverse populations.
Caregiver involvement and support	*Appropriate involvement of families or caregivers where it supports engagement and recovery.*	My family or caregivers were appropriately involved in my care when I wanted them to be.	We appropriately involve and support families and caregivers where it aids engagement and recovery.
Peer-led services and peer support groups	*Availability of peer-led support grounded in lived experience.*	I had access to peer support or people with lived experience as part of my care.	We offer or connect users to peer-led services and support groups.

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Collecting patient-reported experiences	*Routine collection and use of patient-reported experience and outcomes to improve care.*	I was asked for feedback about my experience of care.	We routinely collect and use patient-reported experiences and outcomes to improve services.

20. Annex 9. Item Bank: Demand-Side Dimensions

Recommended item bank, not a mandatory instrument. Adopt the assessment strategy, the component and its definition, the side it is measured on, and the safeguards (Section5.2) then use these items verbatim, adapt their wording to local language and context, or replace them, provided each continues to measure its assigned component on the correct side. Comparability across contexts is preserved through the scoring approach (Section 5.5), not through identical wording.

How to read these tables. Dimensions follow Levesque et al. (2013); components and definitions are from Section 2.1.4.2. All items use a five-point Likert scale (1 = Strongly disagree to 5 = Strongly agree) worded so that a higher score means better access; reverse-construct components (e.g., stigma, coercion, bureaucratic or fear-based barriers) are phrased positively to keep this polarity. Supply-side components carry two paralleled items an individual item (experienced opportunity, the measure of accessibility) and a provider/system item (provision, a diagnostic comparator only). Demand-side components carry one capacity item and are grouped by the journey stage that maps to each ability. The demand instrument is preceded by a Yes/No use-status screen that routes respondents and is paired with open-ended reason questions (Safeguard 2).

20.1. Ability to Perceive

Demand-side ability · journey stage: "Before you sought care" · 7 components.

Component	Component definition	Item — capacity / means to act (1–5)
Symptom interpretation and awareness about mental health	*Capacity to recognise and interpret symptoms as signs of a mental-health need.*	Before I sought care, I was able to recognise that what I was experiencing was a mental-health need.
Perceived responsiveness of care	*Belief that services would be effective and responsive to one's situation.*	I believed that mental-health services would respond effectively to my situation.

Knowledge of available services	*Awareness of what services exist and what they offer.*	Before seeking care, I knew where to go and how to apply for mental-health support.
Awareness of legal entitlements	*Knowledge of one's legal entitlements to care.*	I was aware of my legal entitlements to mental-health care.
Language-related challenges	*Capacity to understand mental-health information in an accessible language (higher = fewer barriers).*	I could understand information about mental health in a language I am comfortable with.
Social network and support	*Help from social networks in recognising a mental-health need.*	People around me helped me recognise that I might need support.
Stigma around mental health	*Freedom from internalised stigma that blocks recognising or accepting one's own need (higher = less stigma).*	I was able to accept that I might have a mental-health need without feeling ashamed.

20.2. Ability to Seek

Demand-side ability · journey stage: "Deciding to seek care" · 9 components.

Component	Component definition	Item — capacity / means to act (1–5)
Stigma around mental health conditions and care seeking	*Freedom from social stigma about seeking help (higher = less stigma).*	I was able to decide to seek care without being held back by stigma about getting help.

Privacy and confidentiality concerns	*Confidence that seeking care will not expose one's information (higher = fewer concerns).*	I felt able to seek care without fear that my information would be exposed.
Trust in mental healthcare services	*Sufficient trust in providers and the system to approach them.*	I trusted mental-health providers enough to approach them for help.
Prior negative experiences with healthcare	*Past experiences not deterring care-seeking (higher = less deterrence).*	Past experiences with health services did not stop me from seeking care.
Negative peer advice	*Others' negative views or experiences not deterring care-seeking (higher = less deterrence).*	Others' negative views or experiences did not deter me from seeking care.
Social network and support	*Support from one's network in deciding to seek care.*	My family or close circle supported me in deciding to seek care.
Perception about the cost of mental healthcare	*Care-seeking not deterred by beliefs about cost (higher = less deterrence).*	I was not deterred from seeking care by beliefs about how much it would cost.
Perceived language and communication barriers	*Care-seeking not deterred by anticipated communication difficulty (higher = less deterrence).*	I felt able to seek care without being deterred by anticipated language or communication difficulties.
Fear of treatment consequences	*Care-seeking not deterred by fear of harmful consequences (higher = less fear).*	I was able to seek care without fear of harmful consequences (e.g., to my autonomy, family or status).

20.3. Ability to Reach

Demand-side ability · journey stage: "Reaching the service" · 12 components.

Component	Component definition	Item — capacity / means to act (1–5)
Mental health status and condition	*One's condition not preventing the practical act of reaching care (higher = less impediment).*	My mental-health condition did not prevent me from getting to care.
Mobility and physical health condition	*Physical health or mobility not preventing reaching care (higher = less impediment).*	My physical health or mobility did not prevent me from reaching care.
Occupational flexibility	*Capacity to make time around work to attend care.*	I was able to make time around work to attend appointments.
Caregiving responsibilities	*Caregiving duties not preventing reaching care (higher = less impediment).*	Caregiving responsibilities did not prevent me from reaching care.
Autonomy	*Freedom of independent movement and control over one's time to reach care.*	I was able to travel to care on my own, without needing others' permission or accompaniment.
Language-related barriers	*Capacity to navigate the steps of reaching care in an understood language.*	I could navigate the steps to reach care (e.g., booking, directions) in a language I understand.
Digital access and literacy	*Devices, connectivity and skills to access remote care when required.*	I had the devices, connectivity and skills needed to access care online when required.

Transportation options	*Availability of transport to get to the service.*	I had transport options that allowed me to get to the service.
Physical proximity to healthcare services	*Distance close enough to make attendance feasible.*	The service was close enough for me to attend.
Capacity and emotional resilience for navigating services	*Capacity to manage the practical effort of navigating the system.*	I had the capacity and resilience to manage the practical steps of navigating the service.
Social network and support	*Practical help from others that enables reaching care.*	I received help from others (e.g., childcare, transport, translation) that enabled me to reach care.
Safety and unsupportive living environments	*Reaching and using care without safety risk or exposure in an unsupportive environment.*	I could reach and use care without risks to my safety or exposure in an unsupportive environment.

20.4. Ability to Pay

Demand-side ability · journey stage: "After accessing care" · 2 components.

Component	Component definition	Item — capacity / means to act (1–5)
Financial resources	*Sufficient personal financial resources to cover the costs of care.*	I had enough financial resources to cover the costs of my care (e.g., treatment, medication).

Health insurance status	*Adequacy of insurance or public coverage for the costs of care.*	My health insurance or public coverage was sufficient to cover the costs of my care.

20.5. Ability to Engage

Demand-side ability · journey stage: "After accessing care" · 9 components.

Component	Component definition	Item — capacity / means to act (1–5)
Mental health status and condition	*One's condition not preventing active engagement in care (higher = less impediment).*	My mental-health condition did not prevent me from engaging actively in my care.
Physical health condition	*Physical health not preventing participation, including in remote care (higher = less impediment).*	My physical health did not prevent me from participating in my care (including remote care).
Living conditions	*Living conditions allowing follow-through with care.*	My living conditions allowed me to follow through with my care (e.g., storing medication, attending follow-ups).
Language-related barriers	*Capacity to communicate and understand well enough to participate fully.*	I could communicate and understand information well enough to participate fully in my care.
Motivation and readiness to engage	*Internal motivation and readiness to take part in care.*	I felt motivated and ready to take part in my care and treatment.

Trust	*Sufficient trust in providers to be open and honest.*	I trusted my providers enough to be open and honest during care.
Fear of treatment consequences	*Openness in care not inhibited by fear of consequences (higher = less fear).*	I could be fully open in care without fear of harmful consequences (e.g., hospitalisation).
Self-advocacy skills	*Capacity to speak up and advocate for one's needs in the service.*	I felt able to speak up and advocate for my needs within the service.
Social support	*Social support that helps sustain engagement with care.*	I had social support that helped me stay engaged with my care.

21. Annex 10. Meso–Macro (HSPA) System-Indicator Set

Companion to Chapter 7. System-level indicators drawn from the project's HSPA analysis (WHO HSPA functions; OECD mental-health benchmark; European primary-care framework) and mapped onto the Levesque dimensions and the shared components used at the micro–meso level (Chapter 6). Because HSPA assesses provision and its conditions, the set maps predominantly to the supply side; a small group of population-level indicators (literacy, stigma, trust) monitor demand-side conditions. Indicators are exemplary, not exhaustive, and are intended for adaptation to context and care tier.

21.1. Table A. System indicators by HSPA function

Subfunction / area	Indicator (indicative measure)	Care tier	Levesque dimension	Shared component	GA aspect
GOVERNANCE					

Policy & vision	National mental-health policy/strategy that names priority and vulnerable groups	System-wide	Approachability	*Mental-health policies*	Governance / Equity
Policy & vision (equity)	Strategies ensuring cultural, age and gender appropriateness for named priority/vulnerable groups	System-wide	Approachability / Acceptability	*Mental-health policies; cultural inclusivity*	Equity / Governance
Multisectoral collaboration	Health-in-All-Policies; intersectoral links (education, employment, social protection)	System-wide	Appropriateness	*Integration across services*	Governance
Multisectoral (outcomes)	Education gap and employment gap (people with vs without mental distress); MH support in unemployment / housing / social services	System-wide	Appropriateness (structural)	*Integration across services (social)*	Equity
Participation	Mechanisms for service-user and community participation in planning and review	System-wide	Acceptability	*Shared decision-making (voice)*	Governance / Equity
Information & knowledge	MH data systems, M&E, datasets; capacity for equity-disaggregated monitoring	System-wide	Approachability	*Visibility & information channels*	Governance
Information (PROMs/PREMs)	Whether PROMs and PREMs are collected and reported	System-wide	Appropriateness	*Collecting patient-reported experiences*	Governance / Experience
Legislation & regulation	Mental Health Act; rights; anti-discrimination law covering gender, disability, ethnicity, sexual orientation	System-wide	Acceptability	*Freedom from coercive practices; cultural inclusivity*	Governance / Equity

Health workforce	MH workforce density per 1,000 (psychiatrists, psychologists, nurses); mix and geographic distribution	System-wide	Availability & Accommodation	*Workforce availability and distribution*	Effectiveness / Equity
Frontline-actor training	MH training for frontline actors (teachers, ED staff, paramedics, GPs, police, unemployment counsellors)	System-wide / Public health	Approachability	*Frontline actors*	Effectiveness / Equity
Infrastructure & equipment	Facility and psychiatric-bed density and distribution; telehealth infrastructure	System-wide	Availability & Accommodation	*Facility infrastructure; alternative care delivery*	Availability
Pharmaceuticals	Availability and distribution of essential psychotropic medicines	System-wide	Availability & Accom. / Affordability	*Medicines availability / direct cost*	Availability / Affordability
Governance of resources	Accreditation and quality standards; continuing professional development; workforce planning	System-wide	Appropriateness	*Clinical quality of care; provider awareness and knowledge*	Quality / Governance
Revenue raising	Mental-health spending as % of government health spending; CHE as % of GDP	System-wide	Affordability	*Public financing of mental health*	Efficiency / Equity

Revenue raising (equity)	Out-of-pocket expenditure as a share of health spending	System-wide	Affordability	*Direct / indirect cost of care*	Equity
Pooling	Population coverage and per-person expenditure by pool; administrative spending	System-wide	Affordability	*Financial protection mechanisms*	Efficiency / Equity
Purchasing	Allocation according to need; strategic purchasing for efficiency	System-wide	Affordability	*Financial protection mechanisms*	Efficiency
Governance of financing	Comprehensiveness of coverage (breadth/depth, incl. psychological therapies)	System-wide	Affordability	*Coverage breadth and depth*	Affordability / Equity
Coverage (unmet need)	Unmet need for MH care due to financial barriers (%)	Cross-tier	Affordability	*Direct cost of care / financial protection*	Affordability / Equity
SERVICE DELIVERY — PUBLIC HEALTH & PRIMARY CARE					
Public health	Preventable mortality; prevention, screening and promotion programmes (incl. school and workplace)	Public health	Approachability	*Prevention & screening; awareness programmes*	Effectiveness
Primary care — entry	MH integrated into primary care; entry points without referral (hotlines, web, ED)	Primary	Approachability	*Integrated mental-health entry points*	Access
Primary care — GP role	MH provided by GPs; people with mental illness who have a GP treatment plan	Primary	Approachability / Appropriateness	*Integrated entry points; continuity of care*	Access / Quality

Primary care — access	Amenable mortality; first-contact access and comprehensiveness	Primary	Availability & Accommodation	*Service availability and capacity*	Effectiveness / Access
Primary care — experience	Person-centredness: consultation duration; involvement in decisions	Primary	Acceptability	*Shared decision-making; interpersonal quality*	Experience
Community-based care	Community MH services and day centres (individuals in community teams per 1,000)	Community	Availability & Accommodation	*Community-based outreach*	Access / Equity
Primary ↔ specialist	Continuity (patient list) and coordination / gate-keeping with specialist care	Cross-tier	Appropriateness	*Continuity of care; referral & coordination*	Quality
SERVICE DELIVERY — SPECIALISED CARE & CROSS-CUTTING					
Effectiveness	In-hospital 30-day mortality; evidence-based treatment	Secondary / Tertiary	Appropriateness	*Clinical quality of care*	Effectiveness
Safety	Inpatient suicide rate; safe care	Secondary / Tertiary	Appropriateness	*Clinical quality of care (safety)*	Safety
Coercion	Use of coercive measures (physical/mechanical restraint, seclusion); policies restricting them; days held involuntarily without review	Secondary / Tertiary	Acceptability	*Freedom from coercive practices*	Safety / Quality

User experience	PREMs: courtesy/respect; enough time; clear explanations; involved in decisions	Secondary / Tertiary	Acceptability	*Interpersonal quality; collecting patient-reported experiences*	Experience
Choice	Patient choice of provider (primary, specialist, hospital)	Cross-tier	Acceptability	*Ability to choose provider*	Experience
Access	Access gap (% with mental illness using services); waiting times	Cross-tier	Availability & Accommodation	*Waiting times; service availability and capacity*	Access / Equity
Proximity	% of households >5 / 10 / 20 km from a health facility or pharmacy	Cross-tier	Availability & Accommodation	*Proximity of services*	Access / Equity
Unmet need (waiting/transport)	Unmet need for MH care due to waiting times / transport (%)	Cross-tier	Availability & Accommodation	*Waiting times; transportation (Ability to Reach)*	Access / Equity
Equity	Effectiveness / access indicators disaggregated by population subgroup (subnational)	Cross-tier	Cross-cutting (structural)	*Intersectional disaggregation (structural determinant lens)*	Equity
Efficiency	Avoidable / ambulatory-care-sensitive admissions; readmission; length of stay (see Table B)	Secondary / Tertiary	Signals upstream dimension	*See Table B*	Efficiency

Integration	National strategy for integrated care; physical-health checks for MH service users	Cross-tier	Appropriateness	*Integration across services*	Quality
Continuity	Follow-up after discharge within the recommended period	Cross-tier	Appropriateness	*Continuity of care*	Quality / Safety
Peer support	Peer-delivered services and support groups	Cross-tier	Appropriateness	*Peer-led services & peer support*	Quality
Telehealth	Telemedicine / online counselling availability and use (teleconsultations per person)	Cross-tier	Availability & Accommodation	*Alternative care delivery models*	Access
Cultural responsiveness	Services specifically designed for vulnerable groups; interpreter availability	Cross-tier	Acceptability	*Cultural inclusivity*	Equity / Quality
POPULATION-LEVEL MONITORING OF DEMAND-SIDE CONDITIONS					
Mental-health literacy	Population mental-health literacy levels (e.g., MHLS, MAKS); digital health literacy	System-wide	Ability to Perceive (demand)	*Symptom awareness; knowledge of services*	Prevention / Equity
Stigma	National / regional surveys of mental-health stigma	System-wide	Ability to Seek (demand)	*Stigma around mental health*	Equity / Prevention
Trust	Population trust in the healthcare system	System-wide	Ability to Seek / Engage	*Trust in services*	Experience / Equity

Rate-based access indicators above (e.g., access gap, unmet need, contacts per 1,000) should be reported disaggregated by vulnerable group, with explicit numerators and denominators and a general-population comparator, on the model of Table B.

21.2. Table B. Efficiency as equity-anchored utilisation

Rather than new efficiency metrics, standard utilisation metrics are disaggregated by vulnerable group against a general-population comparator in the same catchment; the gap is read through the Levesque dimension whose upstream failure it signals (§7.5). Each metric is expressed as a rate — numerator over denominator — and compared with the general population; it is informative only when disaggregated.

Utilisation metric	Numerator (events, vulnerable group)	Denominator (base, vulnerable group)	Equity comparison	Signals (Levesque dimension)	Care tier
Psychiatric hospitalisation rate	Psychiatric admissions among the vulnerable group (catchment, period)	Vulnerable-group population in the catchment	*Rate ratio vs the same rate in the general population*	*Approachability / Availability*	Secondary / Tertiary
Involuntary / compulsory admission	Involuntary admissions among the group	Total psychiatric admissions among the group	*% involuntary, group vs general population*	*Acceptability / Approachability*	Secondary / Tertiary
Crisis / ED as first contact	Group members whose first MH contact was via crisis / ED	Group members entering MH care in the period	*% first-contact-via-crisis, group vs general*	*Approachability / Availability*	Cross-tier
Community / outpatient use	Community / outpatient MH contacts among the group	Vulnerable-group population in the catchment	*Contacts per capita, group vs general*	*Availability / Affordability*	Primary / Community
30-day readmission	Group discharges readmitted within 30 days	All group discharges in the period	*Readmission %, group vs general*	*Appropriateness*	Secondary / Tertiary

Follow-up after discharge	Group discharges with follow-up within the recommended period	All group discharges in the period	*Follow-up %, group vs general*	*Appropriateness; Ability to Engage*	Cross-tier
Did-not-attend / drop-out	Appointments not attended (or people dropping out) among the group	Scheduled appointments (or people starting care) among the group	*DNA / drop-out %, group vs general*	*Acceptability*	Cross-tier

Denominator note: each ratio requires a defined group denominator — the vulnerable-group population (or relevant base) in the catchment — which depends on registries that capture intersectional identifiers (§7.6). Where exact denominators are unavailable, best-available estimates should be used and their limitations reported.

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COMMUNITY-DRIVEN INCLUSIVE, EQUITABLE, MENTAL HEALTHCARE ACCESS

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PARTNERS

WHITE

university of groningen

Erasmus School of Health Policy & Management

KOÇ ÜNİVERSİTESİ

SEERC SOUTH-EAST EUROPEAN RESEARCH CENTRE

GIVMED Share medicine Share life

AMALIPE Center For Interethnic Dialogue and Tolerance

LADAPT

LGBT IRELAND For Inclusion For Equality For Everyone

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

Zentralinstitut für Seelische Gesundheit

Q-PLAN INTERNATIONAL

JIGSAW Young people's health in mind

EHTEL Collaborating for Digital Health and Care in Europe

diesis network

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

EASPD European Association of Service providers for Persons with Disabilities

Funded by the European Union

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