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COMMUNITY-DRIVEN INCLUSIVE, EQUITABLE, MENTAL HEALTHCARE ACCESS

Task 1.5:

Barriers of end-users to accessible mental health and care services

JIGSAW

29/06/2026

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Executive Summary

Timely and appropriate mental healthcare remains unevenly accessible across Europe, with people in vulnerable situations often facing additional social, practical, financial, and service-related barriers to care. This study aimed to identify barriers to help-seeking and accessing mental healthcare among people in vulnerable situations across Europe. The task used the Levesque et al. (2013) framework (referred to herein as the *Levesque framework*) to examine user-side dimensions of access, focusing on people's ability to perceive a need for care, seek care, reach services, pay for care, and engage with mental healthcare. In addition, the ability to engage was targeted for an in-depth exploration of experiences of engaging with mental healthcare. This was informed by the Patient Health Engagement Model (Kimerling et al., 2020), which emphasised self-management, health information use, communication, and healthcare navigation. This study is the first of its kind to focus on both the user-side of the Levesque framework and the Patient Health Engagement model in the context of people in vulnerable situations seeking mental healthcare.

A mixed-methods design was applied as the micro-level component of Task 1.5, focused on place-based barriers to mental healthcare access across EQUICARES pilot areas. Data collection comprised of a structured survey capturing quantitative and qualitative data (n = 202), implemented in paper-based and digital formats to support accessibility, and reflective diaries/testimonies (n = 21), used as a participant-led form of observational fieldwork to capture first-person experiences of service access and engagement. Pilot partners, cultural mediators and mental health experts informed local recruitment, target-group selection and ethical implementation.Target groups and pilot sites included migrants (recruited at ZI – Germany, FISEVI – Spain, SEERC - Greece), the Roma community (FISEVI, AMALIPE – Bulgaria), ethnoreligious minorities (AMALIPE) youth, legal guardians of unaccompanied minors (both GIVMED – Greece), older adults (SEERC), older adult migrants (ZI), the LGBTQIA+ community (LGBTI – Ireland) and people with intellectual or physical disabilities (LADAPT – France). Recruitment used a purposive, site-specific approach across eight European sites, with safeguards in place to support the safe and ethical participation of individuals experiencing vulnerable situations. Findings were integrated to provide a comprehensive account of the journey of help-seeking and engaging with services in populations experiencing vulnerable situations.

Key findings highlight the significant work required of individuals in vulnerable situations, with help-seeking often emerging as a non-linear process involving repeated attempts to seek, reach, and remain engaged with care while navigating system barriers. Mental health literacy shaped whether people recognised distress as a need for care, while stigma, mistrust, and concerns about being

treated unfairly discouraged help-seeking. The ability to pay for private services was identified as a leading barrier, while freely available publicly funded services were often overwhelmed and involved long waiting times. Perceived access also varied across groups, with particularly constrained access reported among survivors of the Hatay earthquake and among participants with poor or very poor mental health-related quality of life. Facilitators included supportive adults, trusting relationships with mental health professionals, and experiences of care where participants felt understood, validated, and able to take part in decisions about their mental healthcare.

The findings were applied to inform the use of the Levesque framework and Patient Health Engagement model with people in vulnerable situations and to provide recommendations for policy and practice. Implications for future Smart Health Labs within the EQUICARES consortium are also discussed, with emphasis on designing solutions that reduce the additional burden placed on service users in vulnerable situations when accessing and engaging with mental healthcare.

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List of Terms and Definitions

Terms and Definitions

Abbreviation	Definition
AMALIPE	EQUICARES partner organisation (Bulgaria)
DPIA	Data Protection Impact Assessment
EU	European Union
FISEVI	EQUICARES partner organisation (Spain)
GDPR	General Data Protection Regulation
GIVMED	EQUICARES partner organisation (Greece)
KU	Koc University – EQUICARES partner organisation (Turkiye)
IPA	Interpretative Phenomenological analysis
LADAPT	EQUICARES partner organisation (France)
LGBTI	LGBT Ireland – EQUICARES partner organisation (Ireland)
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual (occasionally abbreviated as LGBQ+ to focus on sexual orientation only in analyses)
MoU	Memorandum of Understanding
MHQoL	Mental Health Quality of Life (measure)
NGO	Non-governmental organisation
OECD	Organisation for Economic Co-operation and Development
PHE	Patient Health Engagement (model)
SEERC	EQUICARES partner organisation (Greece)

SHLs	Smart Health Labs
WHO	World Health Organisation
ZI	EQUICARES partner organisation (Germany)

1. Introduction

1.1 Access to Mental Healthcare

Mental health difficulties represent a substantial public health challenge across Europe and continue to place considerable demands on health systems (Kyu et al., 2018; Organisation for Economic Co-operation and Development [OECD], 2018). Although the need for care is widespread, access to timely and appropriate mental healthcare remains uneven, leaving many people without access to evidence based care (Rickwood et al., 2005; Rodrigues et al., 2025). This has important consequences both for individual wellbeing and people's ability to participate in daily life, education, work, and relationships (OECD, 2018; World Health Organisation [WHO], 2015).

Despite the growing policy momentum relating to access to mental healthcare, persistent disparities in access and outcomes remain, particularly for people facing vulnerable situations (European Parliament, 2023; Lopes & Llena-Nozal, 2025; WHO Regional Office for Europe, 2021). These disparities reflect a complex combination of social determinants, historical exclusion, and systemic inequities that are often insufficiently captured by traditional health systems research (Alegría et al., 2018; Kirkbride et al., 2024). Recent European policy briefs and public health reports have emphasised the disproportionate mental health risks experienced by people in vulnerable situations including young people, older adults, persons with disabilities, LGBTQIA+ individuals, and migrants (European Parliament, 2023; Unicef European Union, 2024; WHO Regional Office for Europe, 2021; Priebe et al., 2016). These groups are more likely to experience barriers to mental healthcare access, discrimination, social exclusion, and poorer psychological outcomes across the European region. This challenge is not limited to under-resourced health systems. Evidence suggests that inadequate access to mental healthcare can persist even in high-income countries with universal health coverage and established community care infrastructure (Alonso et al., 2004).

Although the mental health needs of these populations are increasingly recognised, less is known about how access is experienced and negotiated at the micro level by those attempting to use services (Axelsson et al., 2020). Existing evidence is often fragmented across populations, countries, and service settings, and tends to focus on system or provider level indicators over the perspectives of service users themselves (Barbui et al., 2025). As a result, there is still limited understanding of how people in vulnerable situations perceive their needs, seek care, navigate services, afford care, and sustain engagement over time within different social and service contexts across

Europe (Axelsson et al., 2020). This study responds to the need for more context-sensitive, user-centred evidence on the micro-level barriers and experiences that shape access to mental healthcare across Europe. This study will complement other research studies in the EQUICARES consortium which focus on macro- and meso- level analysis of mental health access.

Consistent with international health equity research (Fernández-Sánchez et al., 2024), the present study uses the term “people in vulnerable situations” to emphasise that vulnerability is not an inherent individual characteristic, but rather arises from adverse social determinants such as discrimination, housing and income inequalities, displacement, and experiences of violence.

1.2 Conceptualising Access to Mental Healthcare: the Levesque Framework

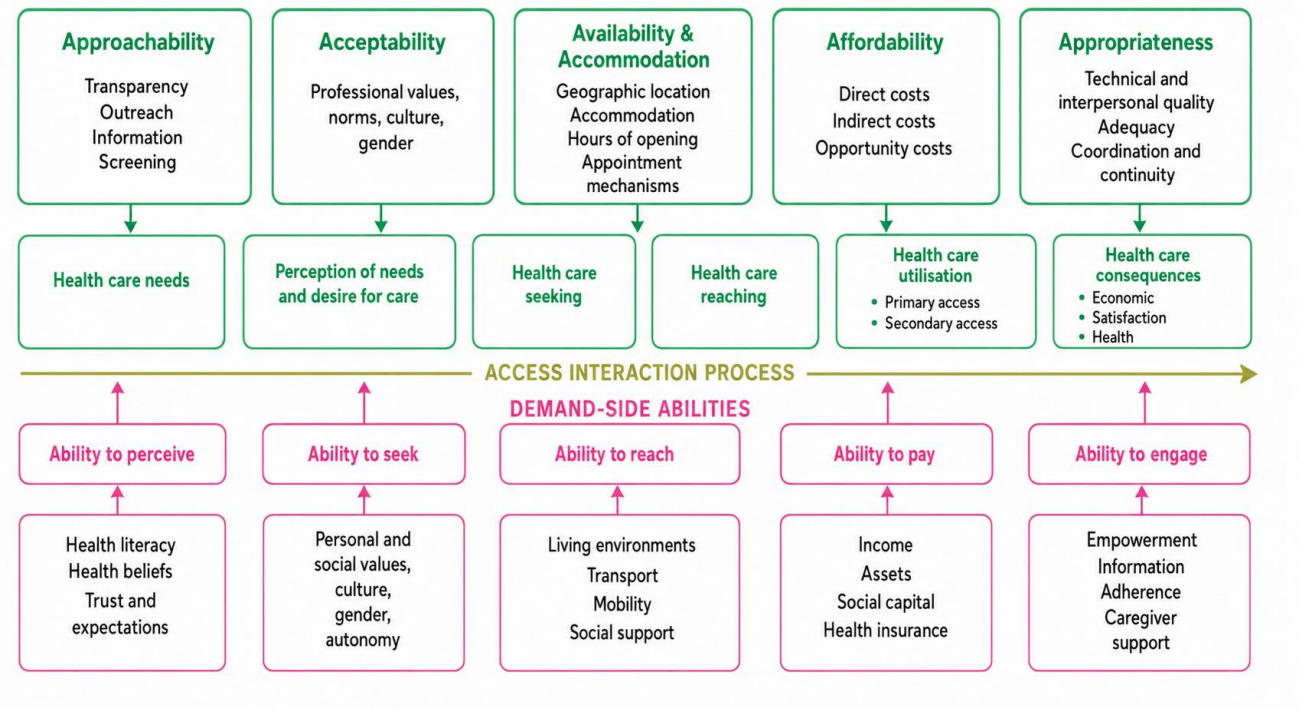
Research on mental health access in Europe has often measured access using service-level indicators, such as service availability, workforce capacity, and the geographic distribution of resources (Barbato et al., 2016; Barbui et al., 2025). Some recent work has incorporated dimensions such as realised access, contact coverage, and patient-side barriers (Barbui et al., 2025). As a concept, access remains characterised by definitional and methodological inconsistency (Levesque et al., 2013). For example, studies have conceptualised access in terms of service availability, healthcare utilisation, affordability, geographic proximity, treatment coverage, or patients’ ability to engage with care, resulting in substantial variation in how access is defined and measured (Levesque et al., 2013). Rather than viewing access as the presence or use of services, contemporary approaches increasingly conceptualise it as a dynamic and relational process shaped through the interaction between health systems and the social, economic, cultural, and personal circumstances of those attempting to obtain care (Levesque et al., 2013; Russell et al., 2013).

Levesque et al. (2013) developed a patient-centred access framework which offers a comprehensive lens to examine this complexity, encompassing both supply-side characteristics (such as approachability, acceptability, availability, affordability, and appropriateness of services) and service-user-side abilities (to perceive, seek, reach, pay for, and engage with care; see Figure 1). This dual perspective enables a more nuanced exploration of how structural, cultural, and interpersonal dynamics interact to facilitate/enable or obstruct/prevent access to mental healthcare (Cu et al., 2021). The Levesque framework has been applied to many areas of healthcare such as chronic conditions (Schwarz et al., 2022), patients with HIV/AIDS (Fan et al., 2025), primary care (Davy et al., 2016), and mental healthcare (Ash et al., 2026; Dumke et al., 2024; Lowther-Payne et al., 2023; Shah et al., 2025). In addition, the framework has been applied using a health equity lens (Lowther-Payne et al., 2023), with a focus on people in vulnerable situations, such as women experiencing family

violence (Hollingdrake et al., 2025), Indigenous people (Davy et al., 2016), people with intellectual disabilities (Eveleigh et al., 2025), Black perinatal women (Ash et al., 2026), and refugee and asylum-seekers (Dumke et al., 2024).

Figure 1

The Levesque Framework (Levesque et al., 2013)



1.3 Patient Engagement with Mental Health Services

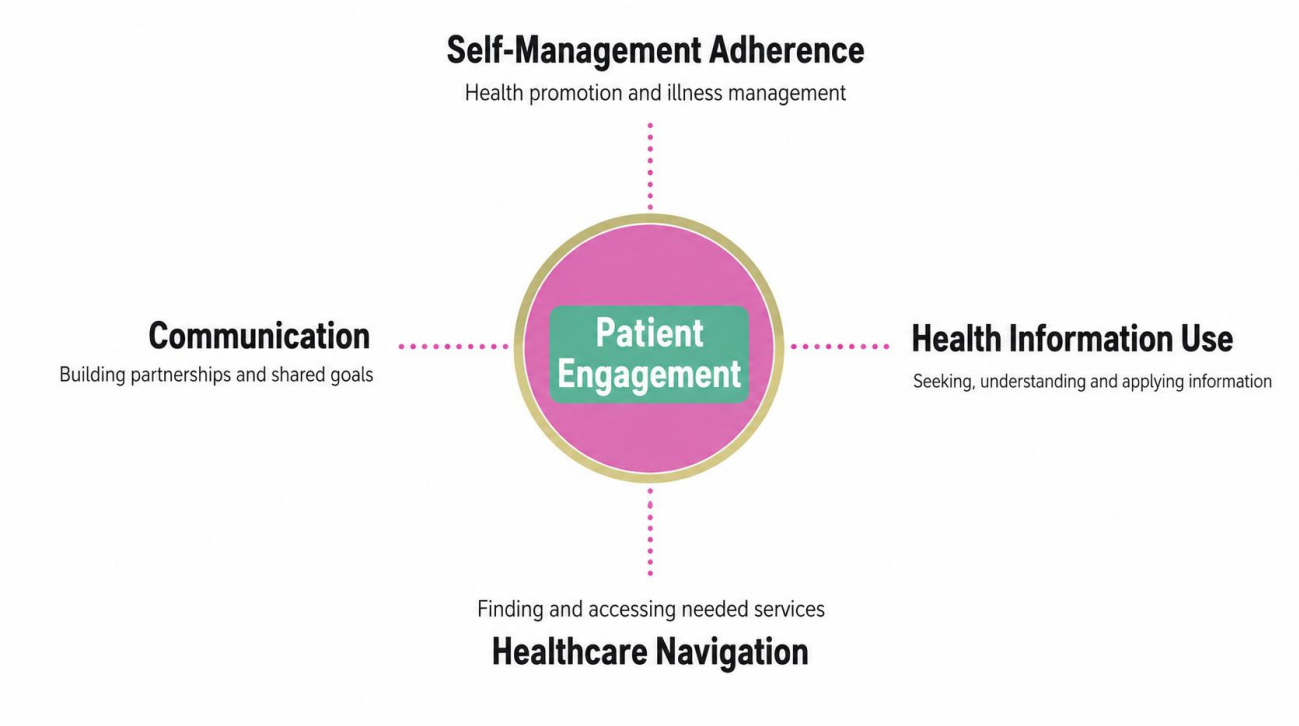
Patient engagement is recognised as a critical component of high-quality and equitable healthcare (Carman et al., 2013; Graffigna et al., 2015; Hibbard et al., 2004) and a key component on the user side of the Levesque framework. In mental healthcare specifically, engagement extends beyond initial contact with services and encompasses how individuals participate in care, navigate systems, develop trusting relationships with providers, and sustain involvement over time. However, engagement is not experienced equally, with people in vulnerable situations often encountering barriers relating to trust, empowerment, communication, continuity, and cultural safety (Bee et al., 2015; Kimerling et al., 2020).

The Patient Health Engagement (PHE; see Figure 2) model (Kimerling et al., 2020) provides a useful complementary lens for examining the “ability to engage” dimension within the Levesque framework. The PHE framework outlines key dimensions of engagement, including self-management, health

information use, collaborative communication, and healthcare navigation, all of which are particularly relevant to mental healthcare contexts where service users are often required to actively negotiate complex systems over extended periods of time.

Figure 2

Patient Health Engagement Model (Kimerling et al., 2020)



Despite growing research on mental health access and patient engagement, important gaps remain in understanding how people in vulnerable situations experience access to mental healthcare across different European contexts. In particular, the “ability to engage” dimension of the Levesque framework has been less consistently operationalised in empirical access research, creating scope for more focused examination of engagement in mental healthcare contexts (Cu et al., 2021). Integrating the Levesque framework with the PHE framework therefore enables a more nuanced examination of both broader access pathways and the relational processes that shape ongoing engagement with care among populations experiencing vulnerability.

1.4 Aims and Research Objectives

The present study examines the micro-level conditions shaping access to mental healthcare among people in vulnerable situations across eight European sites participating in the EQUICARES project. Attention is given to the user-side dimensions of access and the role of patient engagement in shaping sustained interaction with mental health services.

The research objectives of the study are:

- to identify barriers to accessing mental healthcare from the perspective of people facing vulnerable situations, in the areas of ability to perceive, seek, reach, pay, and engage with mental health services
- to explore the relationships between the five user side abilities (i.e. to perceive, seek, reach, pay for, and engage with care), demographic characteristics, and quality of life among people in vulnerable situations
- To explore the ability to engage with mental healthcare for people in vulnerable situations.

Within the EQUICARES consortium, the findings aim to inform the implementation of Smart Health Labs at pilot sites, to inform future developments of solutions for people in vulnerable situations.

2. Methods

2.1 Research Paradigm

This study is underpinned by a critical realist philosophy of science (Bhaskar, 2016), adopting a realist ontological stance, and employing relativist and phenomenological epistemologies. This approach has been employed regularly in health research, facilitating mixed methods research, with an emphasis on understanding the lived experience of participants within a real-world context (Robson & McCartan, 2016). Critical realism also emphasises the need to understand the agency of individuals within a context of social determinants that create positive or negative conditions that impact upon lived experiences (Bhaskar, 2016), which aligns with the focus of this study with people experiencing vulnerable situations accessing mental healthcare.

2.2 Reflexivity Statement

The research team comprised researchers working in mental health research and innovation. Many of the team had substantial experience in design, implementation and evaluation of mental health services. The lead author of the team (NMD) had lived experience of help-seeking for mental health, and several members of the team had lived experience of migration. These perspectives informed the interpretation of data, particularly in identifying initial codes and comments in the qualitative data and informing the language of identified themes. Ongoing reflective discussions took place throughout the research process to ensure findings accurately reflected the accounts of participants.

2.3 Study Design

The study used a convergent parallel mixed-methods design. In this design, quantitative and qualitative data are collected during the same overall study period and analysed in parallel using approaches appropriate to each data type (Fetters et al., 2013). Equal priority was given to the quantitative and qualitative strands, as the quantitative data identified cross-site patterns in perceived access while the qualitative data provided contextual and experiential explanations for those patterns.

The mixed-methods approach was selected because the research objectives required both an assessment of patterns in perceived access across participant groups and an in-depth understanding of how access and engagement were experienced, interpreted and negotiated by people in vulnerable situations. The study deployed two data collection tools: a structured survey and a reflective diary/testimony component. These were deliberately mapped onto different user side components of the Levesque framework and the PHE (Kimerling et al., 2020). The structured survey focused on all user side domains of the Levesque framework. The reflective diary/testimony was designed to solely explore the ability to engage, capturing relational, emotional, and cultural aspects of service use that are often underrepresented in conventional research approach, as informed by both the Levesque framework and the PHE model (Kimerling et al., 2020). Figure 3 illustrates data collections tools used to assess different domains of the access.

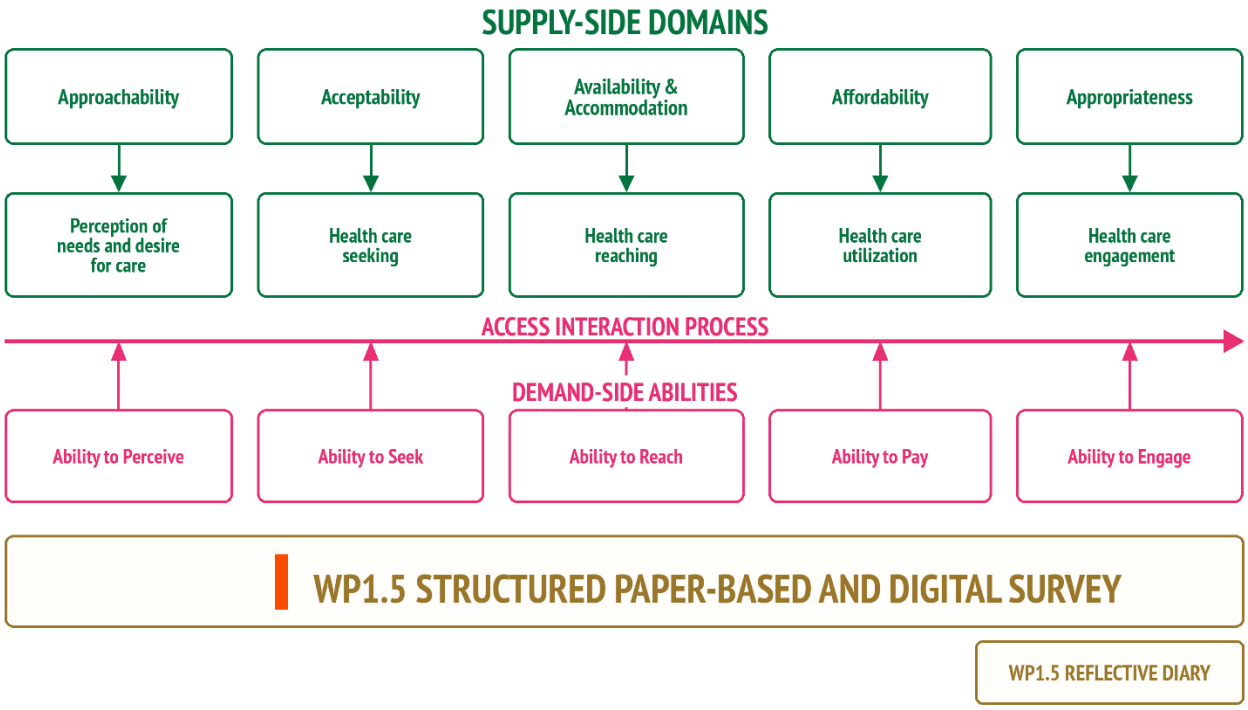
Following consultation with pilot partners, cultural mediators and mental health experts, the reflective diary/testimony approach was selected as an ethically appropriate, context-sensitive implementation of the micro-level qualitative fieldwork component described in the Horizon Grant Agreement. Direct observational fieldwork was considered likely to raise ethical and practical concerns around participant visibility, consent, confidentiality and possible disclosure of mental health status. Reflective diaries/testimonies were therefore used to capture participant lead observations and ethnographically informed accounts of service access and engagement, while reducing participant burden, minimising intrusion and supporting emotional safety.

The study was designed in consultation with EQUICARES partner organisations to ensure that data collection methods were both methodologically rigorous and locally responsive. Harmonised tools were adapted across sites to support linguistic diversity and cultural appropriateness. A participatory and trauma-informed approach underpinned the design, ensuring that people in vulnerable situations could safely share their perspectives on access to care. A study protocol was drafted in advance to support transparency, methodological consistency across sites, and open science principles.

The study design was guided by the view that access to mental healthcare is shaped through the interaction between individual circumstances, social context and health system conditions. The Levesque framework provided the overarching structure for examining access across the full pathway from perceiving a need for care to engaging with services (Levesque et al., 2013). The PHE model was used to explore the fifth Levesque domain (ability to engage), in greater depth by focusing on how people participate in care, use information, communicate with professionals and navigate services. The structured survey provided breadth by identifying patterns in perceived access, demographic characteristics and mental health-related quality of life. Open-text survey responses identified barriers and facilitators across the Levesque domains, while reflective diaries/testimonies provided depth on lived experiences of engagement with formal mental healthcare. Integration was planned through the shared use of the Levesque framework, allowing quantitative and qualitative findings to be brought together around the study's three research objectives.

Figure 3

Data Collection across Levesque Framework User Side Domains



2.4 Participants and Sampling

Data collection took place across eight pilot sites (see Figure 4), with a target of 20 participants per site for the survey (total target sample: *N* = 160) and two participants per site for the reflective diaries (total target sample: *N* = 16).The final sample for the structured survey was *N* = 202 and

21 participants were recruited for the reflective diary component, exceeding the target. Participant recruitment for both data collection was purposive, site-specific strategy across the eight sites. Purposeful sampling enabled targeted recruitment of participants from vulnerable populations with direct experience, generating rich data while applying clear eligibility criteria and safeguards to protect welfare (Palinkas et al., 2017; Council for International Organizations of Medical Sciences, 2016). Local partner organisations at each pilot site identified populations based on contextual relevance, feasibility, and alignment with EQUICARES' inclusion goals. Target populations included young adults (aged 18–25), the Roma community, older adults, ethnoreligious minorities, migrants (predominantly first-generation, although with some participants who were second-generation migrants), LGBTQIA+ individuals, persons with physical or intellectual disabilities, people facing natural disasters, and unaccompanied minors. These populations reflect many of those most affected by structural inequities across Europe and are aligned to EU mental health priorities (European Parliament, 2023). Table 1 details the inclusion criteria.

Eligibility criteria aligned with the study's conceptual focus. The structured survey included individuals from identified populations, regardless of whether they have accessed mental health services. This allowed exploration of early-stage barriers, such as the ability to perceive, seek, reach, and pay for care. The reflective diary/testimony method was limited to those who have used formal mental health services within the past 12 months and were able to reflect on that experience. This ensured data richness in relation to the ability to engage with care, including trust, communication, and continuity.

Figure 4

EQUICARES pilot sites: target groups and data collection

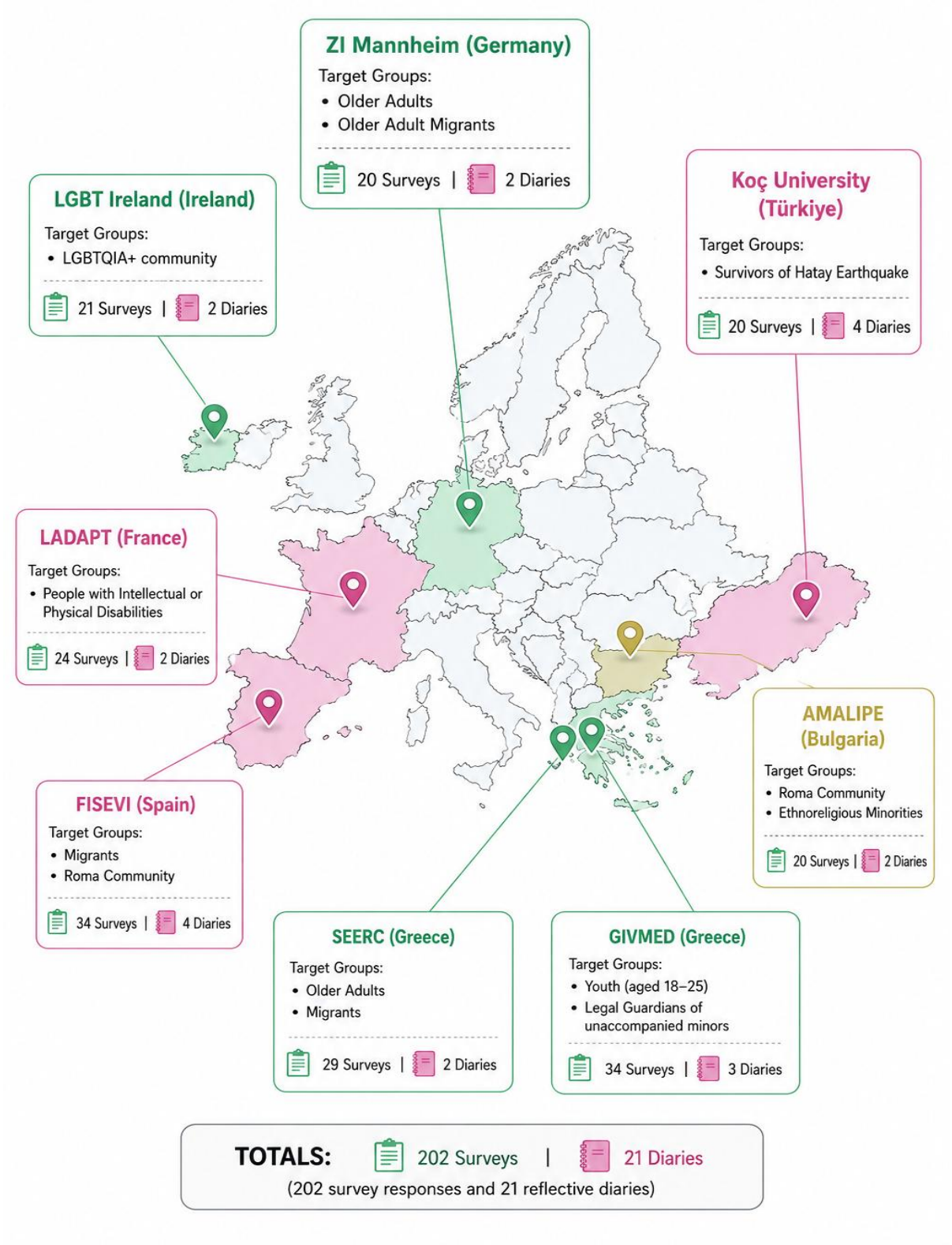


Table 1

Inclusion and Exclusion Criteria

Category	Structured Survey	Reflective Diary
Inclusion Criteria	• Aged 18+ • Member of target groups (specific to pilot sites - see Table 2) • Can provide informed consent (self or via representative)	• Aged 18+ • Member of target groups (specific to pilot sites - see Table 2) • Can provide informed consent (self or via representative) • Must have accessed mental health services in past 12 months
Exclusion Criteria	• Under 18 • Experiencing an acute mental health crisis • Shows distress or dysregulation during recruitment	• Under 18 • Experiencing an acute mental health crisis • Shows distress or dysregulation during recruitment

The structured survey did not exclude participants who had not previously used mental health services. This decision was deliberate and reflected the study's focus on to all domains of services access rather than utilisation alone. For people in vulnerable situations, non-use of mental health services may itself reflect an important access issue, including barriers related to recognising need, knowing where to seek care, affordability, stigma, trust, distance, or service availability. Excluding individuals who had not accessed services would therefore have risked omitting those experiencing some of the most significant barriers to care. The sample still included substantial prior contact with mental healthcare: over 70% of survey participants reported that they had spoken to a mental health professional or service.

Participants at ZI (Germany) were recruited through hospitals, where they already were receiving mental healthcare. Therefore, findings for older adults and older adult migrants were interpreted with caution, as they were already within care and were likely to have overcome or avoid potential access barriers. At all other sites, there was a mix of people who had experience of engaging with mental healthcare and those who had not previously received care.

2.5 Data Collection

2.5.1 Structured Survey

All data collection materials are included in supplementary materials. The structured survey component of the study was designed to capture descriptive, cross-contextual data on participants' experiences of access to mental healthcare. The survey consisted of demographic questions, quality of life questions, quantitative questions focused on service user domains of the Levesque framework, and qualitative questions relating to the same domains. Demographic questions (e.g., age, gender, migration background, disability) allow for disaggregated analysis across populations included in the study. Quality-of-life was measured by the Mental Health Quality of Life measure (MHQoL; van Krugten et al., 2021). The MHQoL is a multi-dimensional concept commonly used to examine the impact of health status on quality of life (van Krugten et al., 2021).

The T1.5 survey was developed in conceptual continuity with the Levesque-informed approach used in T1.4, including learning from a consortium workshop on the Levesque framework. Adapting the work of T1.4, T1.5 shifted attention from service-side and meso-level access barriers to user-side abilities to perceive, seek, reach, pay for, and engage with mental healthcare. As there was no existing measure of the service-user-side domains of the Levesque framework specific to mental health identified by the research team, quantitative questions were developed in consultation with pilot sites across Europe and informed by a review of previous research focused on the Levesque framework (Cu et al., 2021). Twenty quantitative questions were included in the survey, consisting of four items per domain in the Levesque framework, with a mixture of positively (e.g., "I know where to go if I need mental health support from a professional.") or negatively (e.g., "I believe my health insurance or public coverage would not provide enough support to afford mental healthcare") framed questions. For the analysis, scores on this scale are referred to as "accessibility scores", often referring to domains of the framework (i.e.., "accessibility score – perceive/seek/reach/pay/engage"). Question generation was informed by the work of T1.4 and with the team in KU.

Qualitative items in the survey consisted of open-ended questions, each relating to domains of the Levesque framework. The wording of the questions was also designed in consultation with pilot sites and informed by previous research (Cu et al., 2021). The questions were:

- How would you know if need support for your mental health? (ability to perceive)
- What makes it harder for you to look for mental health support? (ability to seek)
- Have you had any challenges travelling to mental health services, like transport or appointment times? (ability to reach)
- Can you describe any experiences where cost (such as travel, medication, or service fees) affected your ability to access mental health support? (ability to pay)
- Have you ever spoken to a mental health professional or service? (ability to engage – answered as “Yes/No”)
- If yes, how would you describe that experience? (ability to engage)
- Are there other challenges in your life that affect your ability to use mental health services (or medication for your mental health)? (general question to capture additional answers)

This approach drew on learning from earlier European projects, including the *VulnerABLE* Pan-European Survey (EuroHealthNet, 2016), which highlighted the importance of brief, low-burden, and mixed-mode tools to ensure accessibility and inclusiveness in populations facing vulnerable situations. To maximise accessibility and participant choice, the structured survey was made available in both paper-based and digital formats across pilot sites.

2.5.2 Reflective Diary and Testimony Methods

This study drew on the PHE model to develop a reflective diary tool aligned with the fifth user-side dimension in the Levesque framework: the ability to engage with care. This data collection strategy was designed to elicit rich, narrative accounts of user-provider relationships, shared decision-making, and continuity, with attention to the cultural, institutional, and interpersonal dimensions that shape experiences of engagement.

The reflective diary/testimony method is rooted in participatory and ethnographic traditions (Cornwall & Jewkes, 1995; Kara, 2015), offering a flexible, user-led approach that prioritises emotional safety and lived experience. Unlike structured interviews or surveys, diaries allow for narrative depth and temporal reflection, key to understanding access from the perspective of those at the margins of care systems (Napier et al., 2014).

Participants were asked to reflect on a specific care-seeking episode from the past 12 months. Open-ended prompts were structured around the four domains of the PHE model (Self-Management, Health Information Use, Collaborative Communication, and Healthcare Navigation) and were designed to capture both subjective meaning and structural context. To support participant choice and accessibility, the diary was available in two formats: paper-based (using locally adapted materials) and digital (using voice notes via the secure Typeform platform), ensuring usability across varying levels of literacy, digital access, and personal preference. A majority of diaries were collected through a paper-based format.

The research management team created an implementation protocol for pilot sites. This included information on data collection and management and user safety. Training was provided by the research team to all pilot sites to support sensitivity in data collection with participants, including a safety protocol at all sites if participants were in distress or disclosed risk of harm. In addition, training focused on developing familiarity with the data collection methods to support consistency across sites in data gathering across groups.

2.5.3 Study Implementation at Pilot Sites

The study implemented a coordinated cross-site approach. Researchers in Jigsaw led overall study design and management and central analysis, while pilot sites were responsible for local recruitment and data collection. Sites were provided with the survey, diary and testimony tools, participant information and consent materials (see Appendix A), recruitment materials, a safety protocol, and a translation protocol. Each site was required to complete a recruitment plan for review by the study management team before data collection began. To support safe and ethical delivery, pilot sites were provided with a safety protocol for working with participants who may have experienced marginalisation, displacement, trauma or mental health difficulties (see Appendix B). Sites were required to appoint a Participant Support Lead, maintain a local support directory, and ensure all participants received information on available mental health, psychosocial, community or crisis supports.

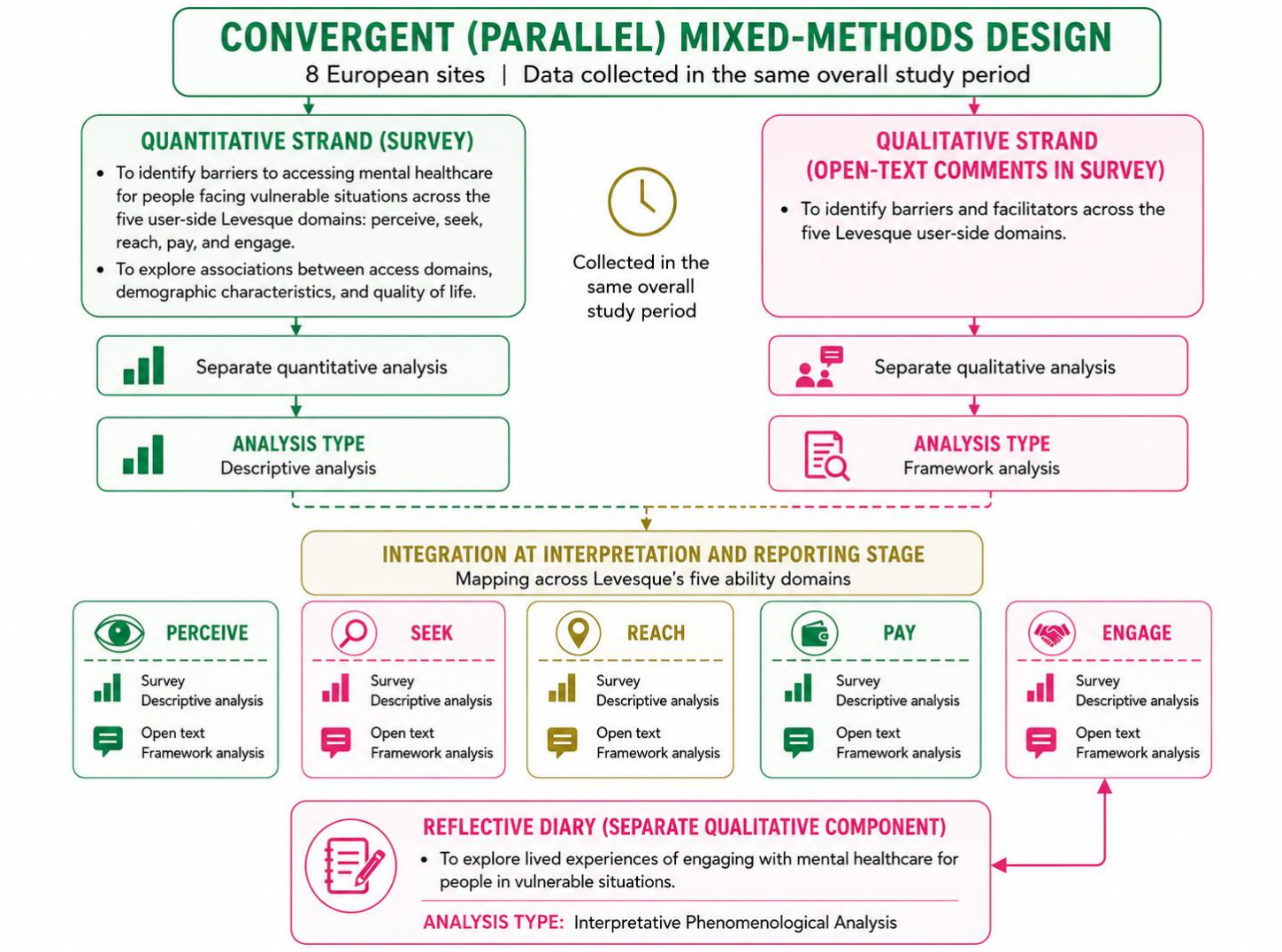
A translation and language management protocol was implemented to support linguistic accuracy across sites. Jigsaw finalised the English master versions of the survey, diary and testimony tools, which were then translated by pilot sites using the EU eTranslation tool and reviewed by local staff for accuracy and appropriateness. Participant-generated data were translated into English for final analysis through the same process, including a local human check for accuracy.

2.6 Analysis

Figure 5 illustrates the integration of quantitative and qualitative findings to across the five user-side domains of the Levesque framework. This enabled the research team to examine where findings converged, diverged or added explanatory depth. Details on quantitative and qualitative analyses are provided below.

Figure 5

Convergent Mixed Methods Design



2.6.1 Quantitative Analysis

Quantitative analyses were conducted in R. Data were cleaned, recoded and cross-checked before analysis to ensure consistency with the scoring rules, subgroup definitions and planned statistical procedures. Analyses were primarily descriptive and were used to describe the recruitment target populations, characterise the wider sample, and summarise MHQoL and perceived access to mental health care. Categorical variables were reported as frequencies and percentages, and continuous variables as means, standard deviations, medians and ranges. MHQoL was analysed as both a continuous score and a categorical variable, with scores below 12 classified as poor mental health-related quality of life and scores of 8 or below classified as very poor (van Krugten et al., 2021).

Participants were first grouped according to the recruitment target population they selected at the start of the survey. Most target populations were retained as separate reporting categories. Two combined categories were created: “Survivors of Hatay earthquake” and “People with physical or intellectual disabilities”. Older adult migrants were retained as a separate group rather than being combined with either migrants or older adults. Cross-cutting participant characteristics were then described, including age group, gender, migration background, disability status, sexual orientation, MHQoL category and previous contact with a mental health professional or service.

Mental health service access was assessed using 20 Levesque-informed items, informed by Cu et al. (2021), with higher values indicating greater perceived access. Items were summarised across the five user-side domains of perceive, seek, reach, pay and engage, and as a total Mental Health Accessibility Score. Internal consistency was assessed using Cronbach’s alpha. Because the domain indicators were developed for this study and were not validated subscales, domain-level findings were interpreted descriptively.

Overall access patterns were first described across the five access domains and then at item level to show which specific barriers appeared most constrained. Differences between the five domain scores were explored within participants, with follow-up paired comparisons used to identify the main contrasts. Access patterns were then described first by recruitment target population and then by participant characteristics. In the main analysis, mean Mental Health Accessibility Scores were shown using dot plots with standard errors. Domain-level heatmaps were included in the appendices to show which aspects of access appeared more or less constrained for each group. These subgroup analyses were descriptive and were used to identify patterns for mixed-methods integration, not to test formal differences between groups. An exploratory linear regression model was also used to examine adjusted associations with the mental health access score. The model included MHQoL category, age group, gender, migration background, disability status, sexual orientation and previous contact

with a mental health professional or service. The non-binary gender subgroup was included in descriptive analyses but excluded from adjusted modelling because of small cell size.

2.6.2 Qualitative Analysis

The primary analytical approaches for qualitative data were framework analysis (Ritchie & Spencer, 1994) and Interpretative Phenomenological Analysis (IPA, Smith et al., 2009). Framework analysis is a method well-suited for applied health research with policy relevance and was applied to qualitative findings from open-ended questions in the survey. Likewise, IPA is appropriate for exploring in-depth lived experiences of accessing mental health services.

Framework analysis balanced deductive analysis, guided by domains of the Levesque framework, with inductive of emergent themes. Data were analysed in five stages: 1) Familiarisation with the data to capture initial impressions and contextual nuance. 2) Identification of a thematic framework, initially guided by the five Levesque user-side domains, 3) Indexing (coding) data into the framework while allowing for emergent codes not captured by the original model, 4) Charting, using thematic matrices to summarise and compare data across cases and sites, 5) Mapping and interpretation, drawing analytical connections between themes, barriers, and contextual conditions.

In the interpretation of the framework analysis, the most commonly reported barriers were included, with recognition that many existing barriers may not have been reported in the responses from participants. Therefore, absence of responses were not conflated with absence of the barrier among the target populations.

IPA was conducted on reflective diary entries / testimonies in line with guidelines from Smith et al. (2009) to help understand participants' lived experiences with help-seeking. IPA emphasises treating each participant transcript as a case study, before comparing identified themes across cases. These steps are 1) immersion in the transcript; 2) initial noting of descriptive, conceptual, or linguistic comments within the case; 3) searching for connections to develop themes across cases; 4) repeating the steps for each case; 5) identifying connections across cases; 6) developing superordinate themes across cases.

All codes (from the framework analysis) and initial noting (from IPA) were conducted by a minimum of two members of the research team, and with each code and comment cross-checked by another researcher for quality assurance. The development and labelling of superordinate themes for the IPA were also cross-checked with the research team for accuracy and relevance to participant testimonies. Differences in interpretation were resolved through discussion within the research team,

with attention to consistency with the Levesque framework and PHE model and fit with participants' accounts.

2.6.3 Mixed-methods integration

Integration was supported by the shared use of the Levesque framework across the survey, open-text responses and integrated findings. Framework analysis was used to interpret brief open-text survey responses in relation to the Levesque domains, while IPA was used to examine richer diary/testimony accounts of engagement with care. Interpretations were discussed and cross-checked by members of the multidisciplinary research team. The mixed-methods reporting was structured with reference to the Good Reporting of A Mixed Methods Study criteria (O'Cathain et al., 2008) and the American Psychological Association Journal Article Reporting Standards for Mixed Methods Research (Levitt et al., 2018), with attention to the rationale for mixing methods, the purpose and sequencing of each strand, the process of integration, and insights generated through integration (see Appendix A).

2.7 Ethical Clearance

Ethical clearance was managed through a dual governance structure. Jigsaw, as the lead partner obtained ethical approval to analyse de-identified cross-site data (ID - 2025_011_EQUICARES). Jigsaw completed a data management plan and DPIA for the overall study. A Joint data controller MOU was signed by all parties to ensure compliance with GDPR. Pilot sites obtained ethical approval from their relevant institutional or national research ethics committee before commencing recruitment or data collection.

3. Results

3.1Target Recruitment Groups

Table 2 shows all recruitment target groups represented in the quantitative sample and the key pilot sites tasked with recruiting these groups. The largest groups were migrants, Roma community members, people with physical or intellectual disabilities, youth and LGBTQIA+ community members. Smaller groups were also represented, including older adults, survivors of the Hatay earthquake, legal guardians of unaccompanied minors, ethnoreligious minorities and older adult migrants.

MHQoL and accessibility scores varied across recruitment target groups, providing a basis for the descriptive access profiles reported below. Mean MHQoL was highest among older adults and youth, and lowest among older adult migrants and legal guardians of unaccompanied minors. In contrast, accessibility total scores were highest among older adult migrants, older adults and people with physical or intellectual disabilities, and lowest among survivors of the Hatay earthquake. Of note, target populations recruited at ZI (older adult migrants, older adults) had the highest accessibility scores, which may reflect that these people were currently receiving care.

Table 2

Recruitment Target Groups

Recruitment target group (key pilot sites)	n	%	MHQoL M (SD)	Accessibility total M (SD)
Migrants (FISEVI, SEERC)	33	16.3%	13.09 (3.91)	67.80 (8.46)
Older adult migrants (ZI)	10	5.0%	11.30 (3.13)	77.30 (8.56)
Older adults (ZI, SEERC)	20	9.9%	14.50 (4.37)	75.90 (11.92)
Roma community (FISEVI, AMALIPE)	30	14.9%	14.10 (3.04)	66.19 (11.44)
People with physical or intellectual disabilities (LADAPT)	24	11.9%	13.38 (3.37)	73.47 (9.60)
Youth (GIVMED)	22	10.9%	14.41 (3.02)	70.62 (10.15)
LGBTQIA+ community (LGBTI)	21	10.4%	12.10 (3.75)	66.00 (11.43)
Survivors of Hatay earthquake (KU)	20	9.9%	13.80 (3.40)	55.82 (3.11)
Legal guardians of unaccompanied minors (GIVMED)	12	5.9%	11.73 (3.58)	64.03 (10.30)
Ethnoreligious minorities (AMALIPE)	10	5.0%	14.00 (3.77)	64.60 (12.37)

3.2 Participant Characteristics

A total of 202 participants completed the quantitative survey. Table 3 summarises cross-cutting participant characteristics and presents MHQoL and Mental Health Accessibility Score values across these characteristics. The sample included participants across a wide age range, with the largest age group being those aged 25–64 years and smaller proportions of younger people and older adults. A majority of participants identified as female (57.9%), followed by male participants (28.2%), and non-binary (3%), with 22 responses indicating “prefer not to say” or missing. Eight participants indicated their gender was different from their sex at birth. (To differentiate between gender identity and sexual orientation, sexual orientation is indicated by the term LGBQ+ in the quantitative analysis, but the use of LGBTQIA+ refers to both gender identity and sexual orientation.)

The participant profile reflected several dimensions of marginalisation and service need. Migrant participants, participants reporting disability and LGBQ+ participants were all represented, and most participants had previously spoken to a mental health professional or service. In addition, some participants were recruited due to being part of one target population, but also shared demographics with other target populations, for example older adult participants who also disclosed they had a physical disability. Table 3 highlights demographics trends across the sample, beyond demographics of specific pilot sites.

MHQoL varied substantially across the sample, with both poor and very poor MHQoL represented. Descriptively, lower mental health accessibility scores were observed among participants with poor or very poor MHQoL and among LGBQ+ participants. Higher scores were observed among older adults and participants reporting disability. As noted previously, higher scores for older adult may reflect the context of recruitment at ZI, in which these participants were currently receiving care in hospital.

The diary sample consisted of n = 21 participants, with each pilot site gathering a minimum of two diaries. Across sites, all target populations of EQUICARES were represented, with many participants intersecting across several of the target groups (e.g., older adult migrants, LGBTQIA+ migrants, older adults with disabilities). The age range of the diary sample was 18-86, (*M* = 43.84*, SD* = 20.03*),* with 18 participants who identified as female and three participants who identified as male - these included participants who were transgender and identified as female or male.

Table 3 *Survey Sample Characteristics, Mental Health Quality of Life, and Mental Health Accessibility Score*

Characteristic	Category	n (%)	MHQoL M (SD)	Mental Health Accessibility Score M (SD)
Age group	25-64	113 (55.9%)	13.69 (3.48)	64.71 (11.12)
Age group	65+	34 (16.8%)	13.38 (4.10)	73.94 (13.83)
Age group	Under 25	43 (21.3%)	13.49 (3.05)	66.35 (11.59)
Gender	Female	117 (57.9%)	13.87 (3.18)	65.57 (11.85)
Gender	Male	57 (28.2%)	13.49 (3.92)	70.98 (11.02)
Gender	Non-binary	6 (3.0%)	14.17 (2.40)	62.83 (8.47)
Disability	No	137 (67.8%)	13.90 (3.39)	65.51 (12.39)
Disability	Yes	39 (19.3%)	12.77 (3.39)	71.85 (10.37)
Migration background	Migrant	35 (17.3%)	12.06 (4.02)	64.54 (13.38)
Migration background	Non-migrant	144 (71.3%)	13.93 (3.51)	66.40 (12.41)
Sexual orientation	Heterosexual	151 (74.8%)	13.60 (3.58)	67.48 (12.36)
Sexual orientation	LGBQ+	32 (15.8%)	12.56 (3.70)	62.84 (10.57)
MHQoL category	Not poor MHQoL	143 (70.8%)	15.20 (2.32)	68.64 (11.24)

MHQoL category	Poor MHQoL	40 (19.8%)	10.10 (0.81)	61.33 (11.40)
MHQoL category	Very poor MHQoL	18 (8.9%)	6.50 (1.76)	57.17 (15.45)
Spoken to MH professional/service	No	52 (25.7%)	14.17 (3.51)	64.35 (12.61)
Spoken to MH professional/service	Yes	147 (72.8%)	13.15 (3.63)	66.80 (12.24)
MHQoL score	Mean (SD)		13.41 (3.61)	
MHQoL score	Median [min, max]		13.0 [2.0, 21.0]	
Mental Health Accessibility Score	Mean (SD)			66.16 (12.32)
Mental Health Accessibility Score	Median [min, max]			65.0 [32.0, 96.0]

3.3 Quantitative results

Key analyses are included in this section, with supplementary analyses of findings included in Appendix D.

3.3.1 Mental Health Accessibility Score: construction and reliability

The mental health accessibility score was calculated from 20 Levesque-informed survey items, with higher scores indicating greater perceived access to mental health care. Items were grouped into five user-side accessibility domains: ability to perceive, seek, reach, pay and engage with care. The total score showed acceptable internal consistency (α = .71), whereas internal consistency was lower for the five domain indicators (αs = .14–.55). For this reason, the domain-level scores are treated as descriptive Levesque-informed indicators rather than validated subscales. For full information of

domain reliability, see Appendix D. Given the low internal consistency of the individual domains, findings at domain level were interpreted with caution and treated as descriptive indicators rather than standalone validated subscales.

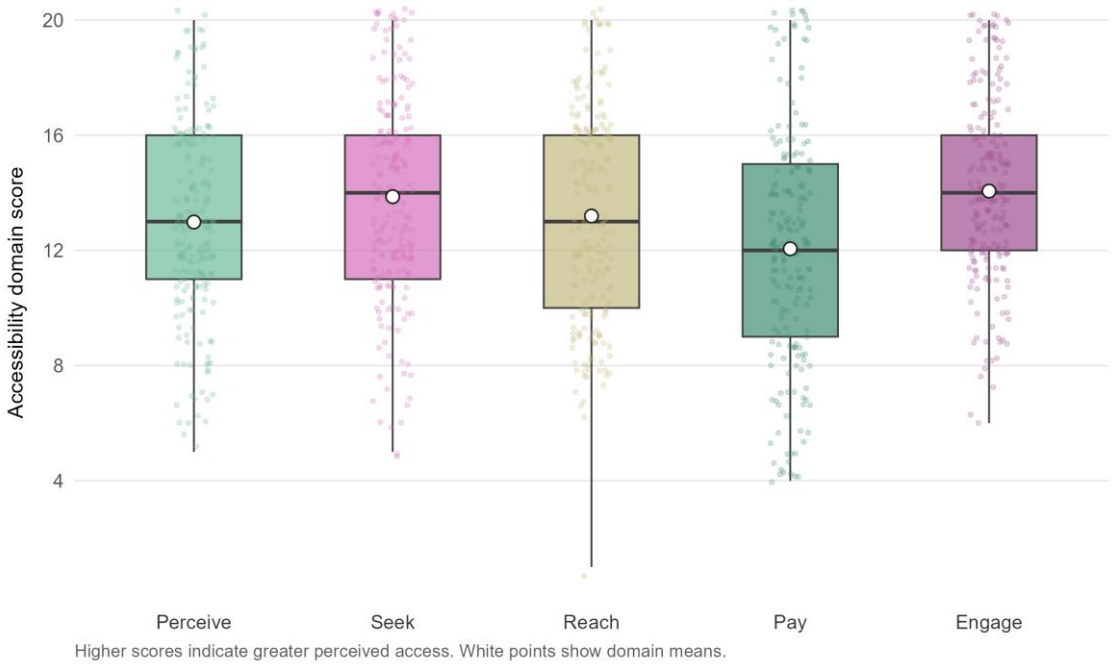
3.3.2 Overall access barriers across domains of access

Figure 6 shows the distribution of perceived access scores across the five Levesque user-side domains. Scores were calculated so that higher scores indicate greater perceived access; lower scores therefore indicate greater barriers to access. The lowest mean score was observed for Pay (M = 12.05, SD = 4.01), followed by Reach (M = 12.60, SD = 2.96) and Perceive (M = 12.99, SD = 3.36). Seek (M = 13.87, SD = 3.57) and Engage (M = 14.06, SD = 3.22) had higher mean scores. The boxplot shows that Pay had both the lowest mean score and the widest interquartile range, suggesting greater variability in affordability-related access across participants and pilot sites.

As an additional within-participant comparison, domain scores differed significantly across the five Levesque domains, $\chi^2(4) = 60.13$, $p < .001$. Pairwise comparisons showed that Pay was significantly lower than Perceive, Seek and Engage, but not significantly different from Reach. Reach was significantly lower than Seek and Engage, but not significantly different from Perceive or Pay.

Figure 6

Distribution of Mental Health Accessibility Scores

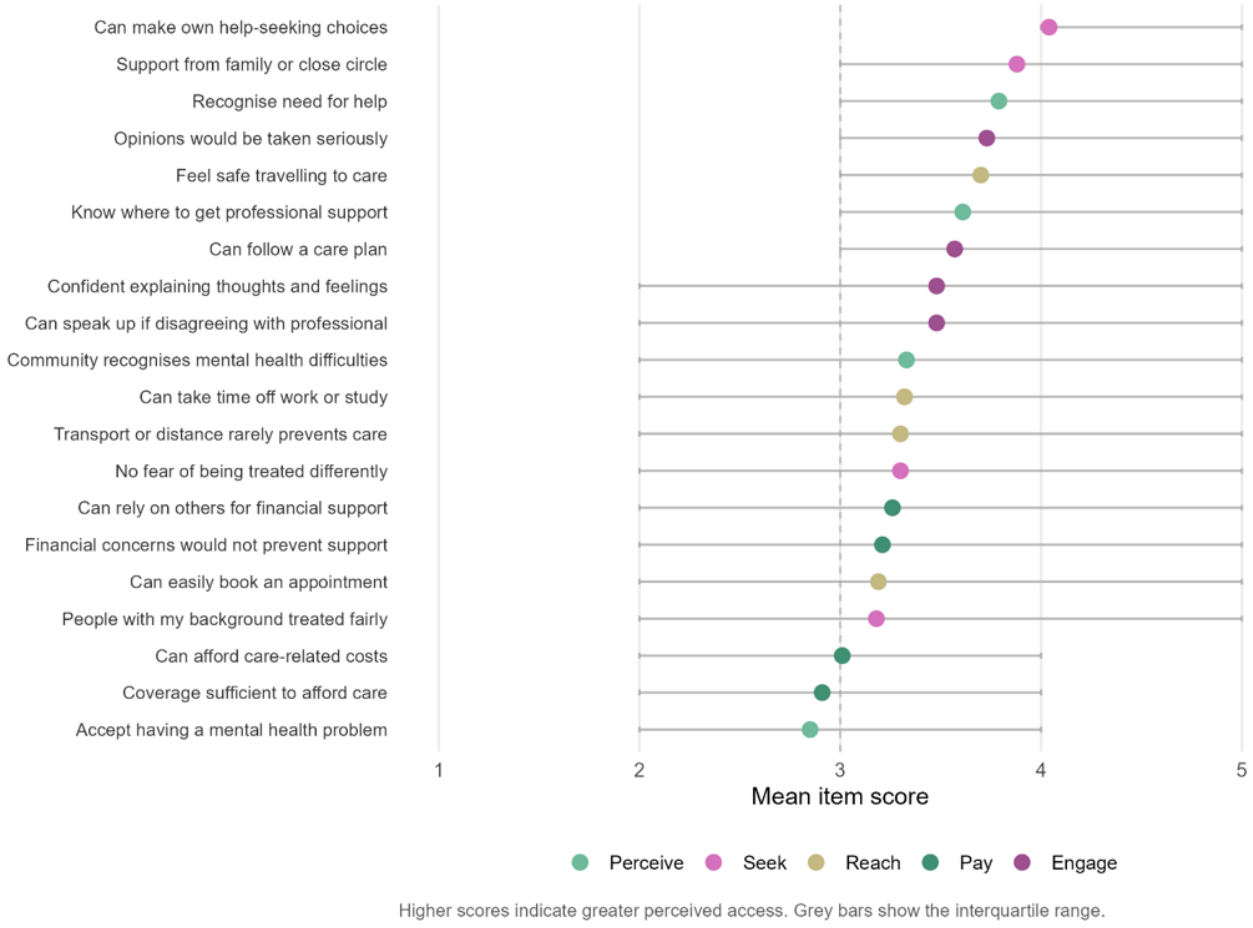


3.3.3 Specific item-level access barriers

Figure 7 provides a more detailed item-level view of these patterns. The lowest-scoring items related to accepting having a mental health problem, affordability and coverage of care-related costs, concerns about fair treatment, and the ability to book appointments. Financial barriers were especially visible, with several affordability items clustered among the lowest-scoring indicators. This indicates that the lower score for the ability to pay domain was not driven by a single item but reflected a broader pattern of concern about the cost of accessing care. The item-level findings also show that access barriers extended beyond cost. Lower scores for accepting a mental health problem, concerns about being treated differently or unfairly, and difficulty booking appointments point to barriers around recognition, stigma, trust and service navigation. In contrast, higher-scoring items related to making one's own help-seeking choices, support from family or close contacts, and recognising the need for help. Overall, the quantitative pattern suggests that participants often recognised the need for care, but perceived access was constrained by affordability, service reachability, stigma-related concerns and confidence in equitable treatment.

Figure 7

Mental Health Accessibility Item-Level Analysis



3.3.4 Patterns of Access across Groups

Figure 8 shows mean mental health accessibility scores by recruitment target group, with standard errors shown around each observed mean. The dashed vertical line represents the overall sample mean. The figure shows clear descriptive variation across target groups. Older adult migrants had the highest mean score (M = 77.3), followed by older adults (M = 75.8) and people with physical or intellectual disabilities (M = 70.8). Youth also scored above the sample mean (M = 68.5). The lowest mean score was observed among survivors of the Hatay earthquake (M = 55.6), indicating substantially lower perceived access than other recruitment target groups. Migrants (M = 61.2), legal guardians of unaccompanied minors (M = 63.6), ethnoreligious minorities (M = 64.6), LGBTQIA+ participants (M = 65.1) and Roma community members (M = 65.2) also had mean scores below or close to the sample mean. These target-group differences are interpreted descriptively and indicate where perceived access appeared more constrained in the quantitative sample.

Additional detail is provided by a heatmaps (see Table D4 – Appendix D) by showing how access profiles differed across the five domains for each recruitment population. These patterns indicate that lower total scores were not always driven by the same type of barrier. Survivors of the Hatay earthquake showed the lowest overall domain profile, with especially low scores for Reach, suggesting that practical barriers to reaching, arranging or physically accessing care were prominent for this group. Legal guardians of unaccompanied minors and LGBQ+ participants showed particularly low Pay scores, indicating that affordability was a more prominent domain-specific barrier. Pay scores were also relatively low among Roma community members and migrants, suggesting that financial constraints were not confined to one recruitment population. Other groups showed different profiles. Older adults and older adult migrants generally had higher scores across several domains, particularly Seek and Engage, while people with physical or intellectual disabilities showed relatively high Reach and Pay scores but a lower Engage score than some other higher-scoring groups. Ethnoreligious minorities showed lower Perceive and Seek scores than their Pay score, pointing more towards recognition, stigma or trust-related barriers than affordability alone. Overall, the heatmap suggests that target groups in vulnerable situations differed not only in the overall level of perceived access, but also in the specific domains where access appeared most constrained.

Figure 8

Total Mental Health Access by EQUICARES Target Groups

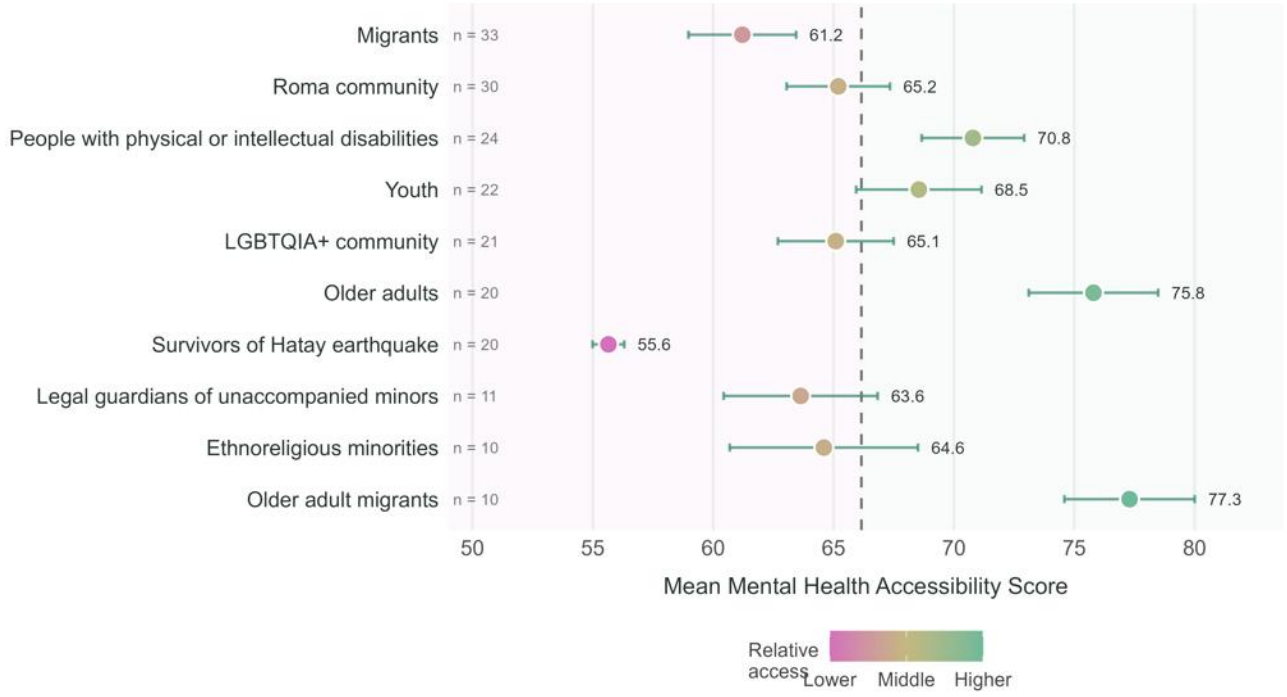
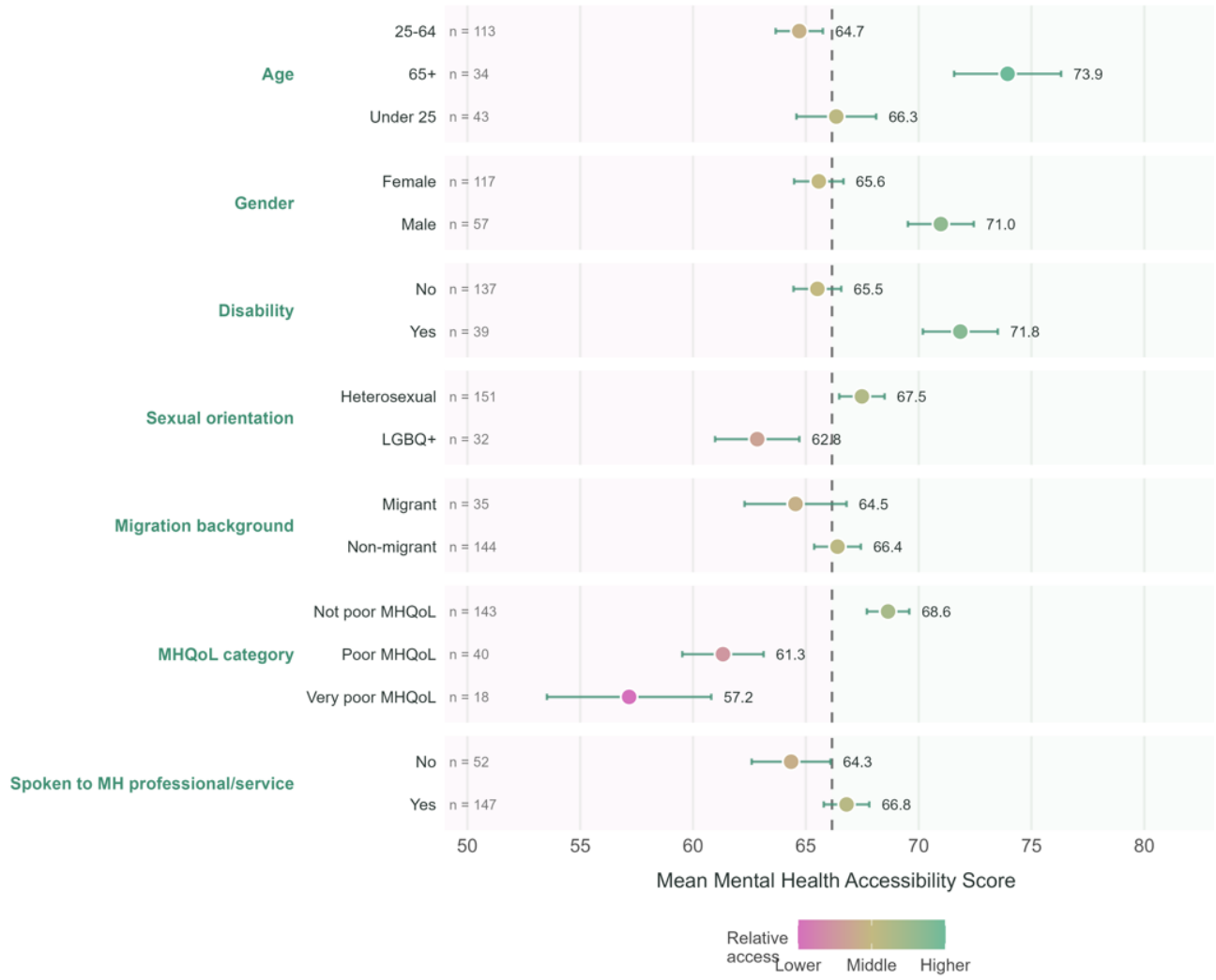


Figure 9 shows mean mental health accessibility scores across cross-cutting participant characteristics, with standard errors shown around each observed mean. The clearest descriptive pattern was observed by MHQoL category. Participants with not poor MHQoL had a higher mean score (M = 68.6) than those with poor MHQoL (M = 61.3) or very poor MHQoL (M = 57.2), indicating that poorer mental health-related quality of life was associated with lower perceived access. Differences were also visible by age, gender and disability status: participants aged 65 years and older had higher scores than younger age groups, men scored higher than women, and participants reporting disability scored higher than those not reporting disability.

Domain-level detail is provided in a supplementary heatmap (see Table D5 – Appendix D) for these participant-characteristic patterns. It shows that lower total scores among participants with poor or very poor MHQoL were reflected across several access domains, rather than being limited to one domain. LGBQ+ participants also showed lower scores in several domains, with ability to pay standing out as a particular constraint. Across participant characteristics, the ability to pay remained one of the more consistently constrained domains, supporting the broader finding that affordability was a recurring access barrier. The heatmap therefore helps explain the total-score patterns by showing which dimensions of access contributed most strongly to lower perceived access for different participant groups

Figure 9

Total Mental Health Access by Subgroups



3.3.5 Associations within Mental Healthcare Access

A supplementary exploratory linear regression was conducted to examine adjusted associations with Mental health accessibility total score. The model included 131 participants after excluding the non-binary gender subgroup from adjusted modelling because of small cell size. The overall model was statistically significant, $F(8, 122) = 7.54$, $p < .001$, explaining 33.1% of the variance in accessibility total scores, adjusted $R^2 = .287$. In the adjusted model, participants aged 65 years or older reported higher accessibility scores than those aged 25–64 years, B = 9.11, 95% CI [4.59, 13.62], $p < .001$. Men reported higher accessibility scores than women, B = 6.85, 95% CI [2.90, 10.80], $p < .001$.

Participants reporting disability also had higher accessibility scores than those not reporting disability, B = 4.96, 95% CI [0.60, 9.32], p = .026. Poor MHQoL was associated with lower accessibility scores, B = -6.70, 95% CI [-10.92, -2.48], p = .002. Age under 25, sexual orientation, migration background and previous contact with a mental health professional or service were not statistically significant in the adjusted model. Full details are available in Appendix D.

3.2.6 Summary

Overall, the quantitative findings suggest that barriers to mental health care were distributed across several stages of the access process, rather than reflecting a single access problem.

- Ability to pay emerged as the most consistently constrained area of access, reflecting concerns about service costs, coverage and care-related financial barriers.
- Practical barriers were also evident, particularly in relation to reaching or arranging care, including transport, time, distance and booking appointments.
- Barriers were not limited to financial or practical issues. Item-level findings also indicated difficulties recognising or accepting mental health need, concerns about stigma or unfair treatment, and challenges navigating services.
- Descriptive differences were observed across groups. Survivors of the Hatay earthquake showed lower overall perceived access, particularly for the ability to reach, while legal guardians of unaccompanied minors and LGBTQIA+ participants showed lower percieved ability to pay scores.
- Lower perceived access was also observed among participants with poor or very poor MHQoL and among LGBQ+ participants, suggesting that poorer mental health-related quality of life may coincide with greater difficulty accessing support.

Overall, the findings provide descriptive indicators of where access barriers appeared more pronounced within this sample and provide a basis for the qualitative analysis to explore how financial, practical, recognition-related, stigma-related and service-navigation barriers are experienced across different contexts.

3.4 Framework Analysis

For the Framework Analysis, open-ended text responses from the survey were analysed. One question was included for each demand-side domain of the Levesque framework (ability to perceive, seek, reach, pay for, engage with care). Findings are presented across paired supply-side and demand-side dimensions, allowing barriers and facilitators to be understood at the interface between

service provision and service-user capacity. The most commonly reported barriers and facilitators are included below, with reference to the number of participants citing each issue.

3.4.1 Dimensions of Access

At the stage of indexing (coding) in the framework analysis, responses were often better reflected by supply-side barriers (e.g, where responses referred to direct costs or opening hours of services) or other user-side domains across responses (e.g., raising anxieties around their ability to pay, in response to questions about the ability to seek care). To address these issues, coding was first conducted on responses within the domain that was asked (e.g., responses that addressed health literacy in response to questions on the ability to perceive a mental healthcare need). Additional coding took place to categorise responses into the wider Levesque framework when broader responses were shared by participants.

3.4.1.1 Ability to Perceive and Approachability

When asked about the ability to perceive, participants commonly discussed mental health literacy (i.e., recognising that their mental health was impacting their daily life), whereby arising difficulties were identified as indicators of a need to access mental healthcare (reported by *n*=153 participants):

> *"A sense of hopelessness is always a key indicator for me to check in with my therapist."* (LGBTQIA+ Participant)

Trust in and expectations of services (*n*=25), as well as individual health beliefs (*n*=17), also shaped how participants accessed care:

> "*Often the fear of engaging with a professional who is transphobic. I always try and find professionals who are demonstrably LGBTQI+ inclusive but even then I worry that I will have to spend a lot of time teaching them about being trans rather than focusing on my mental health needs.*" (LGBTQIA+ Participant)

3.4.1.2 Ability to Seek and Acceptability

For acceptability, professional values (*n*=19) were the most frequently identified influence on help-seeking (e.g. professional knowledge of LGBTQIA+ issues or feeling judged, while awareness within services of culture (*n*=5), the role of gender (*n*=3), and social norms (*n*=3) were also noted, although from fewer participants:

> "*The judgment of some healthcare professionals who make certain statements without knowing everything."* (Person with disability)

Regarding ability to seek, personal and social values (*n*=39) were most frequently reported, particularly in relation to stigma around mental health and help-seeking, followed by having culturally sensitive care (*n*=14) and having autonomy in their own healthcare decision-making (n=6):

> *"The doctor's approach towards me was very positive. I had gone with preconceived notions. I was very well received. Knowing that I was truly understood, being able to express myself, those things were good."* (Survivor of Earthquake)

3.4.1.3 Ability to reach and Availability and Accommodation

Participants reported mostly general barriers relating to availability and accommodation such as waiting times or scheduling options (*n*=24):

> *"Appointment times are not always suitable...the wait can be long."* (Person with Disability)

Other barriers such as opening hours (*n*=17) and the geographic location of services (*n*=9) were also highlighted. Similarly, participants described mostly general barriers (n=23) associated with ability to reach (e.g. finding the time). Additional barriers identified included transport difficulties when attending services and appointments (n=37), challenges around their own living environments (n=10), and having insufficient social support to access mental health services (n=8). These overlapping dimensions highlight the logistical and practical challenges that participants experienced when accessing care:

> *"Public transport (bus) hours are incompatible, the route is not suitable, buses are very rare, there are no private vehicles".* (Survivor of Earthquake)

3.4.1.4 Ability to Pay and Affordability

Within the affordability dimension, the direct financial costs of accessing mental healthcare were the most frequently reported issue including the cost of transport (*n*=31), followed by broader affordability concerns (*n*=5):

> *"Cost is a huge factor to accessing help - I often have to cancel an appointment once a month as I don't have the funds to pay for weekly appointments."* (LGBTQIA+ Participant)

For ability to pay, personal income represented the most prevalent barrier (*n*=30), followed by general financial difficulties (*n*=21) and concerns around health insurance coverage (*n*=9). As both dimensions overlap, this suggests persistent financial barriers can impact access and ongoing engagement with mental healthcare:

> *"I'm considering stopping paying for private appointments with my psychologist because it's a considerable amount of money."* (Migrant)

3.4.1.5 Ability to Engage and Appropriateness

In relation to appropriateness, participants most commonly described the interpersonal quality of care (*n*=22), followed by adequacy of services to meet participant needs (*n*=19):

> *"The first psychologist she met laughed at what she said. She felt terrible and ended her consultations with that person. She then worked with another psychologist she liked, found their approach good, but eventually stopped when the techniques became tiring."* (Survivor of Earthquake)

The technical quality of the care provided (*n*=11), coordination and continuity of care within healthcare services (*n*=11), and more general concerns such as finding the right therapist (*n*=11) were reported consistently by participants. These findings also overlap with the dimension of acceptability, further emphasising the importance of positive interpersonal relationships in accessing and engaging with mental healthcare. Regarding ability to engage, participants most frequently noted general engagement indicators such as having a positive experience with a provider (*n*=64), alongside feeling empowered in managing their own healthcare decision (*n*=26), having access to information to make informed decisions (*n*=14), and adhering to care provided (*n*=13):

> *"I am glad I have had access to these experiences as it pushes me to find a therapy that works better for me."* (LGBTQIA+ Participant)

3.4.2 Summary

The most commonly reported barriers from open-text responses included:

- Fears around the ability to trust service providers (ability to perceive)
- Personal and social values, especially relating to mental health stigma (ability to seek & acceptability)
- Difficulties with transport, waiting times, opening hours (ability to reach & availability/accommodation)
- Cost of services, cost of transport, and low personal income (ability to pay & affordability)

Facilitators cited by participants included:

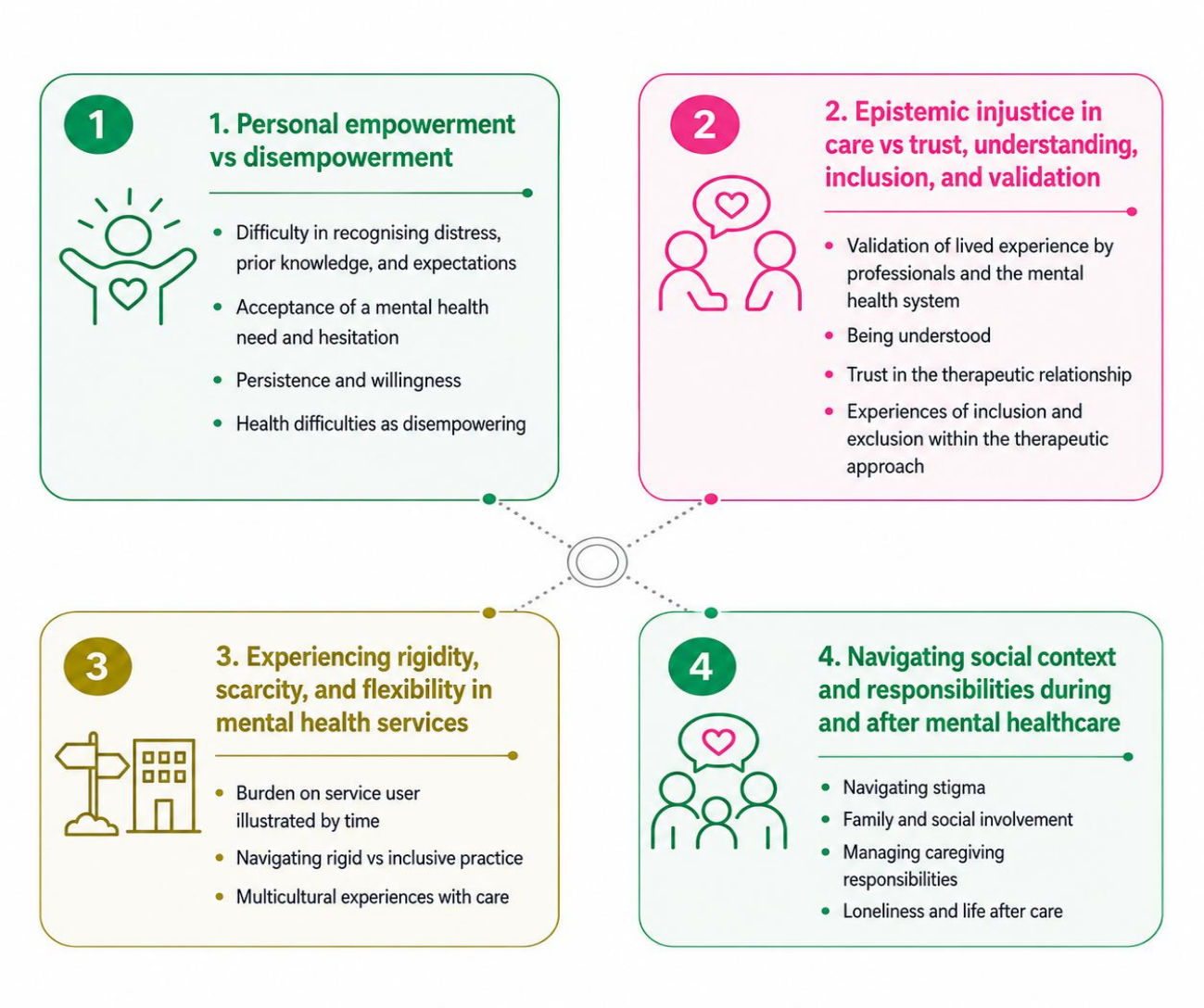
- Mental health literacy, particularly in knowing when to seek help based on feelings of distress (ability to perceive)
- Personal empowerment in care, positive experiences previously with care, and positive interpersonal relationships with staff (ability to engage & appropriateness)

3.5 Interpretative Phenomenological Analysis

Diary data were analysed using IPA (Smith et al., 2009) to understand the lived experience of the participant regarding the ability to engage with mental health services. Four themes were generated from the analysis; (1) Personal empowerment vs disempowerment (identified in the accounts 18 of 21 participants), (2) Epistemic injustice in care vs trust, understanding, inclusion, and validation (noted in 20/21 participant accounts), (3) Experiencing rigidity, scarcity, and flexibility in mental health services (19/21 accounts), and (4) Navigating social context and responsibilities during and after mental healthcare (15/21 accounts). A summary of themes is provided in Figure 10.

Figure 10

Summary of Themes from IPA



3.5.1 Theme 1: Personal empowerment vs disempowerment

Participants highlighted how factors affected their engagement with the therapeutic process on a personal level, especially relating to their own psychological traits, motivation, prior knowledge, and existing health difficulties. Collectively, these factors either promoted the sense of agency of the participants or contributed to a loss of agency when help-seeking and engaging with care. Although some aspects of barriers to help-seeking were attributed to a lack of knowledge on behalf of the participant, help-seeking was also identified as an emotionally charged experience. There was an inherent difficulty for participants in recognising their own distress as a mental health issue, and the ability to accept a need for care.

3.5.1.1 Difficulty in recognising distress, prior knowledge, and expectations

Challenges with recognising one's own psychological distress, along with low levels of information about mental health and care were disempowering for participants, contributing to delayed help-seeking or access to appropriate services. Particularly for mental health difficulties that presented with somatic symptoms (e.g., panic attacks), low mental health literacy alongside a lack of acceptance of the issue as a mental health difficulty impacted on the type of care sought, and relying on doctors to realise that mental healthcare was needed. Low mental health literacy was illustrated by the sense that the participant had to "learn" that their difficulties related to anxiety, rather than having the prior knowledge about mental health:

> *"For almost six or seven months, I had to keep going to hospitals, getting IV drips and various treatments, trying to understand what kind of illness might be causing what I was going through ... I had become very weak, I could hardly eat, and I constantly had heart palpitations ... I only learned later, after seeing the doctor, that what I had experienced was a panic attack and that my anxiety level was very high."* (Survivor of Earthquake)

Conversely, prior knowledge of mental health services was empowering for participants to support their engagement. Several participants either worked in the field of mental health, or knew mental health professionals personally who could provide recommendations for care, facilitating their ability to seek care swiftly:

> *"It was easy, as I am in the field; I asked a psychologist I know well and like, and she gave me some recommendations."* (Migrant)

When considering care, participants typically had poor expectations of the provision of care in the public mental health system, often stemming from previous negative experiences with care. In addition, participants expected private mental healthcare to be more person-centred, and were surprised when they experienced empathic care from staff in the public system:

> *"You might expect that level of care from a private professional you are paying, but I was especially surprised to find such empathy among general practitioners in the public system."* (Member of Roma Community)

3.5.1.2 Acceptance of a mental health need and hesitation

Hesitancy to seek help was present in many participants, also relating to low levels of information of mental healthcare, and underpinned by fear of accepting a mental health need:

> *"I used to have no idea what to expect and was also afraid of it."* (Older Adult)

Acceptance and questioning the mental health difficulty was an issue contributing to hesitancy. Participants wondered if their difficulty was significant enough to meet the threshold for seeking help, and were hesitant to accept that they had a need to access services. This raised questions around, the legitimacy of their reasons to seek help, as well as emotional resistance towards acknowledging the existence of a mental health difficulty, suggested by the need to "confess" to themselves of a mental health need:

> *"The first difficulty was my own concern whether I need it and whether I should use such a service because it would mean that I confess to myself that I needed help."* (Member of Roma Community)

Relatedly, for younger participants, delayed help-seeking also related to the hesitation of their parents to accept that they were experiencing a mental health difficulty, influenced by stigma in their wider community. This again led to participants seeking help for physical symptoms, as they did not want to accept the presence of a mental health difficulty:

> *"I remember it took me a very long time to ask for help... At first, we attributed it to dizziness, low blood pressure, or vision problems. I saw several professionals because my mother did not want to accept that it could be a mental health issue — it is the last thing you want to consider."* (Member of Roma Community)

Hesitation was typically discussed around paralysis in choosing to seek mental healthcare, due to struggles in accepting the nature of the mental health difficulty and working through fears of seeking care. However, for participants who entered mental healthcare through emergency departments, the element of "choice" was removed, reflecting a potential loss of agency during severe episodes of mental health difficulties. In these cases, there was reliance on the people around them to initiate access:

> *"The emergency medical services took me to the surgery department first and then to this hospital; I didn't have to choose the hospital myself."* (Older Adult)

> *"I was taken by the ambulance service that my neighbours had called"* (Older Adult Migrant)

3.5.1.3 Persistence and willingness

While some participants spoke about hesitation to seek help, others spoke about a desperation to access care. Participants demonstrated perseverance in their continuous efforts at seeking care, navigating multiple attempts to find a mental health professional, and persisted until they found a

professional that was suitable. This included finding professionals through online searches and by leveraging their personal network of contacts:

> *"At that moment, I was so unwell that I started calling random numbers. I Googled "psychiatrists" and just started dialling."* (Migrant)

> *"I asked a psychiatrist friend for three names. I went to all three."* (Older Adult)

The engagement with therapeutic mental healthcare was also recognised as a process that was challenging, requiring discipline, persistence, and willingness to continue until progress is made. This highlighted the demanding nature of therapy:

> *"The process itself is demanding. Sometimes when I felt emotionally tired, I may have thought about limiting it or even stopping it. However, I think this may have been my own resistance"* (Young Person Under 25)

> *"The person involved receiving care [has] to accept the therapist and above all to be willing to heal"* (Older Adult)

Participants also spoke about the willingness to participate in the context of opening up emotionally to the therapist. This involved hard work to overcome personal defence mechanisms and gradually sharing more with the therapist over time in order to make progress, despite the potential discomfort in opening up:

> *"It took me a while to feel comfortable. From what I saw, I thought I was opening up pretty quickly, but over time I realized that, in the end, I was the one who didn't share so much at first, compared to now."* (Migrant)

3.5.1.4 Health difficulties as disempowering

The nature of mental, cognitive, and physical health difficulties were viewed as inherently disempowering for the participants, affecting their ability to engage with care. For mental health difficulties, participants demonstrated a loss of agency control when experiencing severe difficulties such as self-harm, illustrated by participants feeling powerless in the moment:

> *"Over time, I began to feel as if I had fallen into a swamp. In a way I couldn't understand and don't remember when it started, I began to harm myself."* (Survivor of Earthquake)

In addition, comorbid health conditions – particularly in older adult participants and participants with disabilities – added to the sense of disempowerment. This affected the ability to care for themselves while engaging with mental healthcare or dealing with mental health difficulties:

> *"Due to worsening forgetfulness in everyday life and physical condition, it is becoming increasingly difficult to take care of myself, including my mental health"* (Older Adult Migrant)

3.5.2 Theme 2: Epistemic injustice in care vs trust, understanding, inclusion, and validation

Participants emphasised the relational elements of their engagement with care, both in terms of working with the care provider and in the direct relationship with their mental health professional. Negative accounts emphasised *epistemic injustice* in which the service user's capacity was belittled and their voice was undermined in favour of the perspective of the professionals, reflecting an uneven power dynamic in care. In contrast, positive accounts highlighted a sense of being believed, feeling understood, and an ability to trust professionals.

3.5.2.1 Validation of lived experience by professionals and the mental health system

Contrasting experiences were highlighted by participants indicating a mixture of being believed and taken seriously versus having experiences invalidated by mental health professionals. Epistemic injustice was reflected in how participants felt invalidated when their concerns were not treated as legitimate by professionals:

> *"I received support from different counsellors. Yes, some of them were very satisfying and truly helped me feel better, while others made me feel very bad, as if I were creating major problems out of the smallest things. But kind people, with kind advice, truly helped correct that"* (Survivor of Earthquake)

> *"If I had been understood during this process, if what I said had been listened to, if it had been respected, and if even a small amount of empathy had been shown, perhaps my treatment would have progressed much faster and I could have taken stronger steps forward."* (Survivor of Earthquake)

Invalidation related to the care system as a whole, and not only as a negative feature of the therapeutic relationship, indicating the role of the system as an authority which judged the legitimacy of the service user's experience. Examples of epistemic injustice were especially cited by participants who were transgender or who experienced gender dysphoria. This included administrative difficulties in accommodating changes to their name, insensitive questioning, and power dynamics relating

to diagnosis in which the opinion of professionals were treated as superior to the voice of the service user:

> *"in the public healthcare system … I experienced poor treatment from everyone. [My] health card is under [my previous name], and at the health centre, if they ask me, "Let me see your ID," and I show it to them, I do not appear in the system."* (LGBTQIA+ Migrant)

> *"My initial assessment was a 3-hour interrogation where I was asked invasive sexual questions … questions completely unrelated to my gender or medical care."* (LGBTQIA+ Participant)

> *"They had their diagnosis. They thought they were right."* (LGBTQIA+ participant)

These experiences of epistemic injustice and invalidation contributed to long-lasting feelings of fear, anger and hopelessness towards the public mental health system:

> *"I now struggle with fear, anger, and self-esteem. Fear that I could have my healthcare stripped at any time for arbitrary reasons. Anger at the clinic and what I was put through by the psychiatrists - what they continue to subject trans people to."* (LGBTQIA+ participant)

In contrast, positive experiences with validation helped participants to understand the complexity of their distress within their context, reaffirming that their lived experience mattered and would be taken seriously by the service. This supported them to continue their engagement with mental healthcare:

> *"I told her what was wrong and the psychologist understood perfectly… Although I usually suffer from nervousness and anxiety, the psychologist recognized that my current problem was purely my father's death."* (Member of Roma Community)

> *"Since the beginning I felt my opinions and goals were taken seriously … I've always been taken seriously, that's for sure"* (Person with Disability)

3.5.2.2 Being understood

A sense of feeling understood was central to positive experiences with care. Participants shared that they would continue seeking different professionals until they found a professional who felt they could be understood. This included seeking professionals from similar cultural backgrounds, whose empathic approach aligned with their preferences:

"I kept changing professionals until I found a psychologist who understood me a bit better—and she's also Argentine. Because here … I don't know, they're very straight to the point … I might need a little more warmth" - (Migrant)

Feeling understood helped participants to feel safe in therapy, facilitating them to open up about their difficulties. In addition, being understood was cited when participants were asked to describe an ideal experience with mental healthcare:

"They showed understanding and respect and gave me space to express myself freely about what troubles me. This made me feel safe in the communication I had with them." (Young Person Under 25)

"To be understood, to have someone understand you, to receive the follow-up you need, for them to recognize the need you have at that moment, not to focus on your appearance, but instead, as a professional, to really see what is going on and help you." (LGBTQIA+ Migrant)

3.5.2.3 Trust in the therapeutic relationship

The role of developing trust with the mental health professional outlined the relational nature of therapy, whereby participants felt they needed to be open to trusting the mental health professional, and professionals needed to earn the trust of the participants. Several participants highlighted that it took time for them to trust the professional, slowly building up a sense of comfort in order to share their experience openly:

"[At the beginning] I didn't feel I could trust them, I didn't want to talk or share much. I was speaking cautiously. However, as they spoke to me and gradually guided my path, I began to trust them. I was able to speak more comfortably. I believe that the trust I feel toward the therapist is influenced by the therapist's understanding, approach, and the way they communicate with me" (Survivor of Earthquake)

"In the beginning I didn't trust them, I needed time to trust ... but after that I saw their support and understanding... then I felt good and I gave them my full trust" (Member of Ethnoreligious Minority)

Participants also appreciated when professionals were personable and friendly with them and prioritised relational quality over expertise. This helped to ensure power dynamics were not overwhelming in session, that equal legitimacy was given to the views of the service user and professional, minimising the potential for epistemic injustice to arise in the relationship. This allowed

for the development of a positive therapeutic relationship, facilitating greater openness from the participants:

> *"My doctor's manner: we established a good relationship right away. He was very approachable, not "official," and understanding."* (Older Adult Migrant)

> *"Rather than behaving like a distant, serious psychologist, they listened to me, understood me, and supported me more like a friend. Because of that, I approached them with complete openness… I approached them in an open, comfortable, and warm way, because they treated me in the same way."* (Survivor of Earthquake)

However, participants also spoke of mistrust of professionals, particularly following negative experiences in which their views were not heard or respected, and experienced insensitivity from staff, again echoing concerns around epistemic injustice. This was especially raised in relation to psychiatrists around gender-affirming care, in which participants highlighted frustrating and invalidating experiences with staff:

> *"I do not trust the mental health professionals who "supported" me. I have had to deal with multiple psychiatrists in order to access gender-affirming care, and they have been incredibly offensive"* (LGBTQIA+ participant)

3.5.2.4 Experiences of inclusion and exclusion within the therapeutic approach

Participants showed a preference for shared-decision making during their care journey. Positive experiences emphasised inclusion, collaboration, and a sense of respect for the participant's views during their engagement with care:

> *"When I was listened to, when I was asked for my opinions and included in the process of finding solutions, and when we made plans together, I felt included and respected. I truly saw how important the support I received was in guiding my life and how it helped me live a better-quality life."* (Survivor of Earthquake)

However, several examples were given where participants were dissatisfied with the therapeutic approach, typically when they felt their views were not accounted for. This arose in decisions around treatment goals and tasks over the course of therapy:

> *"The psychiatrists acted in direct opposition to my opinions at every stage of my "treatment". My goals were not just ignored, but actively fought against."* (LGBTQIA+ Participant)

"The therapist focused heavily on theory and techniques ... When I had a panic attack, she would focus on how to manage it, but I already knew the theory perfectly. I wanted to go deeper, to work on the root causes." (Member of Roma Community)

3.5.3 Theme 3: Experiencing rigidity, scarcity, and flexibility in mental health services

Participants shared accounts of structural challenges and facilitators they faced when engaging with services. Contrasting accounts were given of experiences with public and private systems, as well as non-governmental organisations (NGOs). Participants explained the time burden involved in their engagement with care, examples of a rigid versus inclusive scope of practice, the implications of scarcity in mental health systems on their experiences, and how services managed multicultural factors during their engagement.

3.5.3.1 Burden on service user illustrated by time

Participants often demonstrated their frustrations with the care experience by outlining the time demands placed on them when engaging with services. Waiting lists in particular were highlighted as a systemic problem in mental healthcare, with participants needing to endure both the wait for services and the burden of self-management of mental health difficulties such as insomnia in the absence of timely care:

"I was experiencing such severe anxiety that I hadn't slept for four days … [The professional] said: well, if you have private insurance, go through private care, because here you'll wait at least six months before being seen. I thought, how on earth am I supposed to last six months without sleeping and with my head the way it is?" (Migrant)

"Extensive waiting lists are also a huge barrier for patients. When I was referred, the waiting list was roughly 1 year long." (LGBTQIA+ Participant)

Additionally, the time burden was outlined in relation to the time to travel to services, waiting between sessions, and delays to services on the days of appointments:

"It takes me roughly 4 hours to reach the clinic, and another 4 hours to return… In addition, the clinic is typically running late, and I will sometimes be left waiting for up to 2 hours. I am required to attend every 6 months or lose access to my medication." (LGBTQIA+ Participant)

In contrast, ease of access was highlighted by proximity to services, including sessions provided at the home of the service user, or within residential services provided by NGOs:

"I was able to access everything very easily. There was no cost, and the sessions were held where we lived." (Survivor of Earthquake)

3.5.3.2 Navigating rigid vs inclusive practice

Participants had engaged with different types of care, with varied perspectives how structural factors affected their experiences. The scope of practice for suicidality, for example, caused issues for participants who felt the need to downplay the severity of their difficulties to continue receiving care. However, at emergency departments, where there was openness to all presentations, irrespective of severity of complexity, participants shared their sense of validation:

"I have learned to lie to doctors [about suicidality] because being truthful would get me kicked out. I tell them what they want to hear and nothing else." (LGBTQIA+ Participant)

"I always received help when I needed it, both from the nursing staff and from doctors [at the emergency department], for example in the form of conversations and psychotherapy on the ward. It was very important to me that my physical illnesses were also taken seriously." (Older Adult)

Participants were highly critical of public mental health systems and of psychiatry, due to a perceived emphasis on medication over the provision of psychological care. Scarcity within the public mental health system was also positioned in terms of short appointment times, along with a lack of appointments for the participant to talk about their mental health in depth when participants wanted to open up to professionals:

"I believe there is a tendency to turn quickly to medication … that pharmacological treatment is sometimes prioritized over other therapeutic alternatives." (Member of Roma Community)

"They should be more willing to understand the person, listen without constantly questioning why or rushing through the conversation. When you are trying to express yourself and you feel that the other person is constantly racing against time, it affects you in a different way and is honestly very uncomfortable." (Survivor of Earthquake)

The scarcity within the public system was compared to the more flexible availability of private systems, which could often provide sessions sooner to the participant. However, the drawback of private services was the cost, highlighted as the largest access barrier for participants. This occasionally created situations in which participants needed to increase the time between private sessions in order to afford their engagement with the service:

"A lot of the time, they make you feel like you're just another number—especially in the public system, where it's like: I don't have time, you only get 15 minutes, and in 15 minutes, what can I really tell you about my life? … So there isn't that closeness; it's just not allowed to happen. Of course, if you pay for a private doctor who costs 120 euros, then it's different." (Migrant)

"In private practice, there is more flexibility, but the cost forces sessions to be spaced out." (Member of Roma Community)

NGOs, where they were available to participants, provided relief which combined the flexibility offered typically seen in private services, with low cost or free service provision that would typically be offered by the public system. Participants had positive experiences with NGOs providing mental healthcare, emphasising their ability to choose a therapist, feeling welcome at services, and affordability:

"I had heard about [an NGO], which does psychotherapy ... And so I was able to choose from a menu of psychotherapists who I would like to see… I chose a psychotherapist who deals with LGBT issues." (LGBTQIA+ Participant)

"At the NGO, it was absolutely wonderful. The way they welcomed me was incredibly positive for me. I already completed the program with them — it lasted 18 months — and it was an excellent service for me." (LGBTQIA+ Migrant)

"In terms of cost, seeing the NGO psychologist … was free for me. And the appointments… it depends, it depends on how much I need them. If I really need them, then I have them every week, or every two weeks, depending on how she [the psychologist] sees me progressing." - (LGBTQIA+ Migrant)

3.5.3.3 Multicultural experiences with care

Participants from migrant and Roma backgrounds shared about experiences of racism and prejudice in mental healthcare, impacting negatively on their engagement. Direct experiences of racism were shared, relating to preferential treatment of the native population over migrants in appointment times:

"When I walked in, I heard the doctor ask the nurse, very clearly: "Why are you letting her in first?" The nurse replied, "Because it's her appointment time." And he said, "But she's a foreigner; she shouldn't have been called first. She should be the last one." I was shocked." (Migrant)

Other examples of racism and prejudice were shared in a qualified manner, in which a migrant participant also noted poor treatment of locals when explaining her own experience, and where a participant spoke about negative assumptions and expectations of people in the Roma community:

> *"I have come across people who were xenophobic, even racist… that is something very hurtful. But we do not make too much of it because, well, we are in a foreign country, fighting for our goals, and we are doing okay here. Although I do not think having Spanish nationality makes much difference, because I have also seen doctors treat local people badly." (LGBTQIA+ Migrant)*

> *"In professional settings, I have never felt directly stigmatized for being Roma… I also believe there are sometimes prejudices toward Roma women. Certain assumptions may be made about sexism, parenting, or family dynamics without truly listening to the individual experience. For example, it may be assumed that the husband is abusive or that the woman wants to leave her neighbourhood, without giving her space to express her own reality."* (Member of Roma Community)

Language was also a key issue in the experience of migrants engaging with mental healthcare. Migrant participants showed surprise when they had experiences with professionals who could speak their native language, indicating that this was rare occurrence. In addition, the need for interpreters was raised in the context of care for unaccompanied minors, where sessions typically would not take place unless an interpreter could join:

> *"We didn't know that there were Russian-speaking psychiatrists, so it was very fortunate that we happened to meet one in the emergency room."* (Older Adult Migrant)

> [Question: *What could have made it easier for you to stay engaged with support from a mental health professional?]* Participant: *"Having an interpreter available regularly"* (Guardian of Unaccompanied Minor)

3.5.4 Theme 4: Navigating social context and responsibilities during and after mental healthcare

Outside of healthcare services, several factors also affected participants' ability to engage with care, largely relating to their social and family context. Some participants noted the prevalence of stigma in their communities and immediately family context, whilst others highlighted the positive role of their family supporting their engagement and providing emotional support. The role of caregiving

was also explored by participants as a challenge when accessing care, and participants shared concerns around exiting mental health services.

3.5.4.1 Navigating stigma

Participants noted the stigma of seeking mental healthcare, particularly through the use of the word "crazy", which indicated a reluctance to accept the need for care and a fearing the opinions of others socially. Accessing psychiatric care and using medication was particularly stigmatised, as opposed to accessing psychosocial care, for which some participants showed more openness. One participant noted that they influenced to stop taking medication due to the stigma around medication in their social circle:

> *"Going to see a psychologist … it's the first step because sometimes there are preconceived ideas already, sometimes people associate "psy" with "psychiatrist," "psychiatrist means you're crazy," but... whereas here, well, it's a psychologist, and actually, one day, just like that, if I'm offered, I'll go see what it gives, what it brings me."* (Person with disability)

> *"They would ask how long I was going to take medication, tell me to try to get better on my own, say that there was actually nothing wrong with me and that if I said I was fine I would be fine, or that taking so much medication was harmful. Because of all this, there were times when I stopped taking medication and stopped receiving support."* (Survivor of Earthquake)

Participants also emphasised the differences between themselves and their social context in the willingness to seek help. Being understood again stood out as a desire for the participants as they sought care, which was hindered by a lack of understanding in their immediate family and social context:

> *"All I wanted was to be understood and for this situation to be respected. The process itself was already exhausting and draining, but what was even more difficult was people's attitudes, being treated as if I were crazy and not being understood. That was the hardest part."* (Survivor of Earthquake)

> *"Although I have personally prioritized investing in therapy, many people — including members of my family — do not see it as a priority."* (Member of Roma Community)

3.5.4.2 Family and social involvement

Participants also shared the positive role of their families and social support networks in helping them to access care, as well as providing emotional support during their engagement with services. This

included the support of parents, siblings, partners, and neighbours. Participants' network were viewed as influential in noticing the need for care and encouraging them to seek support:

> *"It was my partner … who told me, "If I were you, I'd go see a doctor because things aren't going well anymore." He could see I was unhappy"* (Person with disability)

> *"A neighbour recommended it to me. She saw me at a moment of deep sadness, crying uncontrollably. When you are like that, in that state where the crying doesn't stop, she realised and told me I needed help."* (Member of Roma Community)

For young people, parental involvement was important to initiate contact with mental health services. Although hesitation existed for the parents of some participants, others noted the centrality of the parents in accepting that accessing a service would be beneficial for their child, which facilitated the process positively:

> *"I told [my mother] that I wanted to go to therapy. She paused for a moment and asked, "Will it help?" I said yes. She scheduled the first session for a week later, and that's how I started therapy. The fact that my mother made the appointment made me very happy. My father knew about it too, and I felt relieved."* (Survivor of Earthquake)

The role of family in listening and accepting their distress was also viewed positively. One participant illustrated this through an example of the body language of their mother following a disclosure, which was transformative in feeling supported:

> *"I was so afraid, because my mother entering the [session] room meant she would learn what I had been doing to myself. I told [them] everything. My voice was so quiet that I never turned toward where my mother was sitting. Then we left and got into the car. We didn't speak for a while. She slowly turned toward me, and in that moment I truly felt my mother's support."* (Survivor of Earthquake)

3.5.4.3 Managing caregiving responsibilities

Several participants spoke about their role as a caregiver – particularly as parents – which impacted on their engagement positively and negatively. Structurally, parents struggled to attend sessions due to the need to arrange childcare, or bringing children with them when attending sessions:

> *"Transportation problems can occur from time to time. For example, when I first went with my two children, I had difficulties both in terms of transportation and during the appointment itself."* (Survivor of Earthquake)

Participants also noted the benefits of therapy in supporting their role of parents, which often underpinned their motivation for attending. This also highlighted the persistence of the participants to make progress in therapy for their children:

> *"I wanted to get better or at least feel better. Because I was a "mother". I had to get back on my feet and take care of my child. Not being able to take care of my child was one of the biggest difficulties I faced in my daily life."* (Survivor of Earthquake)

> *"I continued having therapy and I realised it made me make fewer mistakes in my life - in my children's adolescence."* (Older Adult)

Caregiving was also discussed in terms of caring for older adult relatives, while noting that services did not recognise when the participants took time away from paid employment in order to care for relatives. This was raised in the context of a participant who was refused treatment, which was attributed to their unemployment, indicating a lack of compassion and understanding from the service:

> *"I was then explicitly refused treatment for being unemployed. At the time, I was caring for a terminally ill uncle, and my aging grandmother, both of whom would pass in the next few years. I was so shocked by the reasoning."* (LGBTQIA+ Participant)

3.5.4.4 Loneliness and life after care

Several participants who had positive experiences also showed a hesitation to exit services, due to fears about living life without the scaffolding of mental healthcare and the potential for relapsing back into a state of poor mental health. Particularly for participants in which they would be living alone or isolated, that experiencing a discharge from hospital care would be a lonely experience:

> *"I don't know, it's my first experience [with mental healthcare] and I'm still in the hospital. I suspect that being alone could be a problem."* (Older Adult)

Participants shared the need to be ready to leave, suggesting the world beyond care could be harsh, especially for people with disabilities with additional mental health needs. It was suggested that

service user feel prepared to exit services to ensure that can maintain their mental health and wellbeing over time:

"...it's like being in a cocoon, so be careful when you leave, it can be brutal for some. You have to be prepared too. To let go of the assistance, the help, the support of the pros, but unfortunately we are not all prepared, we are not all equal in that regard" (Person with disability)

3.5.5 Summary

Four themes were identified, reflecting personal, relational, structural, and social factors impacting the ability to engage with care:

- The empowerment of people in vulnerable situations highlighted positive and negative examples of recognising a need for mental healthcare, prior knowledge, hesitation, persistence, willingness, and inherent disempowerment when an individual was experiencing a health difficulty.
- Epistemic injustice in care was reflected in participant accounts in which the service user perspective was undermined by the service, contributing to frustration and hopelessness of participants. However, positive experiences were underpinned by feeling believed by services, being understood, having a trusting therapeutic relationship, and shared decision making.
- Participants experienced burden in relation to time and self-management, along with frustration at dealing with scarcity in public systems. In private systems, more flexibility was offered but with a greater financial to participants, whilst experiences with NGOs were flexible at lower costs. Multicultural experiences indicated examples of explicit and systemic prejudice and racism, along with reflections on the necessity to access care in the participants' native language.
- Socially, participants outlined barriers and facilitators in the areas of stigma, family and social involvement, caregiving responsibilities, and expectations of life when they would exit the service.

3.6. Integrated Mixed-Methods Findings by Levesque Access Domain

This section integrates findings from the quantitative survey, framework analysis and IPA diary accounts to examine how access to mental healthcare was experienced across the five Levesque user-side domains. Rather than treating each dataset separately, the analysis brings together

patterns in perceived access scores, open-text responses and lived experience narratives to identify where findings converge, diverge or add further explanatory depth. This integrated approach allows the findings to show not only which access barriers were most commonly reported, but also how these barriers were experienced and negotiated by participants in practice. The section is organised around the five Levesque access domains: ability to perceive, ability to seek, ability to reach, ability to pay and ability to engage. Although diaries were designed to focus on the ability to engage, participants frequently shared experience from their entire help-seeking journey beyond engagement alone, often highlighting barriers across additional domains of the Levesque framework. Figure 11 provides a summary of integrated findings.

Figure 11

Mixed Methods Integration Infographic

DOMAIN	QUANTITATIVE PATTERN	QUALITATIVE EXPLANATION	INTEGRATED INTERPRETATION
PERCEIVE (Recognize Need)	• Mean = 12.99 (SD 3.36) • Third lowest domain score • Lower among participants with poor MHQoL	• Mental health literacy supports recognition of need • Stigma, uncertainty and mistrust can delay recognition • Symptoms are sometimes misatributed	Convergence — Recognition of need depends on mental health literacy and trust, while stigma and uncertainty delay access.
SEEK (Pursue Help)	• Mean = 13.87 (SD 3.57) • Second highest domain score • Lower among LGBQ+ participants and youth	• Stigma, shame and social norms shape help-seeking • Family, peers and community workers can enable first contact • Validation from others often supports action	Convergence — Help-seeking is socially mediated; support and validation often turn recognised need into action.
REACH (Obtain Care)	• Mean = 12.60 (SD 2.96) • One of the lowest domain scores • Transport and distance were key barriers	• Long waits, travel, opening hours and distance constrain access • Local and flexible services reduce burden • Reaching care often requires significant practical work	Complementarity — Structural and logistical barriers make care difficult to reach, while responsive local services make access more feasible.
PAY (Afford Care)	• Mean = 12.05 (SD 4.01) • Lowest domain score • Cost-related items were among the lowest scoring	• Service fees, transport costs and low income disrupt access • Participants often chose between delayed public care and costly private care • NGOs sometimes filled gaps	Complementarity — Affordability is the strongest constraint and shapes whether care is sought, continued and sustained.
ENGAGE (Stay Engaged in Care)	• Mean = 14.06 (SD 3.22) • Highest domain score overall • Lower among participants with poor MHQoL and LGBQ+ participants	• Trust, validation and shared decision-making support engagement • Discrimination, poor fit and discontinuity undermine it • Experiences of care influence future help-seeking	Expansion — Engagement depends on relationship quality and service responsiveness, and experiences of care shape future access.

Quantitative | Qualitative | Mixed methods integration | Convergence = findings align | Complementarity = findings add depth | Expansion = qualitative findings add nuance

3.6.1 Ability to Perceive

Across data sources, mental health literacy emerged as a critical access resource. The survey indicated that participants with poor MHQoL had lower overall perceived access, and the supplementary domain-level heatmap (Table D5) suggested that this pattern was also evident within the Ability to Perceive domain. Framework analysis suggested that strong mental health literacy was a facilitator of access, with participants describing indicators that helped them recognise a need to seek care. However, the ability to recognise and accept mental health difficulties in the moment, alongside mistrust of services, could act as a barrier. IPA diary accounts expanded on this, describing how uncertainty and stigma often delayed help-seeking: several participants initially misinterpreted psychological distress as physical illness or doubted their problem was "serious enough" to justify care, only recognising a need when symptoms became severe or someone else intervened on their behalf. Conversely, participants with prior mental health knowledge or trusted contacts reported earlier recognition of their needs and greater comfort with accessing care. Taken together, these findings suggest that mental health literacy and trust in health systems profoundly influence the first steps of access.

3.6.2 Ability to Seek

Perceptions of legitimacy and social support played a decisive role in converting recognised need into active help-seeking. Quantitatively, *Ability to Seek* was moderately rated overall, while the supplementary heatmap (Table D5) suggested lower descriptive scores among LGBQ+ participants and younger participants. Framework analysis identified personal and social values (including stigma, shame, cultural norms, and perceived autonomy) as important influences on help-seeking decisions. Participants often felt uncertain or undeserving of care; diaries described people feeling "paralysed" by shame, fear, or doubt, and some from conservative or migrant communities recounting family pressure to avoid mental healthcare. This suggests that *Ability to Seek* was socially mediated, help-seeking frequently hinged on external validation from family, peers, or cultural context. Crucially, the diaries also illustrate that when individuals overcame these barriers, it was often due to a combination of crisis and support from others. Many participants credited a friend, family member, or community worker with encouraging or even arranging their initial service contact. This underlines that social context and support networks are crucial to enabling (or inhibiting) help-seeking.

3.6.3 Ability to Reach

The evidence indicates that obtaining timely, convenient access to services often involves significant "work" on the part of individuals. Quantitative analysis found the *Ability to Reach* as one of the lowest-scored domains across all sites. Framework analysis identified a range of logistical barriers

(transportation, lengthy wait times, inconvenient service hours, distance to clinics, and lack of local services) as common barriers to reaching care. In diaries, participants described extensive burdens: many reported waiting months for appointments, taking long trips via multiple vehicles to reach distant providers, and juggling family or work duties to attend sessions. These burdens were sometimes partly alleviated by supportive others (e.g., family driving them), but they were also a source of frustration and exhaustion. Notably, participants who experienced more responsive, locally accessible services (for example, NGO services or drop-in centres in their community) highlighted how much easier it was to get care when providers came to them or offered flexible hours. Thus, *Ability to Reach* reflects structural and infrastructural factors that often lie outside an individual's control: reaching care is feasible only when health systems minimise the physical and logistical barriers to service entry. These findings also influence *Ability to Engage* – as overly burdensome access processes can seed dissatisfaction or fatigue, which can undermine commitment to ongoing care.

3.6.4 Ability to Pay

Affordability emerged as the most consistently constraining domain across sites. On average, *Ability to Pay* scored lower than other domains, and qualitative data revealed widespread concerns about out-of-pocket costs, limited income, and financial insecurity. In the framework analysis, financial barriers (service fees, medication costs, lost income from time off) were among the top access impediments reported. The diaries confirmed this: many participants recounted cutting back on therapy sessions or stopping treatment prematurely because of cost. Critically, diaries also illustrate the broader context of affordability: high costs forced participants into difficult choices between under-resourced public services (with long waits and limited flexibility) and expensive but more accessible private services, often resulting in patchy or unsustainable care trajectories. In some cases, NGOs or community-run services stepped in to fill gaps; participants praised these as crucial stopgaps when they lacked the means for private care.

Notably, when asked qualitatively about the *Ability to Seek* in surveys, many participants were inclined to comment on the cost and inability to pay for services. This suggested that concerns and perceptions about the *Ability to Pay* and *Affordability* arose early in the process for participants, as a key consideration when participants were seeking care. The capacity to afford care determines whether an individual can exercise any "choice" at all when seeking care and shapes the continuity and frequency of care.

3.6.5 Ability to Engage

Engagement was found to be a pivotal and complex domain, reflecting not only the outcome of prior access successes or failures but also a determinant of future access. In the survey, older participants reported higher engagement, whereas LGBQ+ participants, youth and those

with poor MHQoL reported lower engagement, consistent with a trust gap for people in vulnerable situations. Framework analysis and IPA converged on the centrality of relational and interpersonal factors: sustained engagement was facilitated by services that provided trustworthy, validating, and empowering experiences, where patients felt heard and involved in care decisions. By contrast, diaries detailed how epistemic injustice in the provision of support (undermining the perspective and lived experience of the service user) or culturally insensitive care experiences (unwillingness to adapt care to patient needs, perceived prejudice, abrupt discontinuities) triggered frustration, disempowerment, and potential dropout.

3.6.5.1 Integrating Findings with Patient Health Engagement Model (PHE)

These patterns align with the PHE model's emphasis on progression from a state of *adherence driven by fear* to one of *engagement driven by confidence and partnership* (Kimerling et al., 2020). Importantly, the diaries suggest that engagement is not an endpoint but part of an ongoing cycle: individuals' engagement or disengagement feeds back into their attitudes about future help-seeking and self-care. Thus, *Ability to Engage* highlights how access and quality of care intersect - supportive relationships and shared power can transform a person's ongoing access trajectory, whereas negative engagement experiences can set back the entire process.

Quantitatively, the ability to engage was one of the higher scoring access areas overall, suggesting that many participants reported some capacity to remain involved in care once contact with services had been made. However, ability to engage scores were lower among participants with poor MHQoL and LGBQ+ participants, indicating that engagement may be more difficult where people are experiencing poorer mental health or marginalised service encounters. The framework analysis provided further context, showing that engagement was shaped by positive provider experiences, feeling empowered in healthcare decisions, access to information, continuity of care and the perceived fit between services and participant needs. Taken together, this analysis suggest that engagement goes beyond individual motivation alone. It is shaped by whether services create the conditions for people to feel informed, respected, understood and able to participate in care.

4. Discussion

4.1 Rethinking Help-Seeking and Service Access in Populations Experiencing Vulnerable Situations

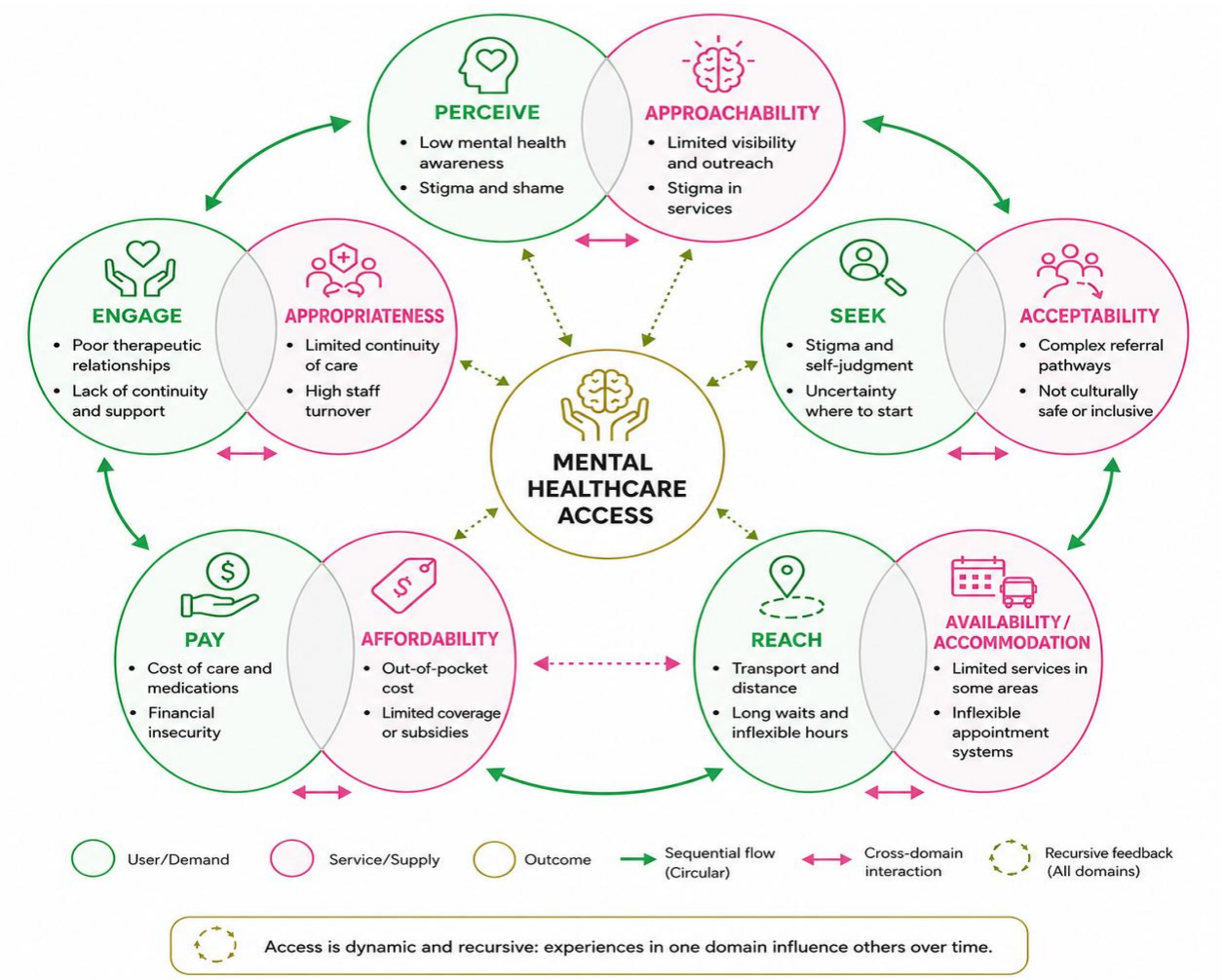
4.1.1 Help-seeking and service access as non-linear

The findings highlighted a multitude of factors influencing help-seeking and mental health service access affecting populations experiencing vulnerable situations, including mental health literacy, prior knowledge of services, stigma, social support, family responsibilities, time burden, transport, cost, cultural insensitivity, and the quality of relationships with service providers. These findings align with previous research on the Levesque framework with people in vulnerable situations (Ash et al., 2026; Davy et al., 2016; Eveleigh et al., 2025; Fan et al., 2025; Schwarz et al., 2022; Shah et al., 2025) or research focused on access to mental healthcare (Ash et al., 2026; Lowther-Payne et al., 2023; Schwarz et al., 2022, Shah et al., 2025). However, this study provides a unique lens in applying the Levesque framework identifying areas of intersectionality between mental health service access and populations experiencing vulnerable situations.

This study's integrated findings demonstrate that mental health access for people in vulnerable situations is not a linear sequence of independent steps but a cumulative and relational process, often consisting of multiple attempts at help-seeking and requiring significant persistence and resilience on behalf of service users navigating care (see Figure 12). This aligns with previous research with Indigenous populations accessing primary healthcare (Davy et al., 2016). Figure 12 summarises findings from this study across each user domain of the Levesque framework, emphasising the non-linear nature of help-seeking and service access, as opposed to the linear model outlined in the original Levesque framework. This has important implications for service design. If help-seeking is non-linear, then access barriers cannot be addressed through single-stage solutions, such as information campaigns alone or appointment availability alone. Instead, services need to recognise that cost, transport, stigma, trust, cultural safety and previous care experiences can interact across the whole access journey. Improving access therefore requires coordinated mental healthcare that reduce the work required of service users at multiple points, from recognising a need for care through to sustaining engagement.

Figure 12

Applying the Findings to the Levesque Framework



Each user-side domain of the Levesque framework represents a stage where new barriers can be introduced or mitigated, and these stages are interconnected. Early barriers (e.g., insufficient knowledge, low perceived legitimacy) limit entry into care and amplify the challenges faced later. However, there were examples of overlapping domains across the Levesque framework, supporting findings from previous research (Cu et al., 2021). In this study, there was evidence that the ability to perceive for young people was affected by personal and social values of their parents, especially with parents initiating help-seeking for young people's physical health but not accepting the existence of a mental health need. This was also noted by older adults in this study, in line with previous research that highlights a lack of acceptance of mental health need related to stigma (Schwarz et al., 2022). Typically, stigma would be classed under the ability to seek in the Levesque framework, relating to social values. However, the evidence from this study indicates a blurring of the ability to perceive and the ability to seek when a parent or caregiver is involved in the help-seeking process, or when societal stigma encourages individuals to minimise their difficulties.

The ability to pay highlights structural difficulties for accessing care, but this arose as a concern for participants both at the point of seeking care and when engaging with care. When seeking care, perceptions in the ability to pay discouraged participants from accessing the private mental health system. When asked about the ability to seek care, many participants first cited the ability to pay and affordability as barriers, implying perceptions about costs arise earlier in the help-seeking journey for these populations than illustrated in Levesque framework. In addition, there was evidence of participants disengaging from care or allowing a longer gap between private sessions in order to ensure they could afford care, echoing previous findings with Indigenous communities, whereby service users could only cover part of the cost of care (Davy et al., 2016).

Likewise, the ability to reach and the ability to pay overlapped significantly in this study. Opening hours were cited by participants as a barrier to reaching services as service availability clashed with work schedules, which would have impacted participants' income. Transport and childcare were both noted as barriers in the ability to reach services, but this also reflected indirect costs of engaging with care. This aligns with previous research on the Levesque framework (Cu et al., 2021; Davy et al., 2016), which noted the difficulties in classifying issues across ability to reach and ability to pay due to conceptual overlap. Finally, cultural sensitivity of services is noted in the Levesque framework at the point of the ability to seek and acceptability, but participant accounts indicated the importance of cultural sensitivity during care, suggesting an overlap with the ability to engage and appropriateness.

4.1.2 Service user access and engagement nested within structural factors

Significant overlap existed between demand- (service user) and supply- (services) side domains of the Levesque framework in this study. Several examples arose throughout the analysis. For example, when participants spoke about positive outcomes as a result of engaging with care, this could have been an indicator of adequacy of services (Appropriateness) or empowerment of service users (Ability to engage). Participants were also likely to cite that private services were too expensive, which could have been interpreted as a lack of income (Ability to Pay), or problems with the direct costs of care (Affordability). In relation to the ability to reach mental healthcare, participants cited a clash between personal work hours (Ability to reach) and opening hours of services (Availability and Accommodation). However, in each case, a hierarchy existed whereby structural factors were determined by services (quality of care, cost, opening hours), requiring service users to adapt to the conditions of the service. Therefore, in line with research with Indigenous communities accessing primary healthcare (Davy et al., 2016), abilities in the Levesque framework in this context (people in vulnerable situations accessing mental healthcare), should be interpreted as nested within the structural conditions of service provision.

Similarly, the need for service users to shoulder the burden of accessing care was reflected in their experiences of service engagement, with themes mapping closely to components of the PHE model (Kimerling et al., 2020); *Self-Management Adherence, Health Information Use, Communication,* and *Healthcare Navigation*. The theme *Personal empowerment vs disempowerment* echoed *Self-Management Adherence* and *Health Information Use*. Difficulty in recognising mental health difficulties, persistence, and managing inherently disempowering mental health difficulties demonstrated the burden on individuals during their engagement with mental healthcare. The theme *Navigating social context and responsibilities during and after mental healthcare* also highlighted positive and negative social factors that could indirectly impact upon self-management and health information use. This included supportive family members, friends, or neighbours who encouraged engagement with care, initiated communications with services, provided emotional support and transport. The role of supportive adults reflects previous research conducted with young people, which identified having “One Good Adult” as a leading protective factor for young people’s mental health (Dooley et al., 2012). In addition, negative social factors in this study related to poor mental health literacy and stigma among the participants’ immediate families or their wider community. Although stigma-reductions initiatives have grown in recent years internationally (Clay et al., 2020; Ma et al., 2022), the findings indicate a prevalence of stigma persisting in many communities, suggesting a need for more co-production in stigma-reduction initiatives to meet the needs of people in vulnerable situations. Several participants who were conscious of stigma in their community spoke about help-

seeking as a private matter without sharing with others in their environment, suggesting a risk of isolation when engaging with mental healthcare.

The themes *Epistemic injustice in care vs trust, understanding, inclusion, and validation* and *Experiencing rigidity, scarcity, and flexibility in mental health services* overlapped with the PHE components *Communication* and *Healthcare Navigation* (Kimerling et al., 2020). The importance of service providers providing equal footing to the perspectives of service users, understanding the service user, providing a validating experience within care, and engaging in shared decision-making (Chmielowska et al., 2023; Slade, 2017) were shared frequently by participants. Yet experiences of developing therapeutic relationships were hampered by scarcity within services, alongside poor experiences with providers in which participants felt undermined or experienced an uneven power dynamic with service providers. This echoes previous research in psychiatry and with young people in the area of epistemic injustice, in which the agency of service users is not fostered, and consequently service users do not feel understood in care (Crichton et al., 2017; Larkin et al., 2025). This contributed to feelings of frustration and desperation for several participants, resulting in poor experiences of navigating through the mental health system. The pervasive impact of scarcity was illustrated clearly by participants when discussing the lack of time to discuss their difficulties with practitioners and a tendency to prescribe medication instead of providing psychosocial care, reflecting similar findings from populations experiencing chronic pain (Schwarz et al., 2022). Particularly when participants highlighted their persistence in seeking care, the lack of time given to them by services highlighted an imbalance in the efforts of service users compared to the quality of service provision.

Relatedly, mistrust of psychiatry was evident in qualitative accounts from many participants, shaped by previous experiences in which they did not feel understood or heard. In the context of the PHE model (Kimerling et al., 2020), this indicated poor communication with service users, as well as tension in the power dynamics between psychiatry professionals and service users in vulnerable situations. Medical mistrust has been identified in previous research on mental health access with people in vulnerable situations, attributed to experiences of feeling unheard in services, compounded by systemic discrimination and exclusion (Ash et al., 2026). These experiences also demonstrate how service user experiences are determined by scarcity at a systemic level, whereby demands on medical professionals lead to a lack of time with service users, compounding experiences of epistemic injustice, along with poor communication and therapeutic relationships, resulting in a lack of trust in mental health services.

However, participants also provided positive accounts of communication with staff, particularly with nurses, emergency department staff, and psychological care, where the emphasis was put on understanding the individual and their needs. This aligns with previous research with young people

accessing mental healthcare (Mac Dhonnagáin et al., 2026), whereby positive therapeutic relationships provide a foundation to appropriate experiences with mental healthcare. Understanding was also attributed to working with practitioners from a similar background or with expertise in specific areas – particularly for migrant and LGBTQIA+ populations – highlighting a need for specialist professionals with a clear understanding of the needs of people in vulnerable situations. Several participants noted their own reluctance to trust practitioners at first, only for trust to grow over time. This suggests people in vulnerable situations may require more time than is offered typically in brief intervention contexts to allow for the development of the therapeutic relationship.

A sense of understanding was also noted at the point of working with administrators in mental health systems. Positive experiences of navigation (Kimerling et al., 2020) through private and NGO settings were shared, which may reflect less scarcity in these systems. However, negative experiences of navigation were shared in the context of public systems, highlighting scarcity, rigidity, and a sense that care was rushed. A welcoming approach from all staff in services is emphasised in youth mental health NGOs internationally (Hetrick et al., 2017), but evidence from this study suggests people in vulnerable situations are not having welcoming experiences with public mental health systems across Europe. In addition, this finding again highlights how structural components of care were raised by participants in the study, rather than merely reflecting on demand-side abilities of the Levesque framework.

Participants with the most severe mental health needs had the poorest levels of access in this study, aligning with previous research (Dawadi et al., 2024). This may be attributed to structural and personal factors identified in this study, including the inherent feelings of disempowerment associated with experiencing mental or physical health difficulties, and the inability for the scope of practice of services to adapt to complex presentations such as comorbidity or suicidality. As a result, and inequalities in mental health access may be compounded for people in vulnerable situations when facing rigid systems of care and a lack of supportive others to encourage engagement with interventions.

These patterns reinforce that demand-side “abilities” are not innate traits of individuals; rather, they are contextual and co-produced. They emerge from a person’s interaction with society and systems: for example, one’s ability to perceive a need depends on societal attitudes and available information, and one’s ability to engage depends on service responsiveness and continuity, not just personal willpower (Levesque et al., 2013; Bee et al., 2015). In practice, each domain is a shared responsibility between the service user and the system. When the system fails to create enabling conditions (e.g., accessible information, supportive networks, reasonable waiting times, financial protection, cultural safety), it effectively offloads heavy “access work” onto individuals who may already be at the limits of coping (Russell et al., 2013). This insight is a key conceptual contribution of our mixed-methods

approach, affirming that efforts to improve access must target the user–system interface and not overemphasise individual "motivation" or knowledge alone.

4.2 Implications and Recommendations (Policy, Practice, and Smart Health Labs)

4.2.1 Structural Solutions for Policy and Practice

The evidence signals that demand-side barriers call for structural solutions. Policies and services should avoid framing access difficulties as personal failings; instead, they must address the social and systemic factors that shape user-side "abilities". For example, beyond expanding service supply, mental health strategies should incorporate community-level interventions that reduce the cognitive and social barriers to recognising and acting on mental health needs. This means embedding mental health literacy and anti-stigma initiatives within local cultures and languages, partnering with community leaders to move mental health topics from the margins into mainstream conversation (addressing the abilities to perceive and seek care). It also means building legitimacy for help-seeking by ensuring that populations experiencing vulnerable situations encounter supportive norms and clear pathways rather than judgment, from their own social networks as well as from front-line providers. Given the role of supportive others when people in vulnerable situations access services, peer work for service users, families and carers (Shalaby & Agyapong, 2020; Hopkins et al., 2020) may also add an extra layer of support and reassurance, while empowering people to navigate mental health systems through knowledge sharing from previous service users and families.

Health systems should likewise commit to sharing the "access work": measures such as closer integration of care facilities with public transit, flexible scheduling, and "no wrong door" policies can significantly lighten the practical burden on those seeking help (supporting the ability to reach). Similarly, expanding public insurance coverage and forging partnerships with NGOs can buffer individuals from out-of-pocket costs (enhancing ability to pay). Finally, providers and administrators need to treat relational quality and patient empowerment as core components of access (facilitating ability to engage). Strengthening these areas should be seen as integral to improving access, not just as secondary considerations about quality of care.

4.2.2 Solutions to support individuals – informing design principles for Smart Health Labs

The EQUICARES Smart Health Labs (community-driven, co-design platforms at each pilot site) are a key mechanism to apply appropriate, innovative and contextually tailored solutions to support access to mental healthcare in populations experiencing vulnerable situations. Findings from this study highlight the "work" of accessing mental healthcare for these populations, and Smart Health Labs (SHLs) are ideally placed to support solutions that reduce the burden on service users. Across all Levesque domains, participants described access as an active and often exhausting process involving emotional, cognitive, social, financial and logistical labour. Individuals were frequently required to navigate fragmented systems, tolerate uncertainty, coordinate appointments, repeatedly explain their experiences, manage transport and affordability barriers, and sustain engagement despite prior negative experiences with care. These findings suggest that inequities in access are not simply produced by the absence of services, but by the unequal burden placed on individuals to successfully navigate complex pathways to care.

The following design principles are proposed to guide SHL development across the EQUICARES pilot sites. Beyond SHLs, these principles can also be applied in broader research and community work with people in vulnerable situations to support solutions to access barriers in mental healthcare.

1. Reduce the work of access

Pay and Reach were the lowest scoring access domains, and participants described difficulties with cost, transport, waiting times, appointment coordination and service navigation. SHLs should therefore reduce the practical and administrative work required to access care. This may include clearer signposting, supported navigation, referral tracking, appointment coordination, reminders, help with forms, interpretation support and follow-up during waiting periods.

2. Build trust from first contact

Participants' willingness to seek and engage with care was shaped by trust, expectations of services and previous experiences of judgement, stigma or discrimination. SHLs should ensure that first-contact processes are transparent, validating, culturally safe and trauma-informed. People should receive clear information about what to expect, what choices they have and how they can access further care.

3. Strengthen relational pathways to care

The findings showed that help-seeking was often supported by others, including family members, partners, peers, neighbours, NGOs and trusted professionals. SHLs should build on these relational pathways by involving peer workers, community ambassadors, family supports and trusted local organisations where appropriate. These actors can support people to recognise distress, make first contact and remain engaged with care.

4. Design flexible engagement routes

Engagement was not linear. Participants' ability to continue care was affected by distress, affordability, transport, caring responsibilities, trust and service fit. SHLs should therefore offer flexible routes into, through and back into care. This may include low-threshold entry points, drop-in options, hybrid digital and human support, proactive follow-up, and non-punitive re-entry after missed appointments or disengagement.

5. Support continuity during waiting, cost and service gaps

Participants described long waits, limited appointment availability, unaffordable private care and interruptions to care caused by cost or scarcity. SHLs should treat waiting periods and gaps in provision as points where support and reassurance is needed, not as passive delays. Potential responses include bridging supports, peer contact, guided self-management, NGO referral pathways, preparation for appointments and continuity mechanisms during transitions between services.

6. Identify and redesign hidden exclusion points

The findings showed that exclusion can occur through routine service features, including referral rules, forms, appointment times, transport assumptions, language access, digital access and identity-related administrative barriers. SHLs should use co-design to identify these barriers and redesign them with people most affected. This will help ensure that solutions are acceptable, accessible and responsive to local contexts.

7. Keep technology human-centred

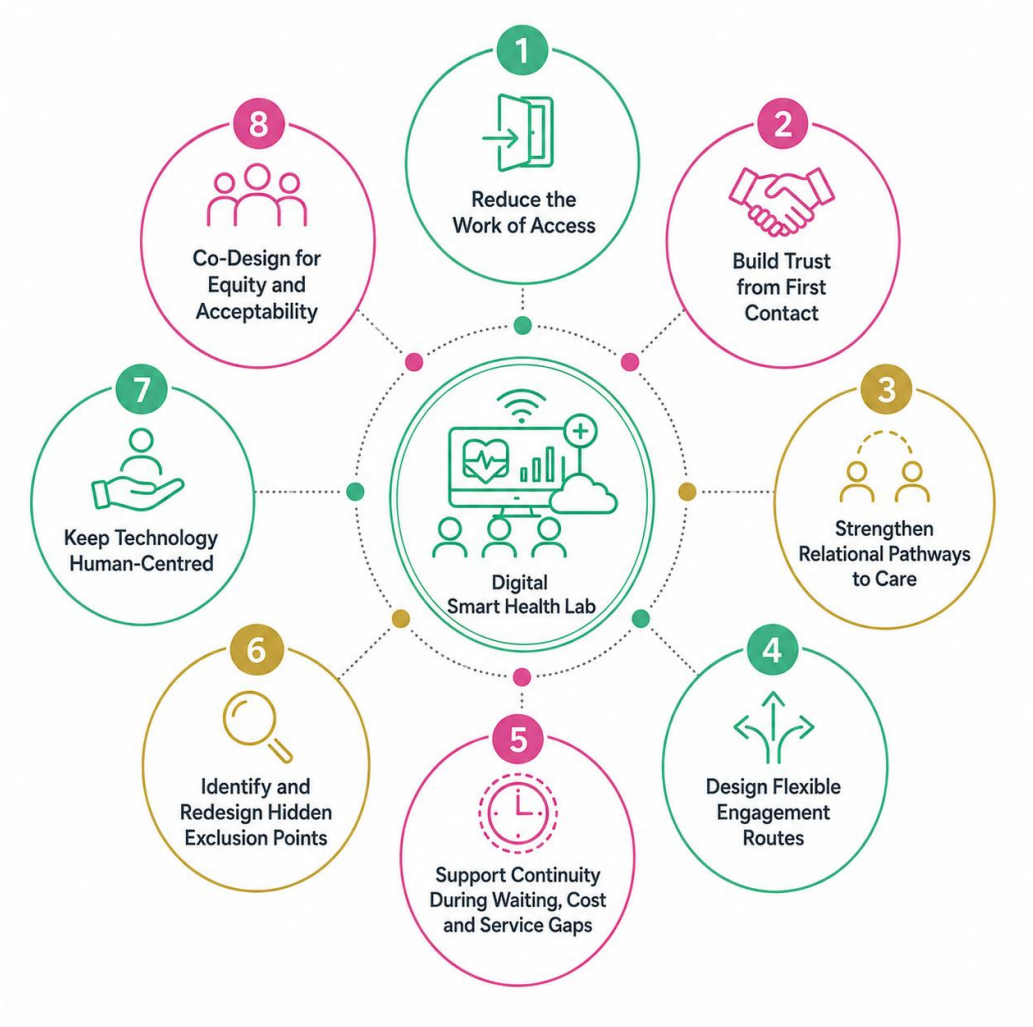
Digital and AI-supported tools may help with information, navigation, preparation, reminders and follow-up, but the findings also show that trust, validation and feeling understood are central to engagement. SHL technologies should therefore act as supplements to, rather than substitutes for human connection. They should include clear routes to human support where users need relational care, safeguarding or crisis response.

8. Co-design for equity and acceptability

Access barriers varied by lived experience, social context, identity, culture, language, disability, sexuality and mental health-related quality of life. SHLs should involve people in vulnerable situations throughout design, testing, implementation and refinement. This will help ensure that interventions are safe, inclusive, culturally responsive and grounded in the realities of those most affected by access barriers.

Figure 13

Design Principles for Smart Health Labs



In summary, SHLs may offer a practical mechanism for operationalising the study's findings across the access pathway. By reducing the work of access, building trust from first contact, strengthening relational routes into care, supporting continuity during waiting or service gaps, and using co-design to identify hidden exclusion points, SHLs can help shift responsibility for access away from individuals alone and towards more supportive, shared systems of care. This positions SHLs as equity-oriented innovation spaces that can respond to the practical, relational and structural barriers identified in this study, while ensuring that solutions remain grounded in the lived realities of people in vulnerable situations.

4.3 Strengths and Limitations

A key strength of the study was its recruitment of participants from populations under-represented in mental health access research. Recruitment through local EQUICARES partner organisations drew on established community relationships and service networks, helping to reach groups less visible through conventional recruitment routes. The mixed-methods design was also a strength, combining survey data on patterns of perceived access with open-text responses and reflective diaries that provided richer insight into how barriers were experienced in practice. The use of the Levesque framework and PHE model gave the analysis a clear conceptual structure, while locally adapted materials and flexible data collection supported participation across diverse contexts. Methodologically, although women represented the largest proportion of participants, this distribution broadly reflects established patterns of engagement with mental health services and mental health research participation (for example, see Moore et al., 2026). Considering the known challenges of recruiting men into mental health research, the inclusion of a substantial proportion of male participants supports gender diversity within the sample.

Several limitations should be considered when interpreting the findings. First, the study used purposive, site-specific recruitment across eight pilot sites. These targeted approaches were appropriate for reaching people in vulnerable situations but limit the generalisability of the findings. The sample should not be interpreted as representative of all people experiencing barriers to mental healthcare across Europe. Some participant groups were also small, meaning that subgroup comparisons, particularly by gender identity and sexual orientation should be interpreted cautiously.

There were limitations associated with measurement and cross-site implementation. The Levesque access items were developed for this study because no established measure of the user-side access domains was identified. (see Cu et al., 2021). Although the overall access scale demonstrated acceptable internal consistency, reliability estimates for individual domain scores were low, meaning that domain-level findings should be treated as descriptive. In addition, the study was implemented across diverse linguistic, cultural and service contexts. While harmonised tools, local adaptation and site training supported consistency, language and cultural variations may have influenced responses. Finally, limitations relate to the mixed-methods design and qualitative data sources. The structured survey supported cross-site comparability but may have simplified complex access experiences that often cut across several Levesque domains. The reflective diary/testimony component provided rich insight into engagement with care, but it was limited to participants who had accessed formal mental health services in the previous 12 months. It therefore offers less direct evidence on people who recognised a need for care but were unable to reach services, or who avoided formal services altogether. The integrated analysis partly addressed these limitations by using qualitative findings to

contextualise quantitative patterns and by interpreting access domains as interconnected rather than discrete stages.

5. Conclusion

This study highlighted multiple barriers arising for people in vulnerable situations accessing mental healthcare in seven countries across the WHO Europe region, informing the development of the Levesque framework for these populations along with implications for policy and practice. Barriers included from personal factors such as poor mental health literacy and hesitation, social factors such as stigma and caregiving responsibilities, structural factors such as cost, transport, proximity, and scarcity within service provision, and relational factors including the quality of care and communication between service providers and service users. The work involved for individuals when accessing mental healthcare emphasised the need for mental health solutions which can alleviate burden on service users as barriers arise. The existence of barriers across personal, social, relational, and structural barriers indicates the need for a parallel approach to address barriers and strengthening facilitators. Many of the challenges currently faced by service users from vulnerable situations are nested within rigid systems of care which further disempowers individuals experiencing mental health difficulties.

Examples were also given of facilitators of mental healthcare access, whereby social support empowered service users, along with therapeutic relationships in which individuals felt understood, had their lived experience validated, experienced shared decision-making with professionals. However, the findings of this study demonstrate that high-quality care is not experienced consistently among people in vulnerable situations. Policy and practice should build on known facilitators to empower individuals seeking care, their families and communities, and target wider access to affordable, person-centred mental healthcare. Together, this should help to reduce the work of accessing mental healthcare, supporting positive experiences with care, and facilitating better outcomes for people in vulnerable situations.

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8. Appendices

8.1 Appendix A: Example of Participant Information Leaflet and Informed Consent Forum

Participant Information Sheet (Structured Survey)

EQUICARES - a European research initiative aiming to understand and reduce mental health inequalities
LGBT Ireland and UCD would like to invite you to take part in a research study. Participation in this research is voluntary. If you don't wish to take part, you don't have to.
If you decide you want to take part in the research project, you will be asked to confirm your consent at the end of this introduction.

By confirming, you are telling LGBT Ireland and UCD that you:

- understand what you have read;
- consent (agree) to take part in the research project;
- consent to participate in the research processes that are described;
- understand how your personal data will be used.

What is this research about?

Everyone deserves access to mental health care that is safe, fair, and easy to reach. But many people still face problems getting the help they need. The EQUICARES project, funded by the European Union, wants to understand what gets in the way, especially for people in vulnerable or marginalised communities. The EQUICARES research project is a four-year project. This part is the first study that is included and will be concluded by April 2026. LGBT Ireland will be involved in the project until December 2028. Read more about the project here: www.equicares-project.eu.
In Ireland, EQUICARES looks specifically at access to mental health services and the obstacles faced by LGBTQI+ people. By listening to your experiences and opinions, we hope to make services better for everyone.

What are you asked to do?

You are asked to take part in an online survey for the EQUICARES project.

You are over 18 years old, live, work, or use mental health services in South Dublin, Wicklow, or Dun Laoghaire, and you are part of the LGBTQI+ community. In the last 12 months, you may have accessed mental health support or tried to access mental health support. You are not experiencing any acute mental health crises.

Taking part in the study is your choice. If you choose not to take part in this study, it will not affect your access to mental health services. The research team has no links to mental health services. You do not have to give a reason for not taking part in this study.

If you choose to take part in the EQUICARES study, you can fill in the online survey on your phone or your own laptop at a time that suits you. If you want, you can also come into the LGBT Ireland office and have someone from the research team support you with filling it in on one of our computers.

We will not collect personal information from you. This means we will not ask for your name, address, date of birth, or anything else that might allow us to identify you later. We will ask some demographic questions, based on your approximate age, gender, sexual orientation, ethnicity, country of origin, and whether you might have a disability.

Your participation will not be compensated. You will not receive any money or other gifts for participating. If you had to travel for the study, for instance to the LGBT Ireland office, we would reimburse your public transport ticket.

What are the benefits of participating in the EQUICARES study?

Taking part in this study may not directly benefit you. However, LGBT Ireland and UCD hope that this research may help to better understand the access barriers LGBTQI+ people in Ireland face when trying to access mental health services, and their experiences with mental health support in Ireland. By taking part in this research, you will contribute to academic knowledge and help us prepare the development of a Smart Health Lab that will invite LGBTQI+ people to test an innovative digital solution to mental health service. You will also support policy development.

The researchers at UCD and LGBT Ireland will benefit from your participation by gaining useful insights into the access barriers LGBTQI+ people experience with mental health support. The findings will be published as a report for Ireland and as academic publications. If you are interested in the Irish findings, have a look at our website www.lgbt.ie/equicares in early summer or follow our social media.

What are the risks of participating in the EQUICARES study?

Some questions that you will respond to will feel personal or bring up strong emotions. You can take a break, skip a question, or stop your participation altogether if this happens. The research team is available if you need support. We have also prepared a list of free support services in Ireland that

you can reach out to directly if you need. It is available at the end of the survey.

How will my data be used?

Your data will be entered into a secure database, where it will be combined with the data from other participants in this research study. The data will be analysed to obtain a better understanding about mental health service access. We use Typeform for the data collection which directly transfers the data securely to Jigsaw.

At the end of this part of the project (April 2026), the data will be stored by UCD and Jigsaw. It will be stored for 10 years and be destroyed after. Only the research team in EQUICARES will have access to the data. It will not be shared externally.

All information which is collected about you during the course of the research will be kept strictly confidential, and any identifiable information about you will be removed. Electronic data will be password protected and accessed only by the research lead. These actions will be taken to protect your personal data. All the members of the Research Team have taken General Data Protection Regulation (GDPR) training at University College Dublin (or equivalent).

If you would like to contact a member of the research team for any research-related reason, you can do it via the contact information provided. If any questions are not answered in a satisfactory manner, then contact can be made with a Data Protection Officer at UCD, the details of which are also provided below. Finally, if none of the UCD contacts have given a satisfactory response, details on the Data Protection Commission are provided.

Dr Mira Fey, research lead, LGBT Ireland, mira@lgbt.ie

For Jigsaw: Dr Neil Mac Dhonnagain, research lead, Jigsaw, neil.macdhonnagain@jigsaw.ie

UCD Data Protection Officer: Email gdpr@ucd.ie

Data Protection Commission: https://forms.dataprotection.ie/contact

Consent Form

- I have read and understood the Participant Information Leaflet about this research study. The information has been fully explained to me, and I have been able to ask questions, all of which have been answered to my satisfaction.
- I understand that I don't have to take part in this study and that I can opt out at any time. I understand that I don't have to give a reason for opting out and I understand that opting out won't affect my future

access to mental health care or LGBTQI+ services.
- I have been given a copy of the Participant Information Leaflet and this completed consent form for my records.
- I give informed consent to take part in this research study having been fully informed of the risks, benefits and alternatives.
- I understand that procedures will be put in place to ensure that my data will be stored safely and securely to protect my identity and confidentiality.
- I understand that the findings of this study may be reported in aggregate/summarised form at conferences and in journal publications, in a way that does not compromise my confidentiality.
- I understand that the coded data collected about me will need to be retained for potential future access to support the research findings.

Please click below if you agree to take part in this research

8.2 Appendix B: Safety Protocol

Safety and Risk Response Protocol

Version: 22.7.2025
Applies to: All EQUICARES Pilot Sites
Prepared by: Jigsaw

1. Introduction

This safety protocol outlines the procedures for managing participant emotional distress or risk disclosure during live interactions in Task 1.5 of the EQUICARES study. Given the inclusion of participants who may have experienced marginalisation, displacement, or trauma, this protocol ensures that responses are handled with care, consistency, and ethical rigor.

This protocol **applies only to immediate risk or distress** observed or disclosed during **real-time interaction**, such as survey facilitation or testimonies. It does **not include any retrospective review** of written responses such as diaries or survey comments. Research staff are not responsible for assessing risk or delivering therapeutic support, but they must be able to recognise distress and ensure timely referral to professional services.

2. Guiding Principles

- **Do No Harm**: Prioritise participant dignity, safety, and emotional wellbeing.
- **Non-Clinical Role**: Cultural Mediators and researchers do not conduct clinical assessments.
- **Referral-Only Model**: Staff connect participants to local services; no therapeutic intervention is offered.
- **Trauma-Informed Response**: Be calm, empathic, and culturally sensitive.
- **Equitable Access to Support**: All participants are provided with local service information, regardless of risk disclosure.

3. Scope of the Protocol

This protocol must be used in **live interactions only**, including:

- In-person or phone-based testimony collection
- Survey or diary facilitation

- Any moment when distress becomes apparent in real-time

It does not apply to written materials reviewed after submission, and does not include safety planning or follow-up beyond appropriate referral.

4. Responding to Immediate Risk or Distress: The RALRR Protocol

Cultural Mediators (CMs) may encounter participants who show signs of distress or make risk disclosures during interaction. In these cases, they must follow the **RALRR protocol** – a trauma-informed model adapted for non-clinical research settings.

Table 1 – RALRR Protocol for Safeguarding

Principle	Actions	Additional Notes
 **Recognise**	CMs should be aware of signs such as: • Crying, silence, dissociation, agitation • Statements like “I can’t cope” or “I want this to end”	Pause data collection. Be present and non-judgmental.
 **Ask**	If risk is suspected, gently ask: “Are you thinking about hurting yourself or ending your life?” “Do you feel unsafe right now?”	Use clear, compassionate language. Asking does not increase risk.
 **Listen**	Create space for the participant to speak. Do not interrupt. Avoid minimising or promising secrecy.	Use grounding techniques if the participant is overwhelmed.
 **Respond**	If suicidal thoughts or distress are confirmed: • Pause all research activity • Contact the Designated Safety Lead (DSL) immediately	Stay with the participant if in active crisis. Follow site referral plan.

 Refer	The DSL assesses the situation and: • Refers to local mental health, emergency, or social services • Logs the incident under the local safety protocol	No safety plan is created. Staff are not responsible for follow-up.

5. Routine Support for All Participants

Even in the absence of distress or risk disclosure, all participants must be provided with information about available local support services. This includes:

- A **printed or verbal list** of mental health, psychosocial, or crisis support services
- A clear explanation that **research staff cannot provide clinical care**
- Reassurance that accessing support is **entirely voluntary**

This ensures that participants receive support resources equitably, without the need for self-disclosure.

6. Responsibilities for Pilot Sites

6.1 Appoint a Participant Support Lead (PSL)

Each site must have:

- One **PSL**
- PSL must be trained in trauma-informed practice and local service pathways

6.2 Develop a Local Safety Plan

This must include:

- Emergency contact details (mental health, social work, crisis services)
- Procedures for handling incidents **outside business hours**

6.3 Maintain a Local Support Directory

Sites must:

- Create a list of local, culturally relevant services
- Translate the list into appropriate local languages
- Review and update this list **every 6 months**
- Provide it **to all participants**, not just those at risk

6.4 Staff Training and Debriefing

All Cultural Mediators must be:

- Trained in the RALRR protocol
- Familiar with how to escalate to the PSL
- Offered routine debriefing after serious disclosures

7. Safety Checklist

Task	Responsible	✅
Informed consent obtained (accessible formats)	Cultural Mediator	☐
Participant informed of right to withdraw	Cultural Mediator	☐
Monitor for emotional distress during session	Cultural Mediator	☐
Apply RALRR protocol if distress is observed	Cultural Mediator	☐
Refer participant through DSL	DSL	☐
No safety plan developed or implemented	DSL	☐
Provide all participants with local service list	Cultural Mediator	☐

No identifiable data shared with central team | Site Team | ☐

8.3 Appendix C: Application of the Good Reporting of a Mixed Methods Study Criteria

GRAMMS criterion	Where reported in this study	How this study addressed the criterion
1. Justification for using a mixed-methods approach	Introduction, Sections 1.1–1.4; Methods, Section 2.3	A mixed-methods approach was used because the study required both quantitative assessment of patterns in perceived access across participant groups and qualitative exploration of how access and engagement were experienced, interpreted and negotiated by people in vulnerable situations.
2. Design in terms of purpose, priority and sequence	Methods, Section 2.6.1	The study used a convergent parallel mixed-methods design. Quantitative and qualitative data were collected during the same overall study period, analysed in parallel, and given equal priority. The quantitative strand examined associations between access abilities, demographic characteristics and mental health-related quality of life. The qualitative strand explored perceived barriers to access and lived experiences of engagement with care.
3. Description of each method in terms of sampling, data collection and analysis	Methods, Sections 2.4, 2.5 and 2.6	The quantitative strand used a structured survey with 202 participants across eight pilot sites. The survey included demographic items, mental health-related quality of life, Levesque access items and open-text access questions. The qualitative strand included open-text survey responses and reflective diaries/testimonies from 21 participants who had

		accessed formal mental healthcare in the previous 12 months. Open-text survey data were analysed using framework analysis, diary/testimony data using IPA, and quantitative data using descriptive, univariable and exploratory multivariable analyses.
4. Where integration occurred, how it occurred and who participated	Methods, Section 2.6.1; Integrated Mixed-Methods Findings section	Integration occurred primarily at the interpretation and reporting stage. Quantitative results, framework analysis findings and IPA themes were mapped across the five Levesque user-side domains to identify convergence, divergence and explanatory depth. Integration was undertaken through team-based interpretation and cross-checking by members of the multidisciplinary research team.
5. Limitations of one method associated with the presence of the other	Discussion or Limitations section	The structured survey supported cross-site comparability but may have simplified complex access experiences that cut across several Levesque domains. The diary/testimony component provided rich insight into engagement with care but was limited to participants who had accessed formal mental healthcare in the previous 12 months, offering less direct evidence on those unable to reach services.
6. Insights gained from mixing or integrating methods	Integrated Mixed-Methods Findings section; Discussion	Integration showed that access to mental healthcare was not a linear process but a cumulative and relational experience shaped by interactions between service users, social networks and health systems. Mixing methods clarified both where perceived access barriers were concentrated and how these barriers were experienced and negotiated in practice.

8.4 Appendix D: Supplementary Analyses

Table D1

Reliability scores of subscales

Score	Number of items	Cronbach's alpha	Complete cases
Accessibility total	20	0.713	158
Perceive	4	0.139	170
Seek	4	0.267	179
Reach	4	0.410	188
Pay	4	0.550	186
Engage	4	0.302	192

Table D2

Pairwise Comparisons between Assess Domains

Comparison	V	p	Holm-adjusted p
Perceive vs Seek	4798.00	.002	.012
Perceive vs Reach	7429.50	.801	1.000
Perceive vs Pay	9787.00	< .001	.005
Perceive vs Engage	5276.50	.003	.013
Seek vs Reach	8936.00	.002	.012
Seek vs Pay	10691.50	< .001	< .001
Seek vs Engage	6438.00	.889	1.000
Reach vs Pay	9276.00	.003	.013
Reach vs Engage	5216.00	.003	.013
Pay vs Engage	3267.00	< .001	< .001

Table D3

Lowest Item across Target Groups

Recruitment target group	Domain	Item	Item label	n	M (SD)
Migrants	Pay	Q30	Coverage sufficient to afford care	33	2.48 (1.20)
Migrants	Seek	Q24	People with my background treated fairly	30	2.63 (1.35)
Migrants	Pay	Q32	Financial concerns would not prevent support	33	2.73 (1.42)
Migrants	Perceive	Q21	Accept having a mental health problem	29	2.76 (1.33)
Migrants	Perceive	Q20	Community recognises mental health difficulties	32	2.81 (1.35)
Roma community	Pay	Q30	Coverage sufficient to afford care	30	2.40 (1.57)
Roma community	Pay	Q31	Can afford care-related costs	30	2.57 (1.30)
Roma community	Perceive	Q21	Accept having a mental health problem	30	2.73 (1.28)
Roma community	Seek	Q24	People with my background treated fairly	30	2.83 (1.44)
Roma community	Reach	Q27	Transport or distance rarely prevents care	29	2.86 (1.38)
People with physical or intellectual disabilities	Perceive	Q21	Accept having a mental health problem	23	2.17 (1.53)
People with physical or intellectual disabilities	Engage	Q35	Confident explaining thoughts and feelings	24	2.62 (1.81)

People with physical or intellectual disabilities	Seek	Q23	No fear of being treated differently	23	2.78 (1.83)
People with physical or intellectual disabilities	Perceive	Q20	Community recognises mental health difficulties	21	3.00 (1.64)
People with physical or intellectual disabilities	Seek	Q24	People with my background treated fairly	22	3.27 (1.78)
Youth	Pay	Q30	Coverage sufficient to afford care	22	2.45 (1.06)
Youth	Perceive	Q21	Accept having a mental health problem	22	2.91 (1.48)
Youth	Engage	Q35	Confident explaining thoughts and feelings	22	3.14 (1.21)
Youth	Reach	Q29	Feel safe travelling to care	22	3.18 (1.33)
Youth	Pay	Q32	Financial concerns would not prevent support	21	3.19 (1.12)
LGBTQIA+ community	Pay	Q30	Coverage sufficient to afford care	21	1.81 (0.98)
LGBTQIA+ community	Pay	Q32	Financial concerns would not prevent support	21	2.57 (1.50)
LGBTQIA+ community	Seek	Q24	People with my background treated fairly	21	2.57 (1.33)
LGBTQIA+ community	Pay	Q33	Can rely on others for financial support	21	2.67 (1.28)
LGBTQIA+ community	Engage	Q36	Can speak up if disagreeing with professional	21	2.95 (1.07)
Older adults	Perceive	Q21	Accept having a mental health problem	20	2.65 (1.60)
Older adults	Reach	Q26	Can easily book an appointment	20	2.65 (1.79)

Older adults	Pay	Q32	Financial concerns would not prevent support	20	3.50 (1.57)
Older adults	Seek	Q24	People with my background treated fairly	20	3.55 (1.70)
Older adults	Reach	Q29	Feel safe travelling to care	20	3.60 (1.57)
Survivors of Hatay earthquake	Reach	Q28	Can take time off work or study	20	1.30 (0.57)
Survivors of Hatay earthquake	Pay	Q33	Can rely on others for financial support	20	1.35 (0.59)
Survivors of Hatay earthquake	Seek	Q22	Support from family or close circle	20	1.35 (0.59)
Survivors of Hatay earthquake	Seek	Q25	Can make own help-seeking choices	20	1.35 (0.59)
Survivors of Hatay earthquake	Engage	Q34	Can follow a care plan	20	1.40 (0.68)
Legal guardians of unaccompanied minors	Pay	Q30	Coverage sufficient to afford care	11	1.91 (1.04)
Legal guardians of unaccompanied minors	Pay	Q31	Can afford care-related costs	11	2.18 (0.98)
Legal guardians of unaccompanied minors	Pay	Q32	Financial concerns would not prevent support	11	2.27 (1.27)
Legal guardians of unaccompanied minors	Seek	Q23	No fear of being treated differently	10	2.30 (1.34)
Legal guardians of unaccompanied minors	Perceive	Q20	Community recognises mental health difficulties	11	2.36 (1.21)
Ethnoreligious minorities	Perceive	Q20	Community recognises mental health difficulties	10	1.90 (1.29)
Ethnoreligious minorities	Seek	Q23	No fear of being treated differently	10	2.10 (1.37)

Ethnoreligious minorities	Reach	Q28	Can take time off work or study	10	2.60 (1.17)
Ethnoreligious minorities	Seek	Q24	People with my background treated fairly	10	2.70 (1.34)
Ethnoreligious minorities	Perceive	Q21	Accept having a mental health problem	10	2.80 (1.40)
Older adult migrants	Reach	Q26	Can easily book an appointment	10	1.30 (0.95)
Older adult migrants	Perceive	Q21	Accept having a mental health problem	10	2.70 (1.77)
Older adult migrants	Pay	Q33	Can rely on others for financial support	10	2.80 (1.93)
Older adult migrants	Seek	Q23	No fear of being treated differently	10	3.10 (1.52)
Older adult migrants	Seek	Q24	People with my background treated fairly	10	3.70 (1.64)

Table D4

Relative accessibility domain scores by target group

Target group	Perceive	Seek	Reach	Pay	Engage
Migrants	11.5	12.5	12.9	10.8	13.4
Roma community	13.0	14.2	12.8	11.0	14.2
People with physical or intellectual disabilities	13.5	14.9	15.1	14.2	13.1
Youth	13.6	14.6	13.2	12.4	14.8
LGBTQIA+ community	13.7	13.8	14.1	10.0	13.5
Older adults	14.3	16.2	14.3	14.8	16.1
Survivors of Hatay earthquake	11.5	11.6	9.1	11.3	12.2
Legal guardians of unaccompanied minors	13.0	12.3	13.8	9.7	14.8
Ethnoreligious minorities	11.9	12.6	13.2	13.2	13.7
Older adult migrants	15.0	16.2	13.9	15.3	16.9

Note. Cell values are observed means. Higher scores indicate greater perceived access; green indicates higher relative scores and pink lower relative scores. Colours are scaled within each domain column only; compare colours vertically, not across rows

Table D5

Relative mean accessibility scores across domains by participant characteristics

Grouping	Category	Perceive	Seek	Reach	Pay	Engage
Age	Under 25	12.8	14.4	12.8	12.4	13.9
	25-64	13.1	13.2	13.2	11.4	13.8
	65+	14.2	15.8	13.8	14.4	15.8
Gender	Female	13.1	13.9	12.6	11.9	14.0
	Male	13.5	15.0	14.5	13.4	14.6
	Non-binary	14.0	12.3	13.0	10.2	13.3
Disability	No	13.1	13.9	12.8	11.6	14.2
	Yes	13.3	15.0	14.6	14.4	14.6
Sexual orientation	Heterosexual	13.1	14.3	13.1	12.6	14.3
	LGBQ+	12.9	12.9	13.2	10.6	13.2
Migration background	Migrant	12.5	13.5	13.1	11.5	13.9
	Non-migrant	13.1	14.0	13.0	12.3	14.0
MHQoL category	Not poor	13.5	14.4	13.6	12.5	14.6
	Poor	11.7	12.5	12.2	10.9	12.8
Spoken to MH professional/service	No	12.5	13.7	12.8	11.2	14.2
	Yes	13.2	14.0	13.3	12.4	14.0

Note. Cell values are subgroup means. Higher scores indicate greater perceived access; green indicates higher relative scores and pink lower relative scores. Colours are scaled within each domain column only; compare colours vertically, not across rows

Table D6

Regression

Independent Variable	*B*	*SE*	*95% CI*	*t*	*p*
Intercept	66.43	1.82	[62.82, 70.04]	36.47	< .001
Age: Under 25 vs 25-64	2.57	2.17	[-1.73, 6.88]	1.18	.239
Age: 65+ vs 25-64	9.11	2.28	[4.59, 13.62]	3.99	< .001
Gender: Male vs Female	6.85	1.99	[2.90, 10.80]	3.43	< .001

Sexual orientation: LGBQ+ vs Heterosexual	-4.40	2.70	[-9.76, 0.95]	-1.63	.106
Disability: Yes vs No	4.96	2.20	[0.60, 9.32]	2.25	.026
Migration background: Migrant vs Non-migrant	2.83	2.62	[-2.36, 8.01]	1.08	.283
Poor MHQoL vs Non-poor MHQoL	-6.70	2.13	[-10.92, -2.48]	-3.14	.002
Spoken to MH professional/service: Yes vs No	-1.64	2.03	[-5.66, 2.37]	-0.81	.420

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LGBT IRELAND For Inclusion For Equality For Everyone

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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

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