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COMMUNITY-DRIVEN INCLUSIVE, EQUITABLE, MENTAL HEALTHCARE ACCESS

D2.4: Multi-dimensional evaluation of innovative mental health services

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Executive Summary

This deliverable presents the results of Task 2.4 of the EQUICARES project, which aimed to evaluate selected mental health services in terms of their contribution to improving equitable access to mental healthcare for vulnerable populations. Building on the service identification and mapping activities conducted in Tasks 2.2 and 2.3, twenty services across Ireland, Spain, Turkey, and France were assessed using a common evaluation framework based on the Levesque conceptualisation of access to healthcare. The evaluation focused on five dimensions of access: approachability, acceptability, availability and accommodation, affordability, and appropriateness. A mixed-methods approach was used to capture both quantitative and qualitative perspectives on service accessibility. Stakeholders, healthcare and social care professionals, service providers, researchers, and other relevant actors, assessed the selected services using a structured questionnaire. In addition to rating services across the five access dimensions, participants completed a weighting exercise to determine the relative importance assigned to each dimension. The qualitative data were collected through focus group discussions, which explored perceptions of service accessibility, barriers and facilitators to access, and explanations for the observed rating patterns.

The findings demonstrate that access to mental healthcare is inherently multidimensional and that no single access dimension alone determines whether a service is perceived as accessible. Across countries, stakeholders consistently emphasised that services should not only be available and affordable, but also acceptable, appropriate, and available. However, the evaluation also showed that the relative importance of these dimensions differ according to context and the needs of specific population groups. Stakeholders highlighted that vulnerable populations often face multiple and overlapping barriers to care, including stigma, language barriers, limited awareness of available services, financial constraints, social exclusion, and difficulties navigating complex healthcare systems. As a result, services that may be highly accessible for one population group are not necessarily perceived as equally accessible for another. The weighting exercises revealed both shared priorities and country-specific differences. Appropriateness emerged as one of the most important dimensions across countries, reflecting the importance of services that effectively respond to users' needs and circumstances. Acceptability and approachability were particularly valued in Ireland and France, where stakeholders emphasised the importance of stigma reduction, cultural sensitivity, trust, and clear communication. In Turkey, affordability and availability received the highest weighting, reflecting concerns related to service capacity, geographical access, and financial barriers. In Spain, availability and appropriateness were prioritised, highlighting the importance of timely access to services that adequately address the needs of diverse and often vulnerable population

groups. Across countries, the most highly rated services shared several common characteristics. Community-based delivery models, outreach approaches, health mediation, peer support, early intervention, and culturally responsive services were consistently perceived as effective mechanisms for reducing barriers to care. In particular, services targeting specific vulnerable populations, including migrants and refugees, ethnic minorities, women during the perinatal period, young people, and individuals living in low-resource settings, received strong evaluations when they combined low-threshold access with tailored and person-centred support. These findings suggest that improving access to mental healthcare requires not only expanding service provision but also adapting services to the social, cultural, and practical realities of the populations they are intended to serve. The qualitative findings further demonstrated that barriers to access extend beyond the characteristics of individual services. Limited awareness of available support, complex service pathways, stigma, language barriers, financial constraints, and geographic distance were frequently identified as obstacles to care. Conversely, community engagement, culturally responsive approaches, integrated care models, trusted intermediaries, and simple, low-threshold access routes were consistently identified as facilitators of service use. Together, these findings highlight the importance of adopting a person-centred and equity-oriented approach to service design and implementation.

Beyond the evaluation of individual services, this deliverable demonstrates the value of combining the Levesque access framework with stakeholder weighting exercises and qualitative reflections to assess mental health services from an access and equity perspective. The approach enabled the identification of both service strengths and limitations while taking stakeholder priorities into account. The findings provide practical insights for service providers, policymakers, and researchers seeking to improve access to mental healthcare and reduce inequalities among vulnerable populations. The results of this deliverable form an important evidence base for subsequent EQUICARES activities.

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1. Role of the Deliverable in the Project

This deliverable reports the findings of Task 2.4 and represents a key step in the EQUICARES project's efforts to identify, evaluate, and promote promising approaches for improving equitable access to mental healthcare among vulnerable populations. Building on the service identification and mapping activities conducted in Tasks 2.2 and 2.3 (an overview of the services selected by each task is presented in Table 1. A more detailed description of the services is provided later in the report), the deliverable provides an assessment of selected mental health services from different national contexts, focusing on their potential contribution to reducing barriers to care and supporting more equitable access to mental health services. The deliverable contributes to the overall objectives of EQUICARES by generating evidence on how different service models address the needs of vulnerable groups and by examining the factors that facilitate or hinder access to care. Through the involvement of multiple stakeholder groups, including possible service users, healthcare professionals, service providers, policymakers, and researchers, the evaluation captures a broad range of perspectives on the accessibility and perceived value of the selected services. The findings presented in this deliverable provide insights into the strengths, limitations, and transferability of innovative and promising practices identified across partner countries. In doing so, the deliverable supports the project's broader ambition to improve understanding of equitable access to mental healthcare and contributes to the identification of services that may serve as examples of good practice within the EQUICARES Atlas, as the most promising services will be promoted here. This deliverable therefore serves as an important bridge between the identification of promising services and the wider project activities aimed at knowledge exchange, policy learning, and the promotion of effective approaches to improving access to mental healthcare for people in vulnerable situations.

Table 1: Selection of services by T2.2 and T2.3

T2.2	T2.3
Spunout Navigator	The Friendship Bench
L'OmÉDIT Normandie	Thinking Healthy Programme
En Buena Edad	Step-by-Step
Gesundheitstreffpunkt Mannheim	StrongMinds
Foundation Health Problems of Minorities	We Matter Too
EPAPSY	
Family physicians in MHC	
Private Health Center Normandie	
Confederación Salud Mental España	
Plus e.V.	
Health mediators via the National Network of Health Mediators	
CAMHI	
Hatay Refugee Response Operations	
Hara	
AMKE IASIS	

2. Introduction

2.1 Background

Mental health problems remain one of the most important public health and social challenges in Europe. They affect around 84 million people in the European Union (EU), roughly one in six people, and were associated with annual costs of more than €600 billion, equivalent to over 4% of the European Union's Gross Domestic Product (GDP)[1,2]. This burden is not temporary or marginal. The GBD 2019 Mental Disorders study found that mental disorders remained among the ten leading causes of health loss worldwide, with no evidence of a global reduction in burden since 1990[1,3].

The situation in Europe has become more acute in recent years. OECD and EU analyses show that the COVID-19 pandemic had a particularly strong effect on young people's mental health: in several European countries, the share of young people reporting symptoms of depression more than doubled, and around half of young Europeans reported unmet needs for mental health care[4]**.** More recent EU survey evidence confirms that mental distress and access difficulties remain widespread: 46% of EU citizens reported an emotional or psychosocial problems in the previous 12 months, 25% said that they or a family member had encountered difficulties accessing mental health services, and around half of those experiencing a mental health issue had not sought professional help[4,5].

Against this background, the conceptual framework developed by Levesque, Harris and Russel (2013)[6] offers a strong basis for evaluating access to mental health services. The framework understands access as the result of an interaction between characteristics of services and the capacities of people and communities to recognize need, seek care, reach services, pay for care, and engage with treatment. It distinguishes five service-side dimensions of access: approachability, acceptability, availability and accommodation, affordability, and appropriateness[6]. This is especially useful in mental health, where access barriers are rarely only financial. The framework therefore provides an analytically clear way to examine not only whether services exist, but whether they are realistically accessible to the people who need them[6]. The mixed-methods design used in T2.4 follows directly from this evidence base. The questionnaire component provides a structured and comparable way to assess selected services across the five Levesque dimensions. Adding swing-weighting strengthens this approach by eliciting the relative importance stakeholders assign to improvements in each dimension, rather than relying only on undifferentiated statements that all dimensions are important. In Multiple-Criteria Decision Analysis (MCDA) terms, swing-weighting asks participants to judge the value of moving a criterion from a low to a high level and is therefore well suited to situations where several relevant criteria must be weighted transparently against one another[7].

The focus group component complements the questionnaire by adding contextual explanation, collective reflection, and practical interpretation. Focus groups are well established in health research as a way of exploring perceptions, experiences, and shared understandings that are difficult to capture through closed-response instruments alone[8]. In mixed-methods research, combining quantitative and qualitative evidence can produce stronger and more actionable findings by allowing numerical patterns to be interpreted, tested, and contextualized[9]. In T2.4, this makes it possible not only to compare how services are rated across access dimensions, but also to understand why certain services are seen as more or less accessible, which barriers matter most in practice, and what kinds of improvements are most relevant from a stakeholder perspective. The expected contribution is therefore twofold: a structured assessment of promising services against a common access framework and a policy-relevant understanding of where and how mental health service access can be improved more equitably across different contexts and population groups.

2.2 Objectives

The objective of this work was to evaluate selected mental health services across participating partner countries in terms of their contribution to improving access to care. The evaluation focused on understanding how services support different dimensions of access and how the services are perceived by different stakeholder groups. More specifically, this work aimed to assess service accessibility across predefined access dimensions, determine the relative importance of these dimensions from stakeholder perspectives, and explore perceived barriers and facilitators influencing access to mental health services. To achieve this objective, the following specific objectives were defined:

1. To assess at least 15 selected mental health services from T2.2 and 5 services from T2.3 across multiple dimensions of access, based on a structured framework reflecting different aspects of accessibility.
2. To determine the relative importance of access dimensions using a structured weighting approach that captures stakeholder priorities.
3. To compare services based on their performance across access dimensions, allowing identification of services that are perceived as more accessible or effective.
4. To explore perceived barriers and facilitators influencing service accessibility, based on stakeholder reflections collected through focus group discussions.

3. Methods

3.1 Study design

T2.4 applied a mixed-methods approach to evaluate access to selected mental health services across participating partner countries. The methodology combined structured questionnaire data with qualitative focus group discussions to provide both quantitative and contextual interpretation of service accessibility. The evaluation focused on services identified by T2.2 and T2.3. Services included preventive, community-based, early intervention, or treatment-oriented initiatives relevant to the target populations. Each partner evaluated approximately five services, resulting in a combined set of services across the consortium. In addition to service ratings, the methodology included a structured weighting exercise based on the swing-weight methodology. This approach allowed participants to indicate the relative importance of different access dimensions and enabled calculation of weighted service scores reflecting stakeholder priorities. The methodological process consisted of four main stages: 1) selection and description of services (in T2.2 and T2.3) 2) collection of quantitative and qualitative data, 3) analysis of questionnaire and focus group findings, 4) integration of results to support interpretation of service accessibility.

3.2 Conceptual framework

The evaluation was guided by the Levesque framework for understanding access to healthcare[10]. Access was considered as a multidimensional concept that reflects both service characteristics and the ability of individuals to use services. Five key dimensions of access were used as evaluation criteria; 1) Approachability: the extent to which services can be identified and understood by potential users, 2) Acceptability: the degree to which services are culturally and socially appropriate 3) Availability and accommodation: the extent to which services can be reached in a timely and practical manner, 4) Affordability: the financial accessibility of services, 5) Appropriateness: the extent to which services meet user needs and provide suitable support.

3.3 Data collection

Data collection consisted of two main components: a structured questionnaire and focus group discussions. Both components were implemented by four partners: KOC University, LGBT Ireland, FISEVI and L'ADAPT.

3.3.1 Participant recruitment

Participants were recruited locally by each partner using purposive sampling strategies to ensure inclusion of individuals with relevant perspectives on mental health services. Recruitment aimed to

include representation from the following stakeholder groups: potential service users in the specific country, healthcare or social care professionals, and other relevant stakeholders, including service providers, community representatives or support organisations. Partners recruited participants through existing networks, collaborating organisations, and local service contacts where appropriate. Each partner recruited a minimum of eight participants to support both questionnaire completion and participation in the focus group discussion.

3.3.2 Methodological and ethical approach to participant recruitment

Participants were recruited as potential end-users and relevant stakeholders able to reflect on the accessibility of the selected mental health services. Recruitment was not based on diagnosis, medical status, or confirmed previous use of the specific services evaluated. This approach was adopted to avoid requiring participants to disclose personal mental health status, clinical information, or proof of service use.

Discussions did not require participants to share personal mental health histories, clinical details, or individual experiences of receiving care. Instead, the focus groups explored perceptions of accessibility, anticipated user experience, barriers and facilitators to access, and the practical relevance of the selected services for people in vulnerable situations. This was considered appropriate for the objective of T2.4, which focuses on access to services and the accessibility of innovative solutions, rather than on clinical effectiveness, treatment outcomes, or individual health conditions.

This ethically informed approach helped minimize data protection and ethics risks by avoiding unnecessary processing of sensitive health-related personal data. Collection of confirmed patient status, diagnostic information, or individual service-use histories would have been more appropriate for a clinical effectiveness or patient outcome study, but was not necessary for assessing perceived accessibility, acceptability, availability, affordability, and appropriateness of the selected services.

Elements of Patient-Reported Experience Measures were therefore used as a conceptual guide to structure discussion around user-centred aspects of access, including clarity of information, ease of navigation, responsiveness, acceptability, perceived appropriateness, and potential barriers to use. PREM elements were not administered as a formal individual-level questionnaire and were not used to collect identifiable patient experience or clinical data.

3.3.3 Questionnaire

A structured questionnaire was developed and implemented in Qualtrics to collect quantitative data on perceived accessibility of selected mental health services and the relative importance of different access dimensions. The questionnaire included standardised service descriptions and was designed to be completed either individual prior to the focus group or during the focus group session itself. A copy of the Irish questionnaire is provided in Appendix A. The Irish version is presented as the original questionnaire was developed in English. Questionnaires used in the other participating countries followed the same structure, content, response options, and rating scales, with translation into the respective local languages where necessary.

The questionnaire consisted of multiple steps: participants were first presented with standardised descriptions of the selected mental health services. These descriptions provided essential information about each service, including the target population, type of support provided, access pathways, and delivery setting. Participants were encouraged to read the descriptions carefully before proceeding to the rating tasks. Where necessary, facilitators provided clarification to ensure the participants understood the purpose and characteristics of each service. Following review of the service descriptions, participants rated each service across the five predefined Levesque dimensions. A standardised rating scale was used across all partners to ensure comparability of results. All participating countries used the same rating instrument, including identical response categories, scale anchors, wording, and instructions for respondents. The scale ranged from 1 to 10, with higher scores indicating a greater perceived contribution of the service to improving access to mental healthcare. After completing service ratings, participants were asked to consider the five access dimensions in relation to each other. Participants were asked to imagine a situation in which all access dimensions were initially at a low level and to identify which improvement would have the greatest impact on access to services. Based on this scenario, participants ranked the five access dimensions according to priority, starting with the dimension considered most important to improve. Following the ranking exercise, participants assigned relative scores to each access dimension to reflect its importance compared to the others. This process followed a structured swing-weight approach. Participants allocated scores to each dimension in relation to the highest-ranked dimension. These scores reflected the perceived importance of improving each dimension from a low to a high level of accessibility. Clear instructions were provided to participants to support completion of this exercise. Where questionnaires were completed during focus group sessions, facilitators provided additional clarification to ensure consistent understanding. The resulting scores were later converted into normalized weights representing the relative importance of each access dimension.

3.3.4 Focus group discussions

Focus group discussions were conducted as part of the data collection process to obtain qualitative information supporting interpretation of questionnaire findings. Each partner organised and conducted one focus group discussion using harmonised guidance materials. Participants in the focus groups were recruited from the same stakeholder groups involved in questionnaire completion. Where feasible, individuals who completed the questionnaire were invited to participate in the focus group discussion to allow direct reflection in their responses. Focus group discussions were structured around predefined themes aligned with the five access dimensions. Discussions focused on collecting qualitative information related to perceptions of the usefulness and relevance of evaluated services, explanations for higher and lower service ratings, perceived barriers to accessing services, factors supporting access and service use, suggested improvements to increase accessibility, and identification of services considered most promising for improving access. These discussion themes were applied consistently across all partner sites. Focus group discussions were documented using standardised note templates provided to all partners. Templates were structured according to predefined discussion themes to support consistent recording of information across partner contexts. Key discussion points were recorded during each session, including identified barriers enabling factors, perceived service strengths, and proposed improvements.

3.4 Data analysis

Data analysis consisted of both quantitative and qualitative components corresponding to the questionnaire and focus group data collected across partner sites. The two components were analysed separately and subsequently combined to support interpretation of findings related to service accessibility. Quantitative analysis focused on processing questionnaire responses to generate service scores and identify patterns across access dimensions. Qualitative analysis focused on summarizing key themes emerging from focus group discussions.

3.4.1 Quantitative analysis

Quantitative analysis began with the processing of service rating responses collected through the questionnaire. Participants rated each selected service across the five predefined access dimensions. Responses were compiled and aggregated for each partner. For each participant, service ratings were combined with the participant's own weighting of the Levesque access dimensions to generate weighted service scores. These participant-level weighted scores were subsequently averaged across respondents to obtain overall service scores for each access dimension and service. This approach ensured that individual differences in the perceived importance of access dimensions were retained in the final results. Following the aggregation of service ratings, responses from the relative importance exercise based on the swing-weight methodology were used to determine the relative importance of the five access dimensions. Participants ranked the access dimensions according to

priority and assigned relative scores to reflect the importance of improving each dimension. These scores were converted into normalized weights representing the relative importance of each access dimension. Weights were calculated at participant level and subsequently aggregated to obtain overall weights at partner level, ensuring that stakeholder priorities were incorporated into the evaluation. Once normalized weights were established, weighted service scores were calculated by combining service ratings with the corresponding access dimension weights. For each service, ratings across the five access dimensions were multiplied by the relevant weights, and the resulting values were combined to produce an overall weighted score.

The quantitative results were summarised using descriptive statistical methods. Outputs included average scores per service, performance across individual access dimensions, relative importance of each access dimension, and overall weighted scores per service. Results were summarised at partner level and used to identify patterns in received accessibility across evaluated services. Where applicable, summarised quantitative results were also used to support reflection during focus group discussions.

3.4.2 Qualitative analysis

Qualitative analysis was conducted using structured notes collected during focus group discussions. Notes from each partner were compiled and reviewed to identify patterns in participants' perceptions of service accessibility and to support interpretation of quantitative findings. The analysis focused on identifying recurring issues and shared perspectives across participants rather than individual statements. Information recorded during the discussions included participant reflections on the usefulness and relevance of evaluated services, explanations for higher and lower service ratings, perceived barriers to accessing services, factors supporting service use, suggested improvements, and identification of services considered most promising for improving access. To support systematic interpretation, focus group notes were reviewed and organized according to predefined discussion themes aligned with the five access dimensions. During this process, statements and observations were grouped into thematic categories reflecting barriers, facilitators, service strengths, and improvement needs. Where similar issues were raised by multiple participants or across different services these were identified as recurring themes.

Following initial organization, thematic summaries were developed for each partner site. These summaries highlighted key factors influencing access to services, including commonly reported barriers such as limited awareness of services, organisational constraints, or contextual challenges affecting service use. Where relevant, qualitative findings were compared with quantitative results to explore possible explanations for observed rating patterns. For example, services receiving lower scores in specific access dimensions were examined alongside qualitive comments to identify

underlying reasons, such as perceived complexity of access pathways or limited suitability for certain population groups. Similarly, services receiving higher ratings were reviewed to identify characteristics considered beneficial by participants.

4. Main results

4.1 Ireland

In Ireland, five mental health services were evaluated in relation to their contribution to improving access to care across the Levesque access dimensions. The assessment was informed by participants involved in the EQUICARES working group coordinated by LGBT Ireland. While not all participants represented LGBTQI+ organisations directly, all were members of the working group and had experience discussing mental health access and policy issues affecting LGBTQI+ populations.

Reflection on the access dimensions

Figure 1 presents the relative importance assigned to the different access dimensions by participant as part of the weighting exercise. Acceptability and approachability emerged as the dimensions considered most important for improving access to mental health care. Availability and appropriateness were assigned similar levels of importance, while affordability received comparatively lower weighting, although it was still considered a relevant component of access to care.

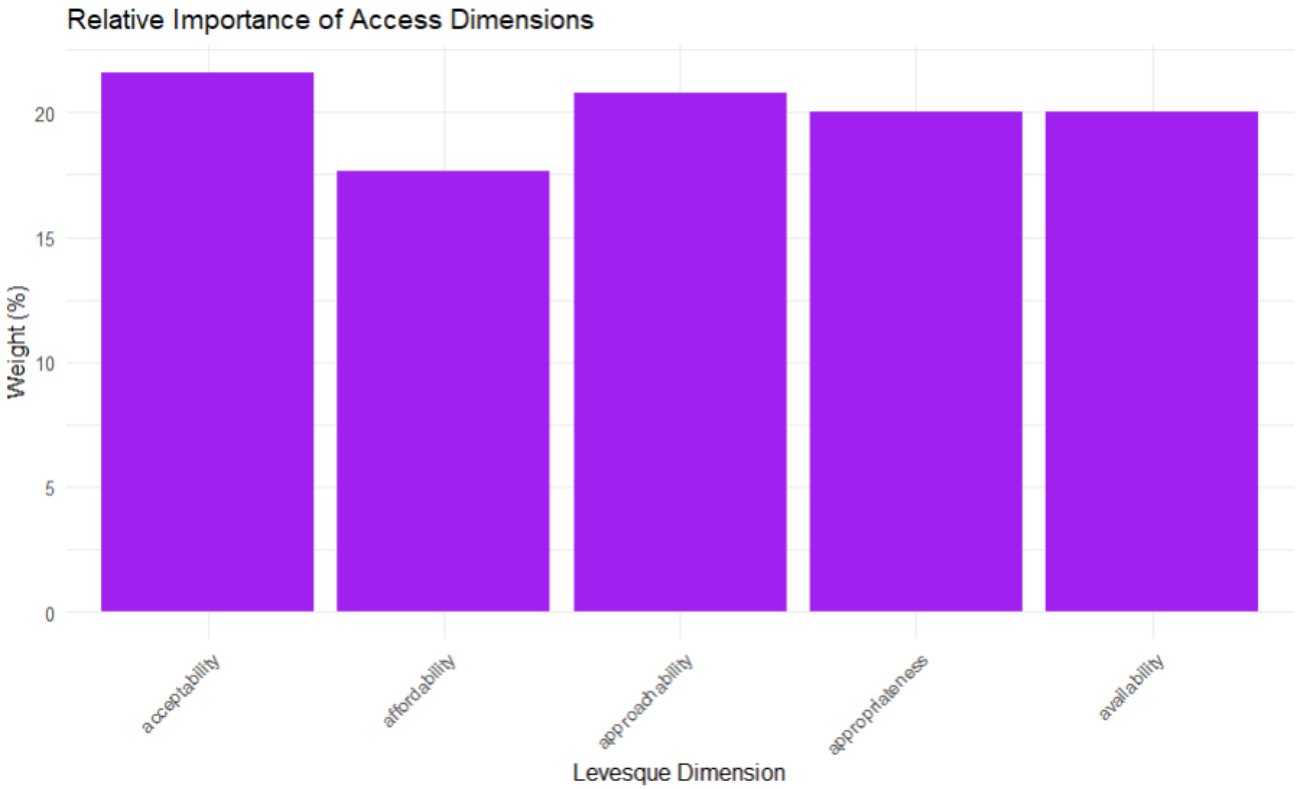

Figure 45: Relative importance of the Levesque access dimensions in Ireland based on stakeholder weighting exercise

Within the focus groups it was discussed that dimensions blend into each other in practice and are hard to rank. Participants stress that for many people, access and affordability can't be really

separated. Travel, time and money are all bound together. One participant noted that for someone who has to move from rural to urban areas to get care: *"access and affordability are fundamentally, for a lot of people, the same thing, even if it's then geographic constraints, which also have cost implications".* They also broaden approachability beyond just visibility: one participant says that *"approachability already includes affordability* , because *"the service is either approachable or not from a financial perspective".* They suggest that the dimensions are better seen as a matrix between the service user and the service, rather than strictly separate concepts. Overall they reject the idea that one Levesque dimension can be dialled up to fix access: *"I don't think that there's one dimension that fundamentally shifts this in a positive way .. they all speak to one another*. Instead they emphasise service responsiveness and trauma-informed care, asking whether the service *"meets the person where they're at*" as the crucial quality.

Interventions

Spunout Navigator

The first service, Spunout Navigator[11], is an online navigation tool that provides personalized information about mental health support options for individuals experiencing mental health difficulties. The service aims to improve navigation within the mental health system by guiding users towards services that best match their needs. The platform can be accessed independently online without the need for referral and is intended to support early identification of appropriate care options**.**

Figures 2 and 3 present the access profile of the Spunout Navigator across the five Levesque access dimensions. Figure 2 shows the unweighted profile, reflecting the raw service scores without taking into account the relative importance assigned to the different access dimensions by participants. Figure 3 presents the weighted profile, in which service scores were adjusted based on the relative importance of the access dimensions derived from the weighting exercise.

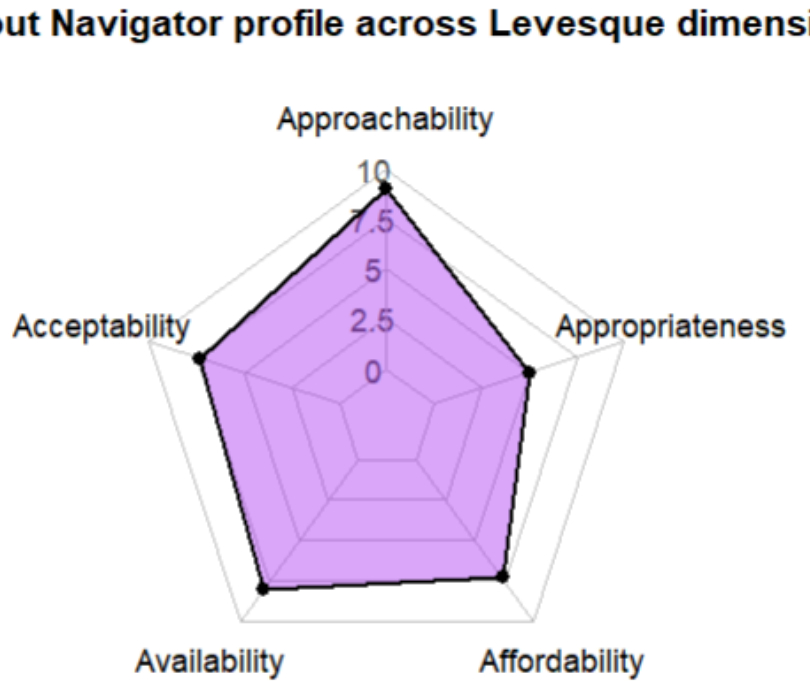

Figure 46: Unweighted access profile of the Spunout Navigator as assessed in Ireland across the Levesque access dimensions

Across both figures, the Spunout Navigator received particularly high scores for approachability. The service also scored relatively positively on acceptability, availability, and affordability, although to a lesser extent. In contrast, appropriateness received comparatively lower scores in both the weighted and unweighted profiles.

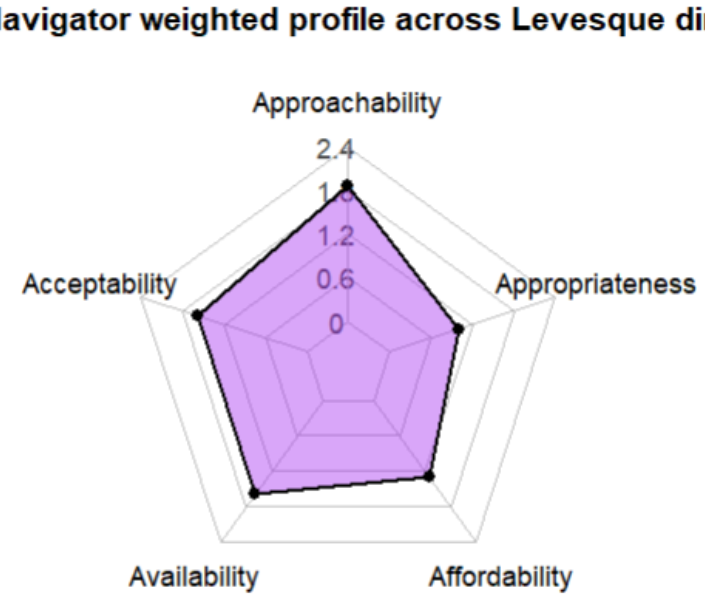

Figure 47: Weighted access profile of the Spunout Navigator as assessed in Ireland across the Levesque access dimensions

In the focus group discussion, participants talk about Spunout Navigator as a very strong, youth-friendly entry point into the system. Participant 1 calls it "*a really practical tool … for young people"*,

stressing that *"you get on it, you're clicking through. It's a really practical tool, I think, for young people like that, ease of access. Don't have to go anywhere. Younger people don't always like to, you know, get up and go out and have to go to the place. It's just on your phone, on your computer, very , very easy to use".* Participant 3, goes even further, saying *"I think the Spunout Navigator is excellent … They really have been excellent. I mean, they offer such a tremendous range of services, and so I really can't speak highly enough of them, and I think the navigator is excellent".* Participant 4 later adds that, from an access perspective, *"the service that's easiest to access in that list is the Spunout Navigator, because it exists online"*, which makes it highly approachable compared to more resource-intensive, please-based services. At the same time, they are quite open about the limitations. Participant 2 says, when asked which service could most improve access: *"I personally would like to say Spunout Navigator, but I don't think that it can, but it can't because it can't address all the systemic issues and the waiting lists and all the other thing that it just refers on."* Participant 1 summarises this by saying that *"Spunout Navigator is definitely part of the picture. But yeah, like it's, it's clearly not the answer is it? It's part of the answer, not the answer".* Participant 4 frames this in terms of depth: *"it's perhaps the service that also has the least direct depth of impact, because essentially, it's a signposting service so the depth it can trigger indirectly by getting people to the right service is quite substantial, but as a service itself, it's quite limited compared to, say, for example, the refugee support".*

Gesundheitstreffpunkt Mannheim

The second evaluated service, Gesundheitstreffpunkt Mannheim[12], provides access to a broad range of self-help groups and peer support networks for individuals experiencing health problems, mental health challenges, or difficult life situations. The service is community-based and participatory in nature, with many activities organized and facilitated by peers rather than healthcare professionals. Through regular meetings, exchange of experiences, and support in navigating health and social care systems, the service aims to strengthen empowerment, social connectedness, and individuals' ability to manage their own wellbeing. Participation is voluntary, generally free of charges, and does not require formal referral.

Figures 4 and 5 present the access profile of Gesundheidstreffpunkt Mannheim across the five Levesque access dimensions. Figure 4 shows the unweighted profile, reflecting the raw service scores without accounting for the relative importance assigned to the different access dimensions by participants. Figure 5 presents the weighted profile, in which the service scores were adjusted based on the relative importance of the access dimensions derived from the weighting exercise.

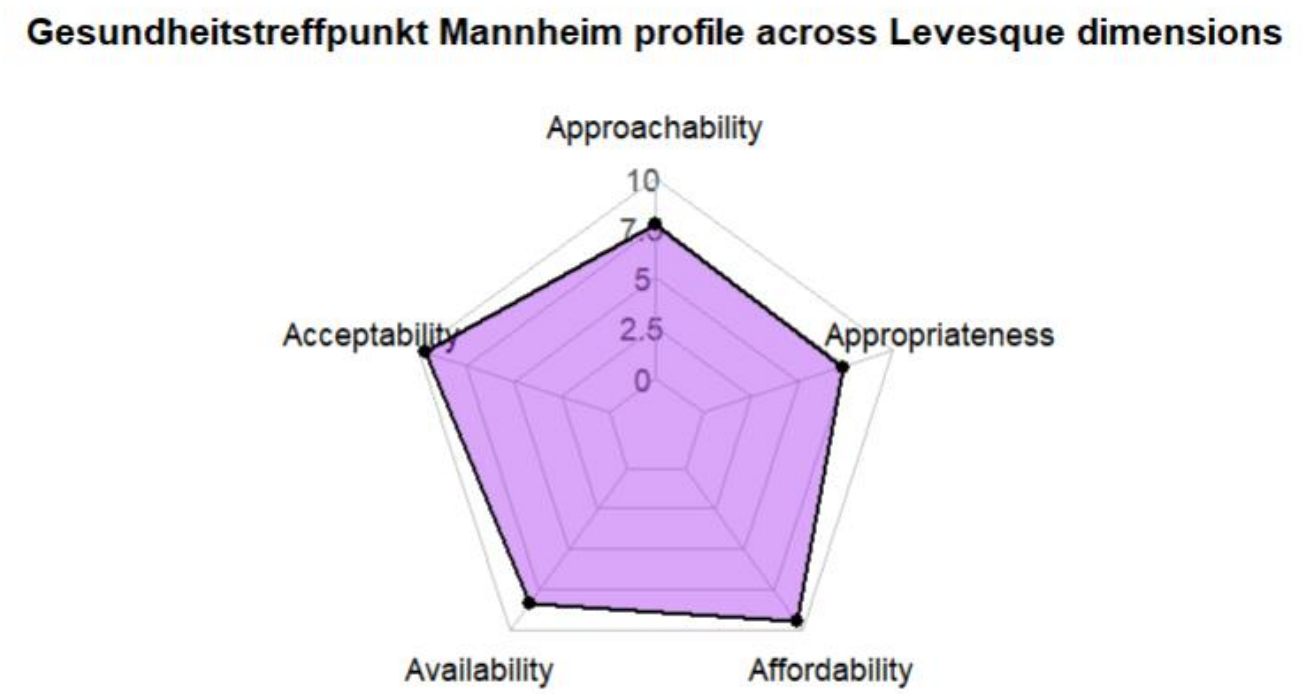

Figure 48: Unweighted access profile of Gesundheitstreffpunkt Mannheim as assessed in Ireland across the Levesque access dimensions

Gesundheistreffpunt Mannheim received relatively high scores across all access dimensions in both the weighted and unweighted profiles. The service scored highest on acceptability. Scores for approachability, availability, and affordability were also consistently positive. Appropriateness received comparatively lower scores than the other dimensions, although it remained positively evaluated overall.

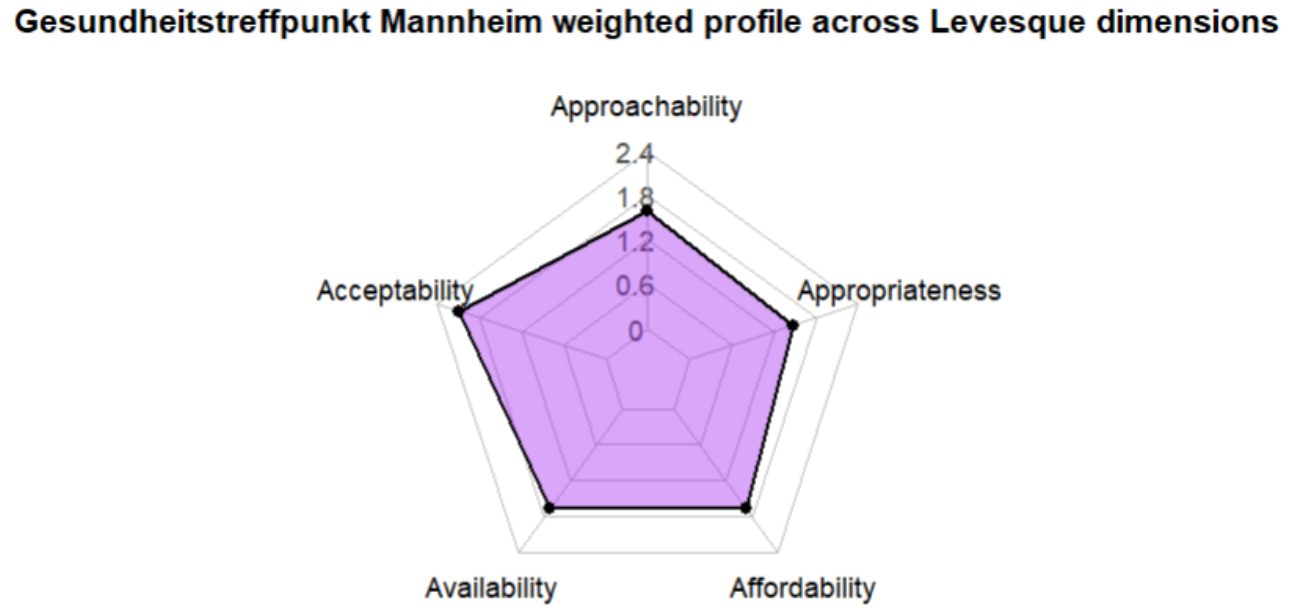

Figure 49: Weighted access profile of Gesundheitstreffpunkt Mannheim as assessed in Ireland across the Levesque access dimensions

The Gesundheitstreffpunkt Mannheim service was discussed more briefly, yet participants still identified clear strengths. One participant described it as *"interesting social connectedness, self-management of health and wellbeing"*, and commented that this *"very much aligns with, you know, broad strokes of mental health policy".* This combination of social connectedness, self-management and participatory organisation was regarded as conceptually attractive and policy-congruent. However, the group repeatedly stressed that they had insufficient information to assess Gesundheitstreffpunkt Mannheim in detail. As stated by one of the participants: *"I need to know a whole lot more about them before I can consider that really"*. As a result, Gesundheitstreffpunkt Mannheim was seen as an interesting community-based, self-organised model with potential, but participants did not feel able to comment on concrete access barriers or feasibility beyond the conceptual level.

We Matter Too

We Matter Too is a community-based initiative focused on improving mental health support for young people through culturally relevant and low-threshold approaches[13]. The service uses creative methods, including hip-hop and rap music, to stimulated conversations about mental health and reduce stigma. In addition to awareness-raising activities, the service provides brief psychosocial interventions for young people experiencing mild psychological distress. Support is delivered in community settings by trained facilitators and trusted local community members, such as barbers. The service also includes activities related to life skills and entrepreneurship support. Its overall aim is to improve access to mental health support by increasing community engagement and reducing barriers related to stigma and service accessibility.

Figures 6 and 7 present the access profile of We matter Too across the five Levesque access dimensions. Figure 6 shows the unweighted profile, reflecting the raw service scores without taking into account the relative importance assigned to the different access dimensions by participants. Figure 7 presents the weighted profile, in which the service scores were adjusted based on the relative importance of the access dimensions derived from the weighting exercise.

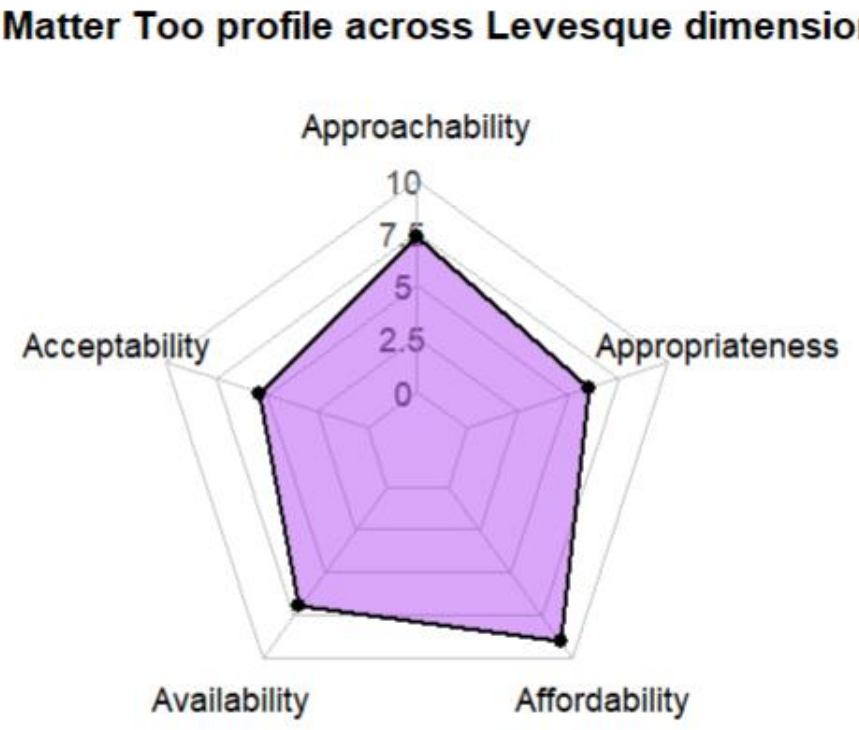

Figure 50: Unweighted access profile of We Matter Too as assessed in Ireland across the Levesque access dimensions

In the unweighted profile (Figure 6), We Matter Too received its highest scores on affordability, indicating that participants received the intervention as highly financially accessible and low-threshold. In contrast, acceptability received comparatively lower scores. Scores for approachability and appropriateness were situated between these two dimensions and were evaluated moderately positively overall. In the weighted profile (Figure 7), the stronger performance on affordability became less pronounced due to the comparatively lower relative importance assigned to affordability during the weighting exercise.

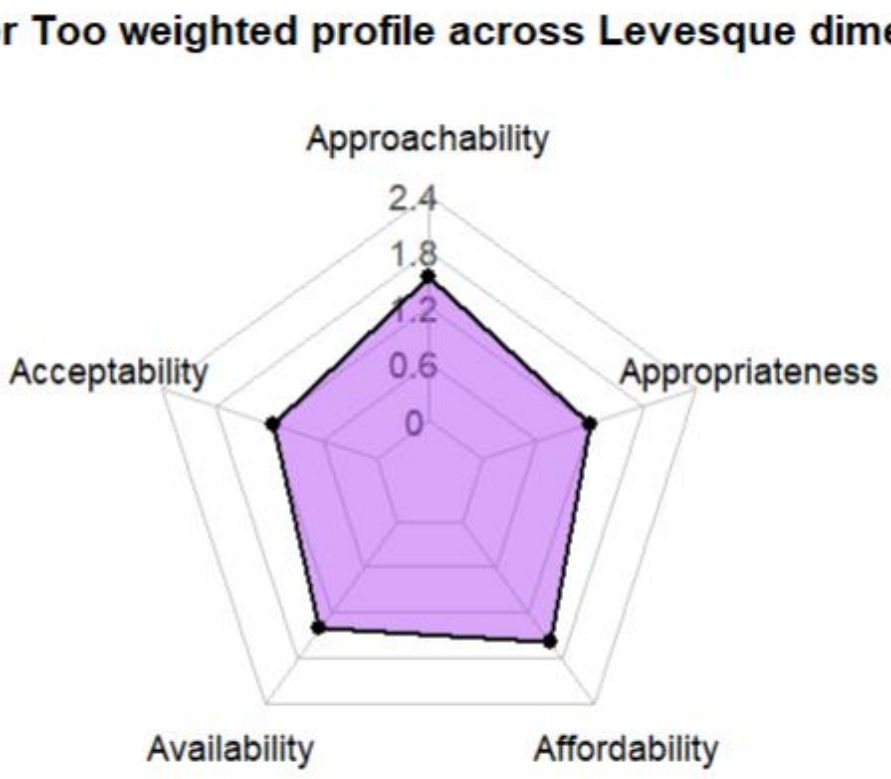

Figure 51: Weighted access profile of We Matter Too as assessed in Ireland across the Levesque access dimensions

The service We Matter Too was only discussed briefly, but was nonetheless singled out as noteworthy, particularly for its target youth focus. Participants appreciated its apparent specificity to certain youth populations and its use of approaches that seemed, at least from the limited description, innovative or engaging. No explicit cons were raised for We Matter Too as an individual service, but it is implicitly covered by the broader methodological limitation highlighted by the group. The key considerations they would have liked to assess: *"physical access and affordability …. but also awareness of services"*, were in their view: *"difficult to measure based on the information provided".* Accordingly, We Matter Too appears in the deliverable primarily as an *"interesting"* and *"very targeted"* youth services with potential, but one for which data on accessibility and barriers currently insufficient.

Plus e.V.

The fourth service, Plus e.V[14], provides counselling, psychosocial support, and community-based assistance for LGBTQIA+ refugees and migrants from diverse cultural backgrounds. The service is tailored to a population group that may experience multiple barriers to accessing care, including stigma, language barriers, legal uncertainty, and limited access to culturally appropriate services. Support activities may include individual counselling, peer support, and guidance in accessing health and social care systems. The service is delivered through community-based organisations and aims to provide safe, inclusive, and culturally sensitive support through low-threshold access pathways.

Figures 8 and 9 present the access profile of Plus e.V. across the five Levesque access dimensions. Figure 8 shows the unweighted profile, reflecting the raw service scores without taking into account the relative importance assigned to the different access dimensions by participants. Figure 9 presents the weighted profile, in which the service scores were adjusted based on the relative importance of the access dimensions derived from the weighting exercise.

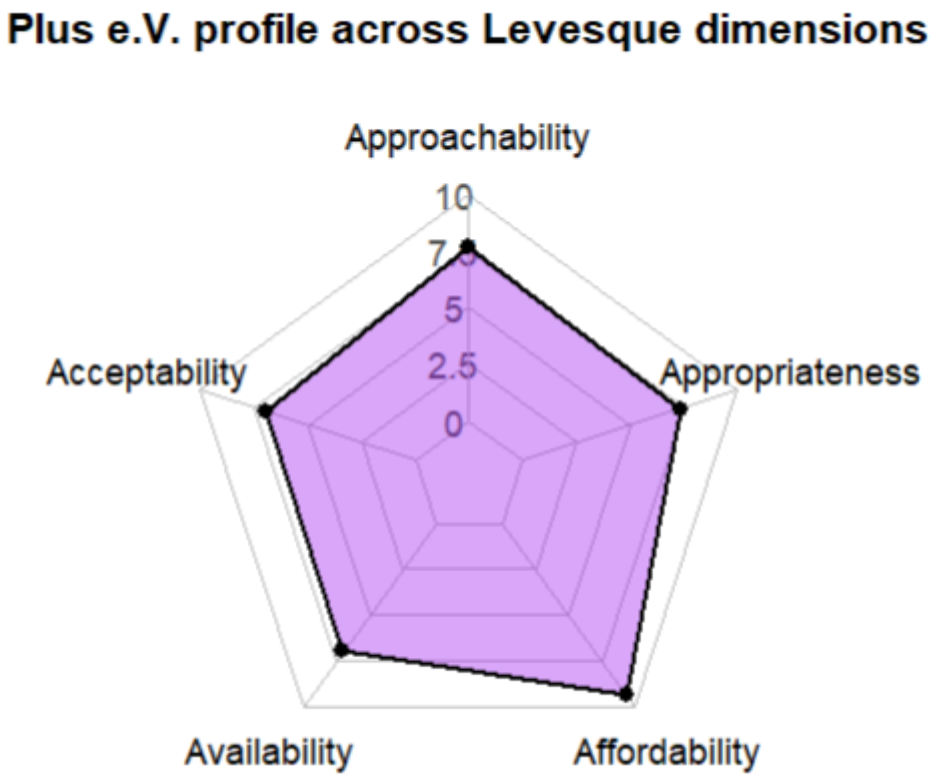

Figure 52: Unweighted access profile of Plus e.V. as assessed in Ireland across the Levesque access dimensions

In the unweighted profile (Figure 8), Plus e.V. received its highest score on affordability, indicating that participants perceived the service as highly financially accessible and low-threshold. The remaining dimensions: approachability, acceptability, availability, and appropriateness, also received relatively high scores overall, suggesting a broadly positive perception of the service across different aspects of access. In the weighted profile (Figure 9), the differences between dimensions became less pronounced, resulting in a more balanced overall profile in which all dimensions scored relatively similarly. This reflects the influence of the weighting exercise, in which affordability received comparatively lower relative importance compared to some of the other access dimensions.

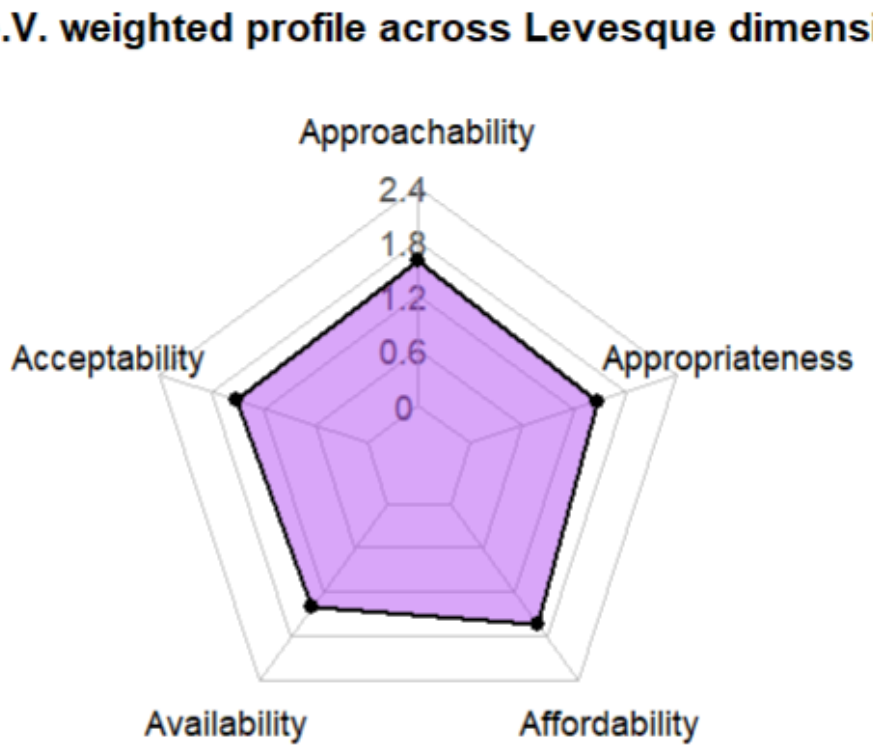

Figure 53: Weighted access profile of Plus e.V. as assessed in Ireland across the Levesque access dimensions

Participants in the focus group responded to this service as both highly important and inherently challenging. One participant said: *"the LGBTQIA+ support for refugees, I think that I'd love to know a whole lot more about that because, I mean, like refugees that were very broad group with all the cultural differences that may come along with that. I'd say that must be that'd be a challenging service to try and operate. But again, probably looks something very, very worthwhile".* Another participant underlined the importance of this focus *"And support for refugees is absolutely so important. And from the brief look that I had on it, it looks really, really interesting. So I'd love to hear more"*. In terms of constraints, participants emphasised both operational and structural challenges. Operationally, they described it as *"a challenging service to try and operate"* because refugees are *"a very broad group with all the cultural differences that may come along with that",* combined with significant language issues. Structurally, they situated the service in a broader context where refugees face major barriers of cost, geography and power. For example, one participant pointed out that: *"If you're a refugee in Ireland in your first six months and you've no right to work and you're housed in and the closes available services are in Limerick … the costs of access there"* creates *"massive friction points in any caregiving relationship"* and raised the question of whether services design *"reimbursement or refund of travel cost for those who face systemic exclusion from an economic perspective or not"*.

The Friendship Bench

The final evaluated service, Friendship Bench[15], provides community-based mental health support for individuals experiencing symptoms of depression and emotional distress. The service is delivered by trained lay health workers who provide structured support using approaches such as problem-solving therapy and behavioural activation. Sessions typically take place in informal community-based settings designed to create accessible and supportive environments. The service aims to reduce barriers to mental health care by providing low-threshold support within local communities and strengthening social connectedness among participants. Access to the service generally does not require formal referral and is intended to reach individuals who may otherwise experience difficulties accessing care.

Figures 10 and 11 present the access profile of the Friendship Bench across the five Levesque access dimensions. Figure 10 shows the unweighted profile, reflecting the raw service scores without taking into account the relative importance assigned to the different access dimensions by participants. Figure 11 presents the weighted profile, in which the service scores were adjusted based on the relative importance of the access dimensions derived from the weighting exercise.

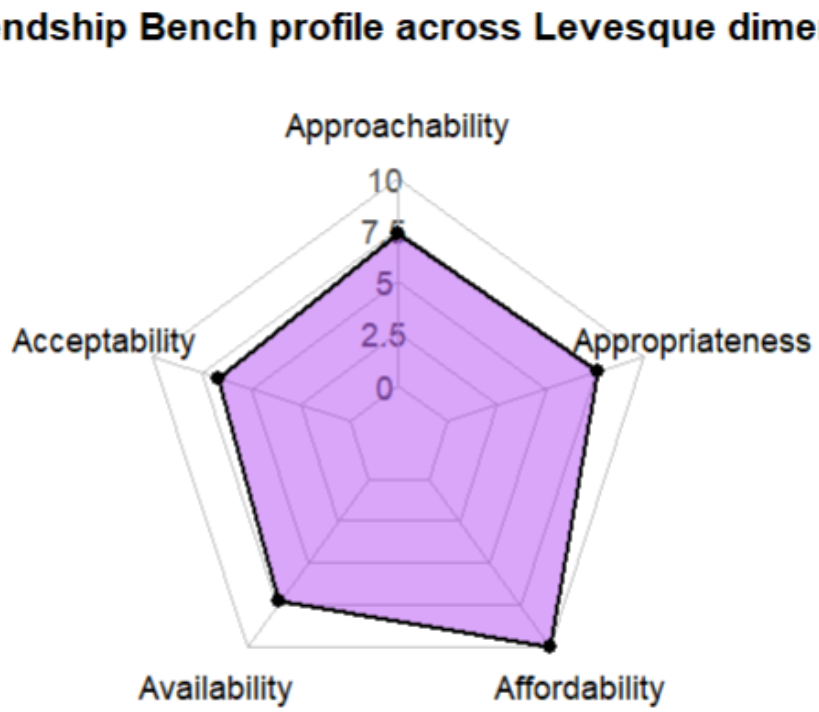

Figure 54: Unweighted access profile of Plus e.V. as assessed in Ireland across the Levesque access dimensions

In the unweighted profile (Figure 10), the Friendship Bench received its highest score on affordability, indicating that participants perceived the service as highly financially accessible and low-threshold. The remaining dimensions also received relatively positive scores overall, suggesting a generally favourable perception of the service across different aspects of access to care. In the weighted profile (Figure 11), the differences between dimensions became less pronounced, resulting in a more

balanced overall profile in which all dimensions scored relatively similarly. This reflects the influence of the weighting exercise, where affordability received comparatively lower relative importance than some of the other access dimensions.

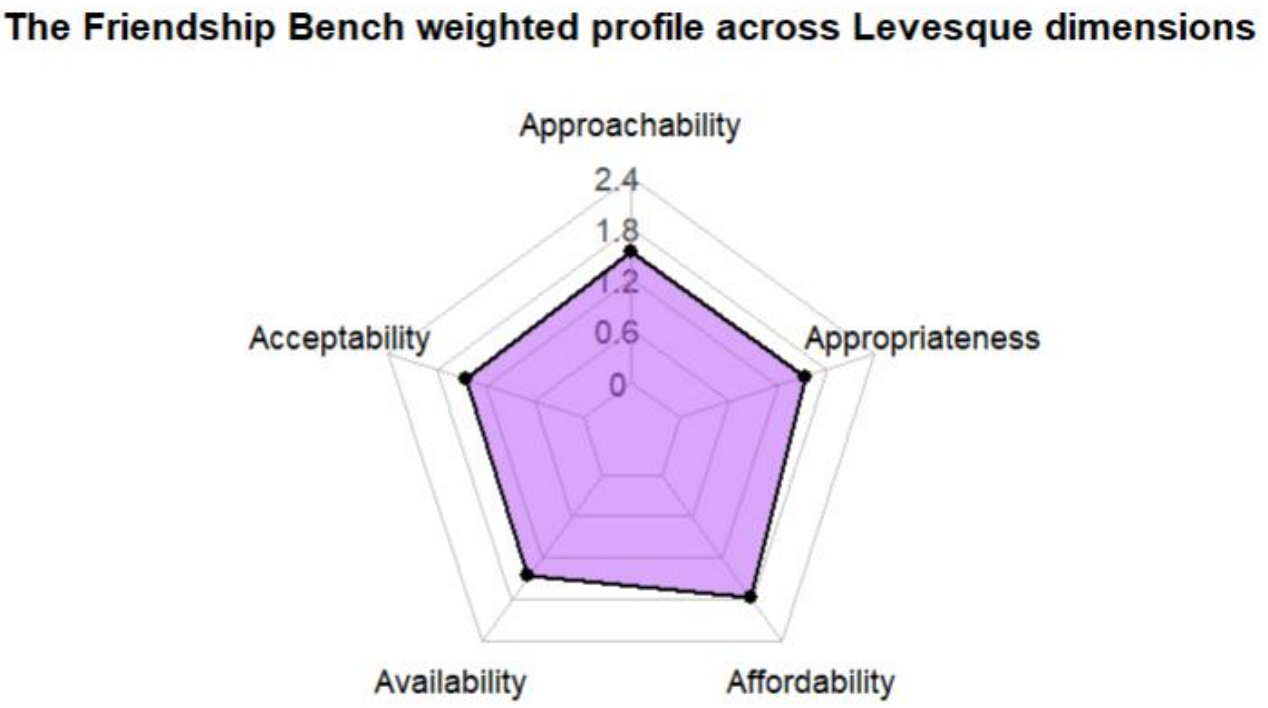

Figure 55: Weighted access profile of Plus e.V. as assessed in Ireland across the Levesque access dimensions

The Friendship Bench was repeatedly identified as an innovative, low-threshold, community-based intervention with an emerging evidence base. When asked which service they found particularly useful, one participant responded, *"I really liked the last one … the Friendship Bench",* recalling that *"it was more group work. I understood it as being more kind of group based, community based, and I thought that was one that kind of did a bit of CBT."* The same participant noted that the website referenced "*randomized controlled trials"* in African countries, which led them to assume *"there's some kind of evidence effectiveness."*. Another participant pointed out that the model had been *"pioneered in Zimbabwe"* and *"replicated across Europe".* By the end of the session a participant remarked: *"This has been the look into the Friendship Bench. Very taken with that … amazing … it's physically a bench … Yeah? Yeah, love it, yeah"* explicitly linking it to ongoing work on loneliness. At the same time, participants articulated several concerns about practical access. One participant admitted they were still unsure *"How does the Friendship Bench work?"* and asked whether *"you … go and present to the service and sit down and there's someone there to talk to you"*. They then highlighted the activation barrier: *"I just wonder sometimes … how do people actually get into that service? That's all, sometimes can be the issue … as I say, it is obviously low threshold. But even then, sometimes that can be an issue for people like, if they have to go somewhere and have to try and present to*

someone". Another participant added a geographical dimensions, saying: *"I understood it as being a physical, yeah, you go to it. So I guess there's location issues",* while still appreciating that it seemed *"quite targeted around depression.".* Capacity to scale was also flagged as a risk: *"There could be some capacity issues if it involves scaling up of lay people and or health … workers … the ability to recruit and sustain the workforce."*

4.2 Turkey

In Turkey, five mental health services were evaluated in relation to their contribution to improving access to care across the Levesque access dimensions.

Reflection on the access dimensions

Figure 12 presents the relative importance assigned to the different access dimensions by participants as part of the weighting exercise. Affordability and availability emerged as the dimensions considered most important for improving access to mental health care. These were followed by appropriateness, which received somewhat lower weighting. Acceptability and approachability received the lowest relative weights, although participants still considered these dimensions important components of access to care

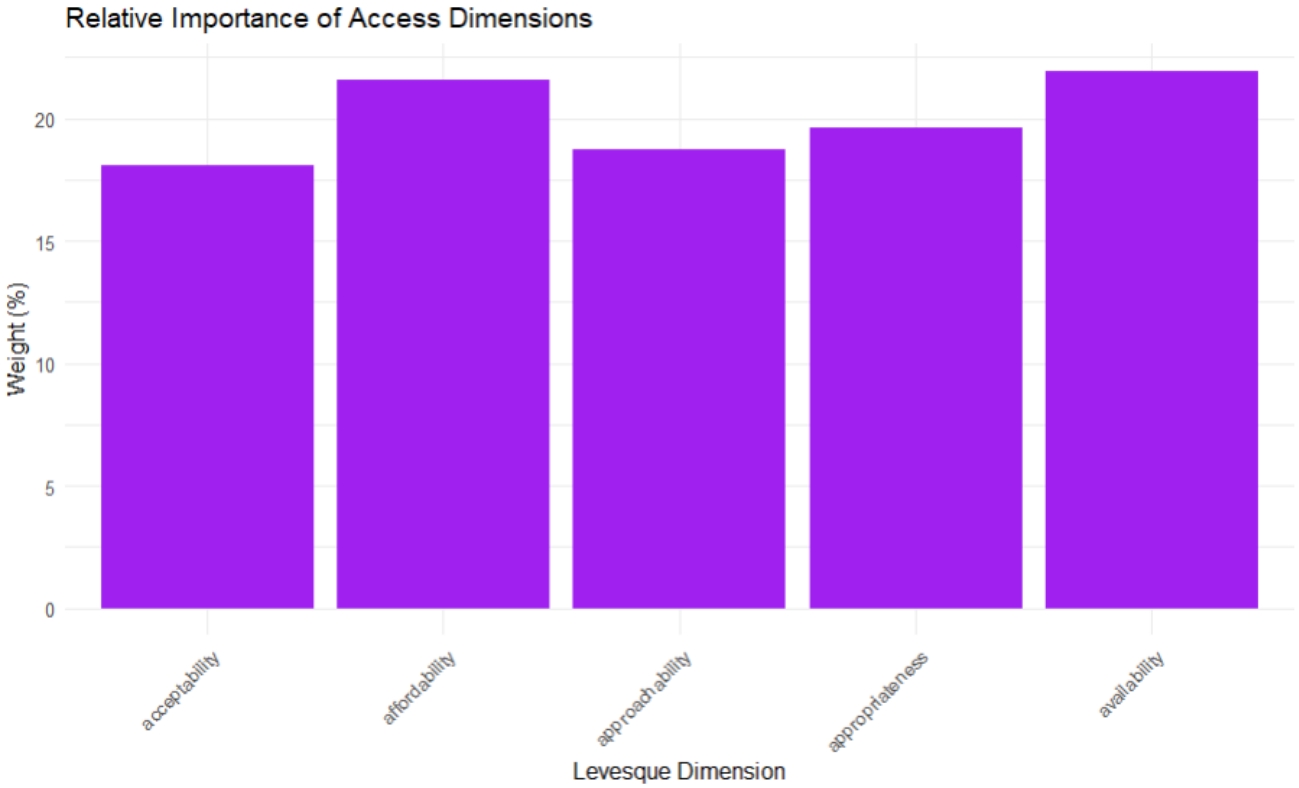

Figure 56: Relative importance of the Levesque access dimensions in Turkey based on stakeholder weighting exercise

Findings from the focus group discussions provided additional insights into participants' perceptions of the different access dimensions. While the quantitative findings suggested variation in the relative

importance of dimensions, most participants emphasized that all dimensions were closely interconnected and should not be considered in isolation. As one participant explained: *"All of these issues are like pieces of a puzzle. If you pull one out, the others will be missing too. I look at it that way. It doesn't seem easy to say one is more important than another."*. This perspective was echoed by several other participants during the discussion. Nevertheless, some dimensions received particular emphasis. Two participants highlighted the importance of appropriateness, stressing the need for services to adequately meet users' needs: *"But I most heavily weighted appropriateness."* and *"It is absolutely vital that services offered actually meet users' needs.".* Similarly, two participants specifically emphasized acceptability and the importance of services being culturally responsive and reducing stigma: *"I want to highlight the issue of acceptability. Services need to be appropriate to cultural values and preferences, and should perhaps contribute to reducing stigma.".* These qualitative findings appear to contrast with the quantitative findings, in which acceptability and approachability received relatively lower scores. This suggests that although some dimensions may have received lower relative weighting when participants were required to prioritize dimensions, they were still perceived as fundamentally important within broader discussions on access to care. Overall, participants emphasized that improving access to mental healthcare requires attention not only to services themselves but also to broader social and structural factors. One participant highlighted the importance of addressing wider determinants*: "Reducing this – economic activities, social policies that reduce inequality, the existence of a social security system – and many other factors such as discrimination, labeling, and stigmatization: these are things that need to be delivered at the base, and to everyone".*

Interventions

Family physicians in MHC

The first evaluated service in Turkey was Family Physicians in Mental Health Care Training (MHC)[16], a training programme designed for family physicians working in primary care settings. The programme aims to strengthen the capacity of healthcare professionals to recognize, assess, and respond to mental health needs among vulnerable population groups, including refugees, migrants, and individuals affected by natural disasters such as earthquakes. The training is delivered with support from international organisations, including the World Health Organization (WHO), and focuses on improving the competences of primary care providers in identifying and addressing mental health problems. By equipping family physicians with the knowledge and skills needed to respond to diverse and complex needs, the programme aims to improve access to mental healthcare and contribute to more inclusive and responsive service provision.

Figures 13 and 14 present the access profile of Family Physicians in MHC across the five Levesque access dimensions. Figure 13 shows the unweighted profile, reflecting the raw service scores without

taking into account the relative importance assigned to the different access dimensions by participants. Figure 14 presents the weighted profile, in which the service scores were adjusted based on the relative importance of the access dimensions derived from the weighting exercise.

From this perspective, Family Physicians in MHC received consistently positive evaluations across all access dimensions. Scores were generally similar across dimensions and were approximately around 7.5. Appropriateness received slightly lower scores compared with the other dimensions, suggesting that participants perceived somewhat greater limitations regarding the extent to which the services fully addressed individual needs or provides sufficiently tailored support.

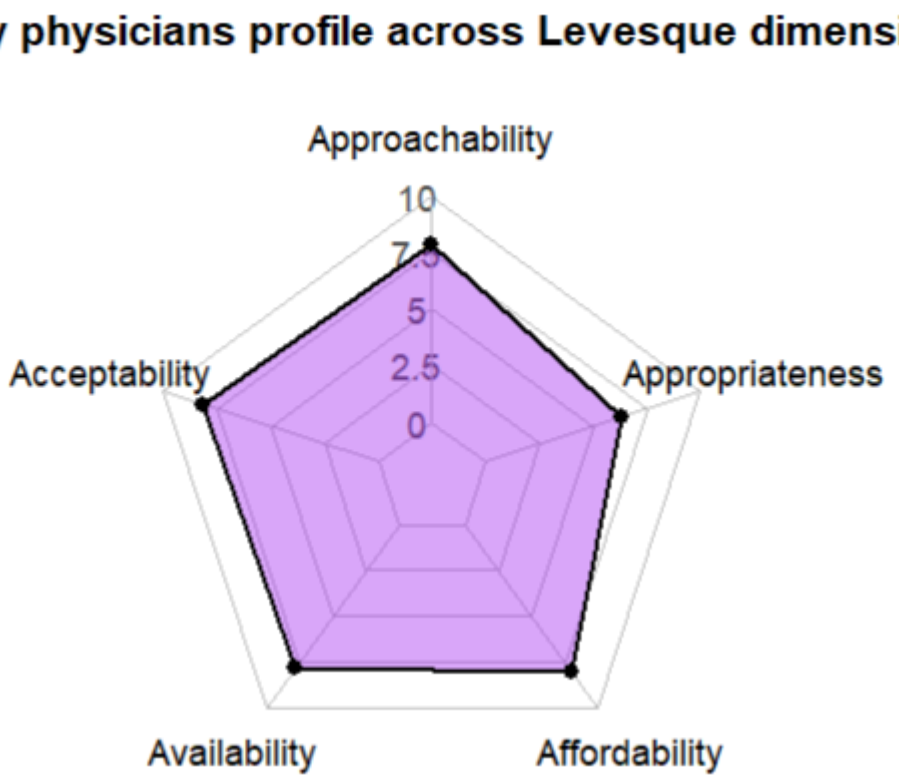

Figure 57 Unweighted access profile of Family Physicians in Mental Health Care training across the Levesque access dimensions

The weighted profile showed a largely similar pattern, indicating that incorporating the relative importance of the access dimensions had limited impact on the overall service profile. This suggests

that the service performed relatively consistently across dimensions and remained positively evaluated when stakeholder priorities were taken into account.

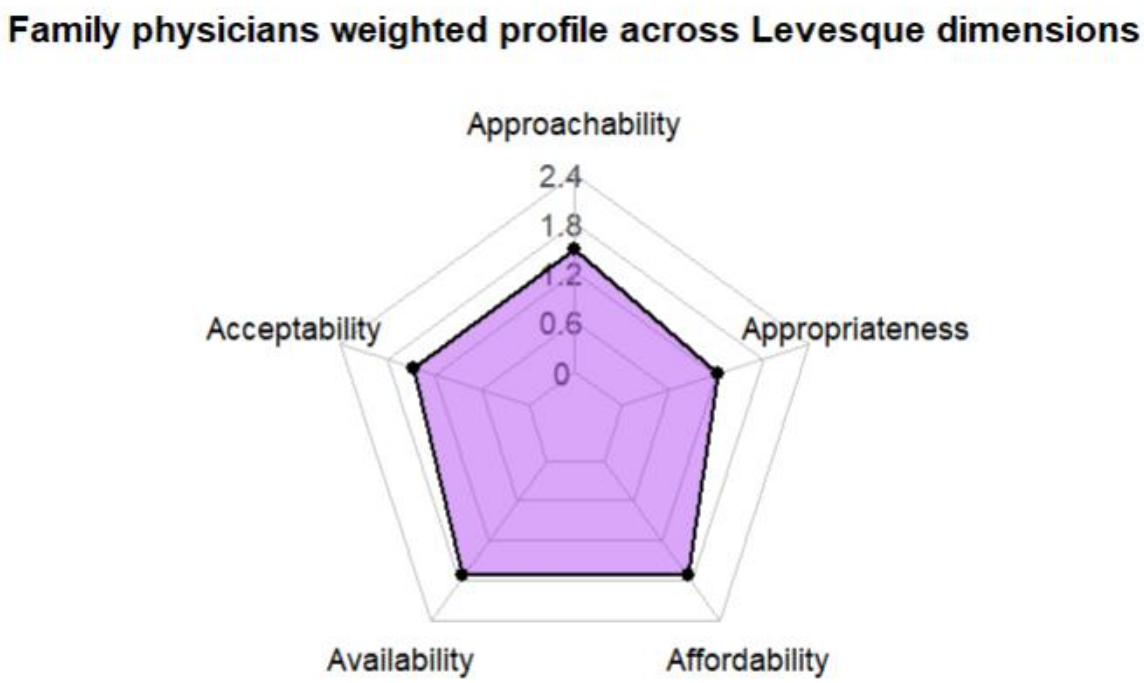

Figure 58: Weighted access profile of Family Physicians in Mental Health Care training across the Levesque access dimensions

In the focus groups, participants were divided on the idea of integrating mental health support into family health centres through training family physicians. One participant explained that they had "*given the family medicine-related service a low score"*, and elaborated that, in their experience "*in family health center units, I've observed that the physicians providing health services are a bit behind the times in terms of current knowledge"*. They also saw important stigma risks around visibility: *"going there is easy, it can be more visible, but it is also very prone to stigmatization. You go there and the neighbors are sitting there waiting in line – "Why are you here, why are you going? – that kind of conversation happens too".* A second community member agreed with this critical stance and located it in broader systemic problems, calling family medicine "*quite political".* They pointed to *"a significant lack of political will and infrastructure affecting family medicine".* By contrast, another participant highlighted potential benefits, especially for disadvantaged groups in Hatay. They argued that *"the idea of having it at a family health center didn't seem bad to me",* because *"at least in terms of accessibility in the first instance, it could work as a referral point."*. They emphasised that *"it may be easier for someone to share a problem initially with a doctor they already know, trust, and have had their child seen by, rather than going straight to a psychiatrist"*. One stakeholder also saw a possible role for family physicians in *"referrals, screenings, and patient follow-up",* as part of a coordinated system in which *"primary and secondary care can work together or … in coordination with a community mental health component combined with a primary care service".*

CAMHI

The second evaluated service in Turkey was CAMHI (Child and Adolescent Mental Health Services Initiative), a community-based mental health initiative aimed at promoting and supporting adolescent mental health through school-based interventions[17]. The service works closely with schools, teachers, parents, and young people to strengthen the mental health promotion activities and support early identification of mental health needs among adolescents. In addition to school-based activities, CAMHI provides advanced training programmes for professionals involved in adolescent mental healthcare, including mental health specialists, paediatricians, and forensic personnel. The initiative adopts a “train-the-trainer” approach, enabling professionals to further disseminate knowledge and skills within their own working environments. Through strengthening coordination between educational and healthcare systems, the programme seeks to improve access pathways and facilitate timely access to appropriate support for adolescents.

Figures 15 and 16 illustrate the access profile of CAMHI across the five Levesque access dimensions. Figure 15 presents the unweighted profile, displaying the raw service ratings across dimensions, while Figure 16 shows the weighted profile in which scores were adjusted according to the relative importance assigned to each access dimension during the weighting exercise.

Overall, CAMHI received highly positive evaluations across all access dimensions. In the unweighted profile, all dimensions except approachability scored above 8, indicating a generally strong perception of the service across multiple aspects of accessibility. Although approachability received slightly lower ratings, it still remained positively evaluated, with scores above 7.5. Appropriateness received the lowest score among the dimensions, although differences between dimensions remained relatively small overall.

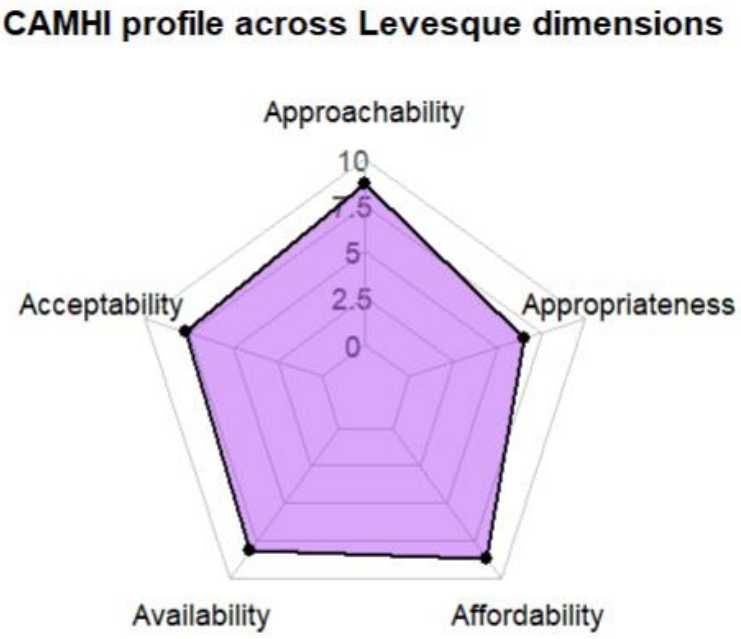

Figure 59: Unweighted access profile of CAMHI across the Levesque access dimensions

Following application of the weighting procedure, some shifts in the service profile became visible. Availability and affordability continued to receive relatively high scores, while acceptability and approachability became somewhat less prominent compared with the unweighted profile. Similar to the unweighted results, appropriateness remained the comparatively lowest-rated dimension. This suggests that dimensions assigned greater relative importance by participants had a stronger influence on the weighted service profile, while the overall positive perception of the service remained stable.

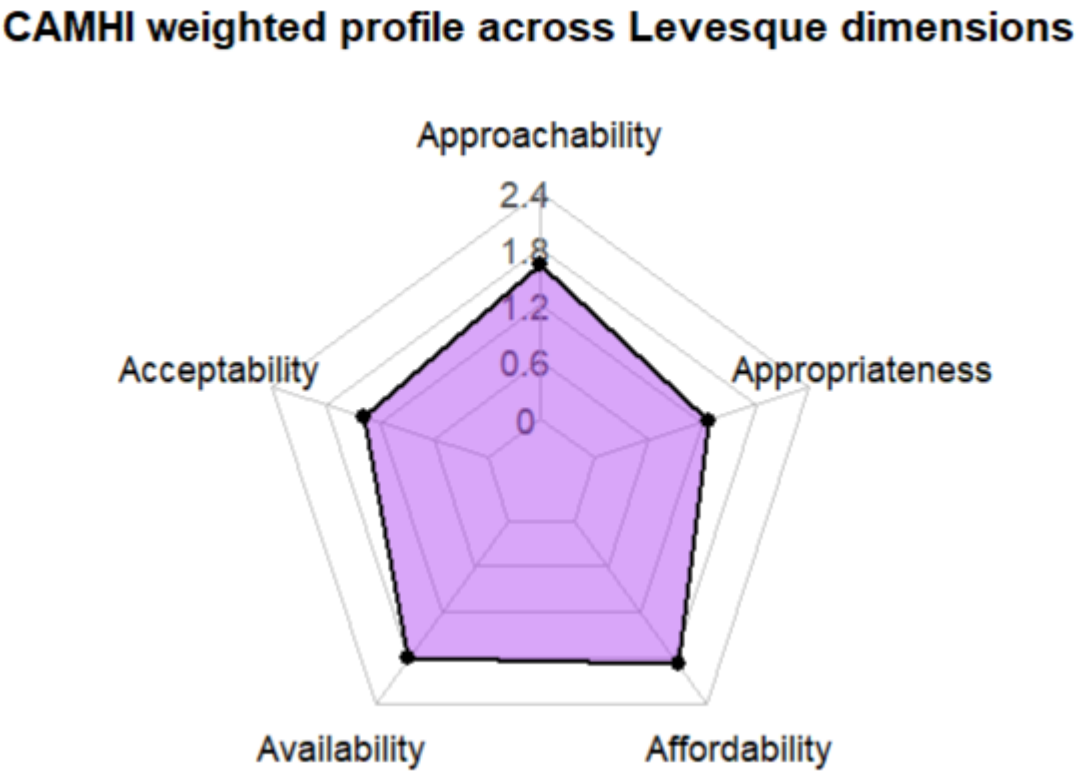

Figure 60: Weighted access profile of CAMHI across the Levesque access dimensions

The school-based service for adolescents (CAMHI) was one of the most positively viewed interventions. A stakeholder emphasised its comprehensive, preventive character, calling it *"a more comprehensive mental health service covering all dimensions – services aimed at preventing the emergence of illness".* Another participant, discussing mental health across the life course, highlighted school mental health as a key lever: *"within the health sector, primary care is extremely valuable – without including primary care, reaching a broad population is very difficult. School mental health is important for the same reason – perhaps it is possible to reach two thirds of society through school mental health.".* When also asked which services the participants would prioritise, they repeatedly singled out this intervention. One argued that *"given the current conjuncture the country is in and the sensitivity created by recent events in schools, it seems to me that the work targeting young people – through schools – is likely to receive support. Political and institutional support."* A community member agreed *"not only because of the current moment",* but because they felt it *"could be the one that contributes the most, in order to save at least the coming generations and those who come after them".* Another community member described *"the service related to adolescents"* as *"something I really liked"* noting *"recent developments also show how important it is, how necessary it is – how essential it is for communication to be established."* The group also reflected on how to make adolescent-focused services engaging in practice. One community member stressed that *"especially for young people and adolescents – applications delivered through smartphones, through platforms they're already familiar with … could be much more engaging for them"*. Explicit cons directed

specifically at the school-based service were limited. Instead, participants raised structural issues that would condition its effectiveness, particularly for queer and migrant adolescents. One community member in Hatay pointed to "*the lack of opportunity to benefit from the right to healthcare in one's mother tongue"* and mentioned *"a lack of specialists who can make this assessment"*.

Hatay Refugee Response operation

Another service evaluated in Turkey was the Hatay Refugee Response Operation, which provides coordinated and multidisciplinary support for refugee populations through a community-based approach[18]. The service delivers a broad range of support activities, including primary healthcare, mental health and psychosocial support, sexual reproductive health services, vaccination programmes, nutritional support, and counselling services. The programme is delivered using a multilingual and community-oriented model designed to address the diverse needs of refugee populations and facilitate access to essential services. A key component of the initiative is the use of mobile psychosocial support teams that actively operate in rural and disadvantaged areas where access to healthcare and social services may be limited. By bringing services closer to communities, the programme aims to reduce access barriers and improve equitable access for vulnerable population groups.

Figures 17 and 18 display the access profile of the Hatay Refugee Response Operation across the five Levesque access dimensions. Figure 17 presents the unweighted profile based on the original service ratings, while Figure 18 presents the weighted profile incorporating the relative importance assigned to the different access dimensions during the weighting exercise.

Overall, the Hatay Refugee Response Operation received very high ratings across all access dimensions. In the unweighted profile, scores were highly consistent, with all dimensions receiving scores of approximately 9 or higher. This suggests a very positive overall perception of the service and indicates that participants considered the intervention highly accessible across multiple aspects of care.

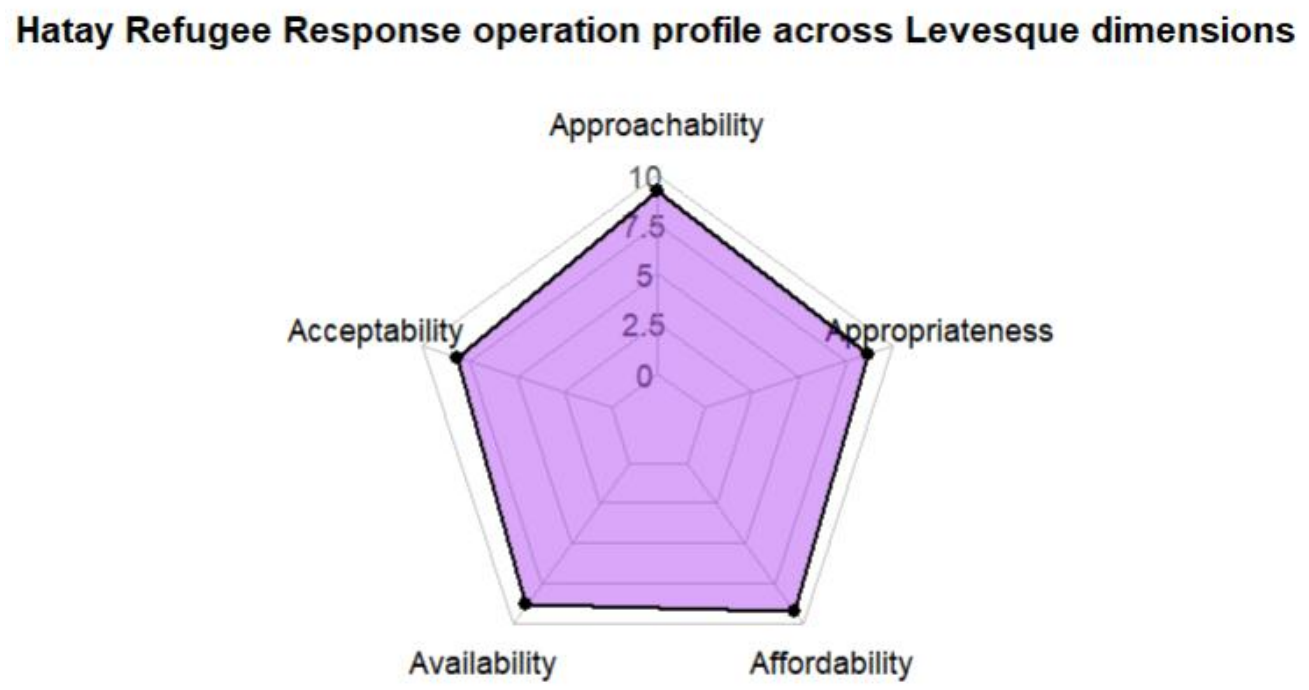

Figure 61: Unweighted access profile of the Hatay Refugee Response Operation across the Levesque access dimensions

After applying the weighting procedure, some variation across dimensions became more apparent. Appropriateness, affordability, and availability received relatively stronger scores, whereas acceptability became somewhat less prominent within the weighted profile. These differences illustrate the influence of the weighting exercise, whereby dimensions assigned greater importance by participants had a larger impact on the overall service profile. Nevertheless, the service remained

highly positively evaluated across all dimensions following weighting.

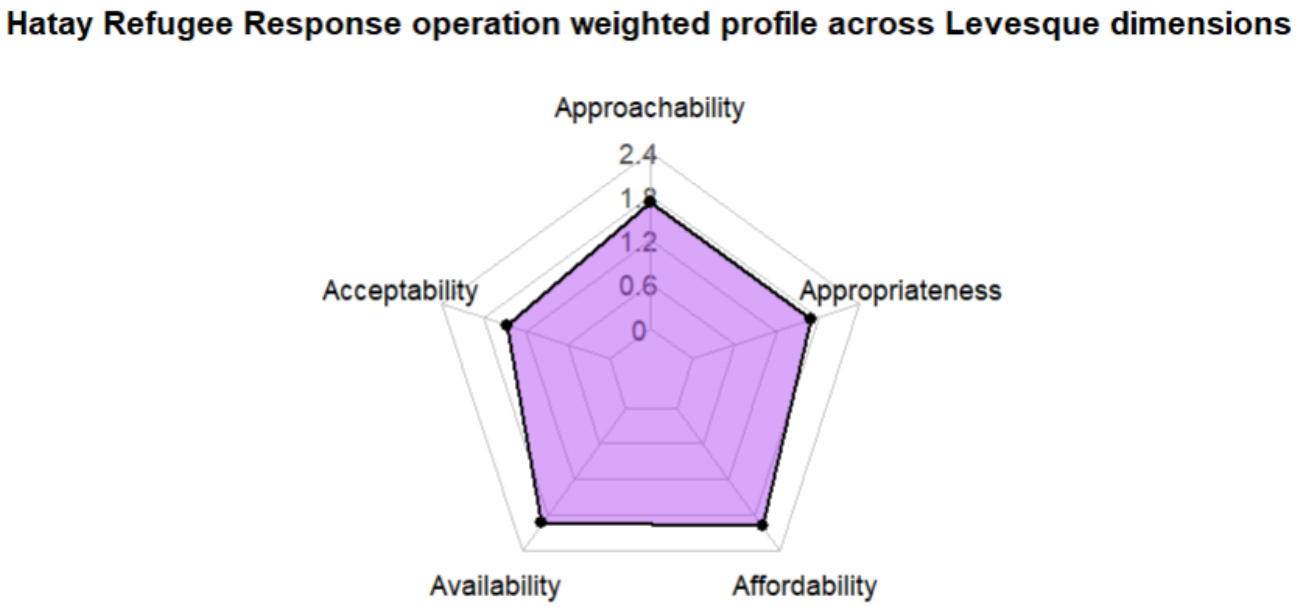

Figure 62: Weighted access profile of the Hatay Refugee Response Operation across the Levesque access dimensions

The Hatay Refugee Support Operation, a multidisciplinary service integrating health and psychosocial support for refugees, was strongly appreciated by community members. One participant said: *"I really liked the Hatay Refugee Support Operation. First it's multilingual."* They added that it *"made me think it could prevent stigmatization – because it is a center, and why you're using it isn't necessarily obvious to the public. You could be there for anything else."* They also valued its broader environment: *"because it provides an opportunity for socialization – it seems they can look at mental health in a many different ways there. There's social support, there are health-related issues, and it's multilingual – you can speak your own language. That's why I liked it."* Stakeholders also highlighted the importance of the model's mobile outreach in an earthquake-affected context. One stakeholder explained that in Hatay *"there's the issues of transportation. In situations like this, getting around is hard for everyone, but for these groups it's perhaps even harder – they may not have a private vehicle, there are problems with public transport".* For that reason, "*the mobile nature of the service – going to people's homes, not requiring them to go somewhere to receive the service – is, I think very important"*, both because of distance and because *"some people are also reluctant to be seen going to a mental health facility."* Used in this way, the Hatay model was seen as lowering barriers across several Levesque dimensions at once (availability, affordability, approachability). At the same time, participants raised concerns about sustainability and broader structural obstacles. A stakeholder based in Hatay noted: *"in a disaster situation … Fundamentally, the issue of sustainability comes up in these situations. There Is a crisis, and after the crisis, projects come in with support."*. They warned that *"when something doesn't transform into a public institution's service – the things that run through*

NGOs are valuable and meaningful in crisis situations, but what comes after remains an open question.”.

StrongMinds

The fourth service evaluated in Turkey was StrongMinds, a community-based mental health intervention aimed at providing support for individuals experiencing depression, with a particular focus on women living in low-resource settings[19]. The service delivers structured group-based interpersonal therapy sessions that can be conducted either face-to-face or via telephone, increasing flexibility and accessibility for participants.

The programme consists of a series of structured sessions delivered over several weeks. During these sessions, participants are supported in identifying factors contributing to emotional distress and developing strategies to manage their mental health and wellbeing. The group-based format additionally encourages peer support, social interaction, and shared learning experiences among participants.

Figures 19 and 20 present the access profile of StrongMinds across the five Levesque access dimensions. Figure 19 illustrates the unweighted profile based on the original service ratings, while Figure 20 displays the weighted profile incorporating the relative importance assigned to the access dimensions during the weighting exercise. Overall, StrongMinds received consistently positive evaluations across the different access dimensions. In the unweighted profile, most dimensions scored around 8, indicating strong perceptions of accessibility across several aspects of care. Appropriateness received slightly lower scores, around 7.5, suggesting that participants perceived somewhat greater limitations regarding the suitability or fit of the service for individual needs.

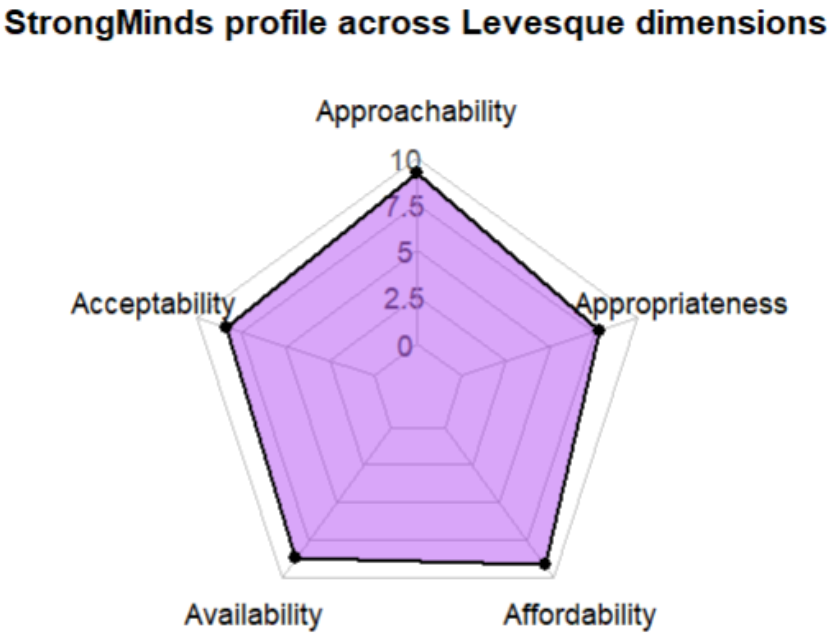

Figure 63: Unweighted access profile of StrongMinds across the Levesque access dimensions

Following application of the weighting procedure, some shifts in the service profile became visible. Approachability, availability, and affordability became somewhat more prominent within the weighted profile, reflecting the greater relative importance assigned to these dimensions by participants. In contrast, acceptability was weighted somewhat lower and reached a similar level to appropriateness. Despite these changes, the overall pattern remained relatively stable and continued to reflect a favourable perception of the service across the access dimensions.

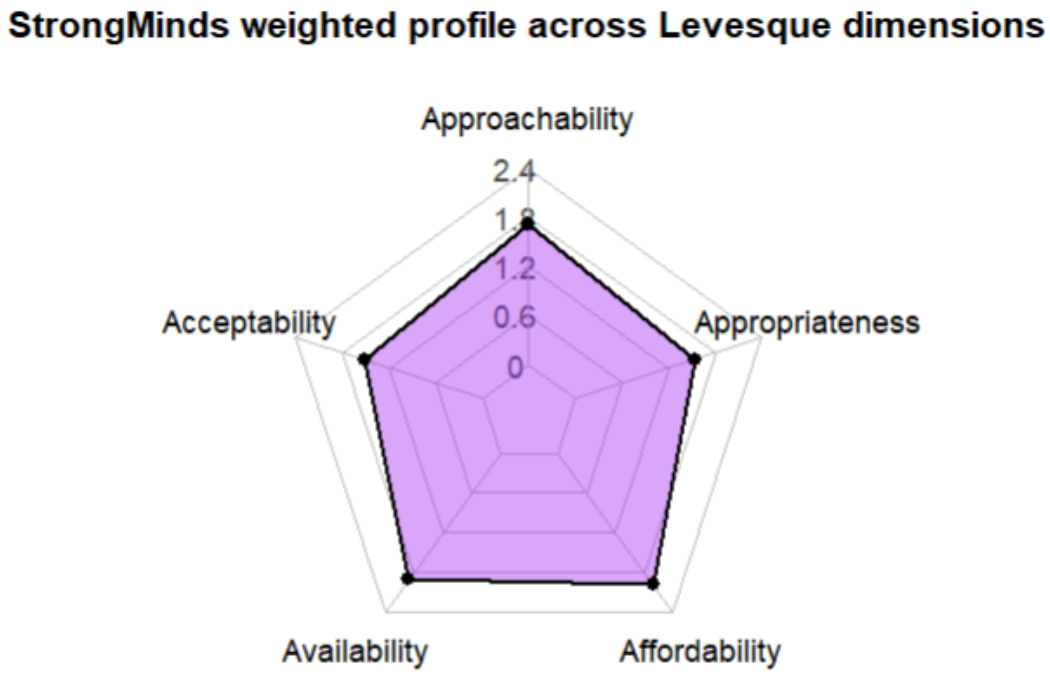

Figure 64: Weighted access profile of StrongMinds across the Levesque access dimensions

Strongminds was seen as conceptually attractive but elicited mixed reactions regarding its format and depth. A stakeholder reflected that: *"for Turkey's environment … the group sessions for women with depression caught my attention. In a densely populated country like Turkey, this is even more important. As someone who practices group psychotherapy myself, I find group therapies even more important for society like ours. Such models feel more inclusive to me."* From this perspective, the group-based nature and peer solidarity in StrongMinds were clear "pros", offering inclusive, scalable support that fits cultural and resource constraints. However, at least one community member reacted negatively to the way StrongMinds was presented, especially its remote, time-limited delivery. They said: *"I didn't like the StrongMinds service for women. Delivering it by phone over a few weeks felt incredibly mechanical. I mean, maybe it works online – it may be making things easier – but there was quite a narrow claim about teaching people how to focus and think over just a few weeks. At least that's how the project was presented. Maybe it works, but I didn't like how the project was described".* Another stakeholder, while more positive overall, acknowledged that *"StrongMinds alone may have limited potential to change things on its own",* arguing that *"without addressing the social determinants of mental health … how much and what can actually change?"*. Nonetheless, they added: *"I still think all of them contribute to making things somewhat better than they were",* underlining that even modest improvements can be valuable for individual women. Later in the discussion, the same member who criticised StrongMinds' *"mechanical"* feel also acknowledged its value relative to the broader context of scarcity: *"I'd recommend all of them in the end. After all, the possibility of benefiting from something free of charge – especially in these economic conditions – whether by phone or otherwise, is genuinely valuable. I did exaggerate a little, but I was trying to compare I with a long-term psychoanalytic process and evaluate it against that. But I think all of them are truly valuable"*.

Thinking Healthy Programme

The final service evaluated in Turkey was the Thinking Healthy Programme, a structured mental health intervention designed for women experiencing depression during pregnancy and the postnatal period, extending up to one year after childbirth[20]. The programme is delivered in community settings by trained community health workers and aims to provide accessible support during a period in which women may experience increased vulnerability to mental health problems. The intervention is based on principles of cognitive behavioural therapy and combines psychological support with practical activities delivered through regular sessions. In addition to addressing depressive symptoms, the programme aims to improve maternal wellbeing, strengthen mother–child interaction, and enhance social support networks

Figures 21 and 22 illustrate the access profile of the Thinking Healthy Programme across the five Levesque access dimensions. Figure 21 presents the unweighted profile based on the original service

ratings, while Figure 22 displays the weighted profile after incorporating the relative importance assigned to the access dimensions during the weighting exercise. The unweighted profile showed consistently positive evaluations across all access dimensions, with scores generally exceeding 7.5. Ratings were relatively similar across dimensions, suggesting that participants perceived the programme as broadly supportive of access to care across multiple aspects of service delivery.

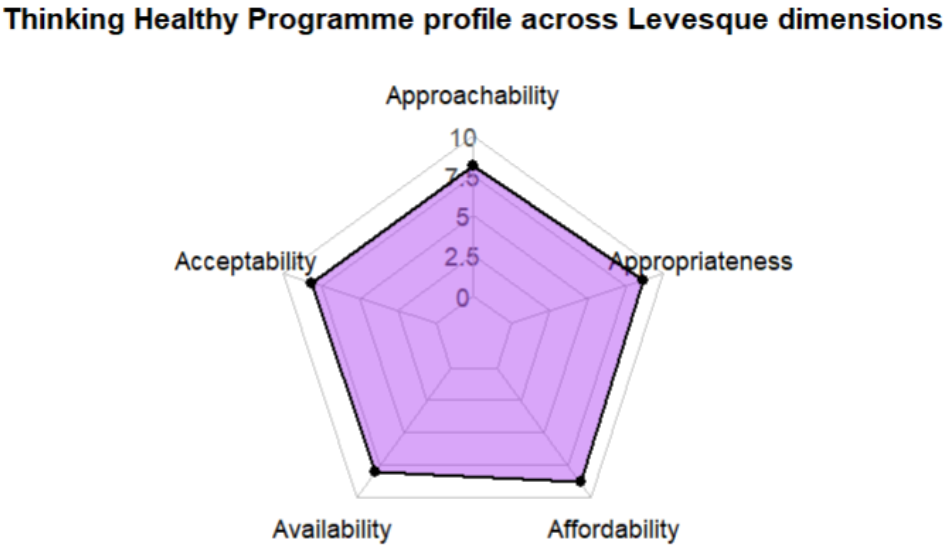

Figure 65: Unweighted access profile of the Thinking Healthy Programme across the Levesque access dimensions

Following application of the weighting procedure, modest shifts in the profile could be observed as a result of the varying importance assigned to the different access dimensions. Nevertheless, the overall pattern remained largely stable, with scores continuing to be relatively evenly distributed across dimensions. This suggests that the programme maintained a balanced access profile even after taking stakeholder priorities into account.

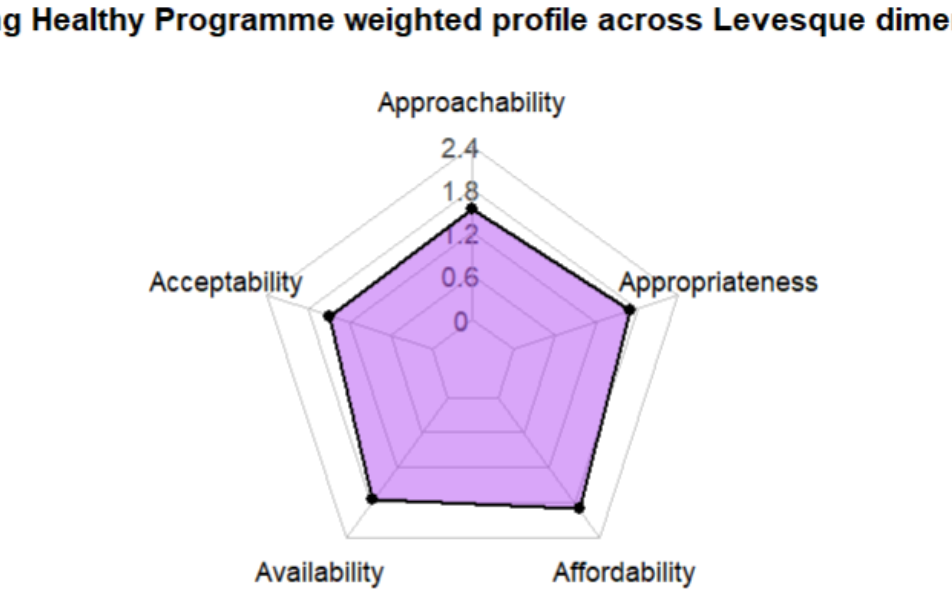

Figure 66: Weighted access profile of the Thinking Healthy Programme across the Levesque access dimensions

The Thinking Healthy Programme attracted strong endorsement in the focus group as a foundational, preventive service. A stakeholder explained that they *"found the Thinking Health programme very necessary"* precisely *"because it addresses things somewhat more from the root – depression in women, the peer solidarity there".* They situated its value in contemporary parenting contexts: *"especially in today's world, when parenting skills are becoming increasingly difficult and are diminishing, supporting and empowering women in this area is very valuable".* They also highlighted well-established evidence that "*the negative effects of maternal depression on secure attachment are a known reality"*, concluding that *"to reduce problems in that most foundational early childhood period – empowering women and mothers seem very precious to me.".* Another stakeholder echoed this from a life-course perspective, arguing that *"postpartum depression seems important for both the mother's and the child's quality of life"*, and broadening the focus to *"mental health services during pregnancy and the postpartum period more broadly. Psychosocial support could be very important."* Community members also related to the service on a personal level. One participant said: *"I actually thought about the pregnancy-related service – I plan to have children in the future, and I'm thinking about going through that period. So I think it would be very beneficial for me personally."* They added that *"making it accessible in terms of time and space will also be a reason for people to choose it*", underlining the importance of home-based delivery and practical accessibility as key *"pull factor"*. No substantial, service-specific criticisms of the Thinking Healthy Programme were raised; the concerns mentioned were more general and structural (e.g. transport difficulties in Hatay, provider attitudes in vulnerable groups, system-wide capacity issues). Where participants were asked which services might have the greatest potential to improve access, stakeholders repeatedly returned to the school-based adolescent model and perinatal mental health support, with one noting that: *"with a similar perspective , and approaching it from the life-course angle – thinking about the social determinants of health and how the earlier, the better – postpartum depression seems important"*, and that psychosocial support in this period could be key.

4.3 Spain

In Spain, five mental health services were evaluated in relation to their contribution to improving access to care across the Levesque access dimensions.

Reflection on the access dimensions

Figure 23 presents the relative importance assigned to the different access dimensions by participants as part of the weighting exercise. Availability and appropriateness emerged as the dimensions considered most important for improving access to mental healthcare. These were followed by affordability, which also received relatively high importance scores. Approachability and acceptability

received somewhat lower ratings and were assigned similar levels of importance. Nevertheless, both dimensions continued to be perceived as relevant aspects of access to care, indicating that participants considered all dimensions to contribute meaningfully to improving mental health service accessibility.

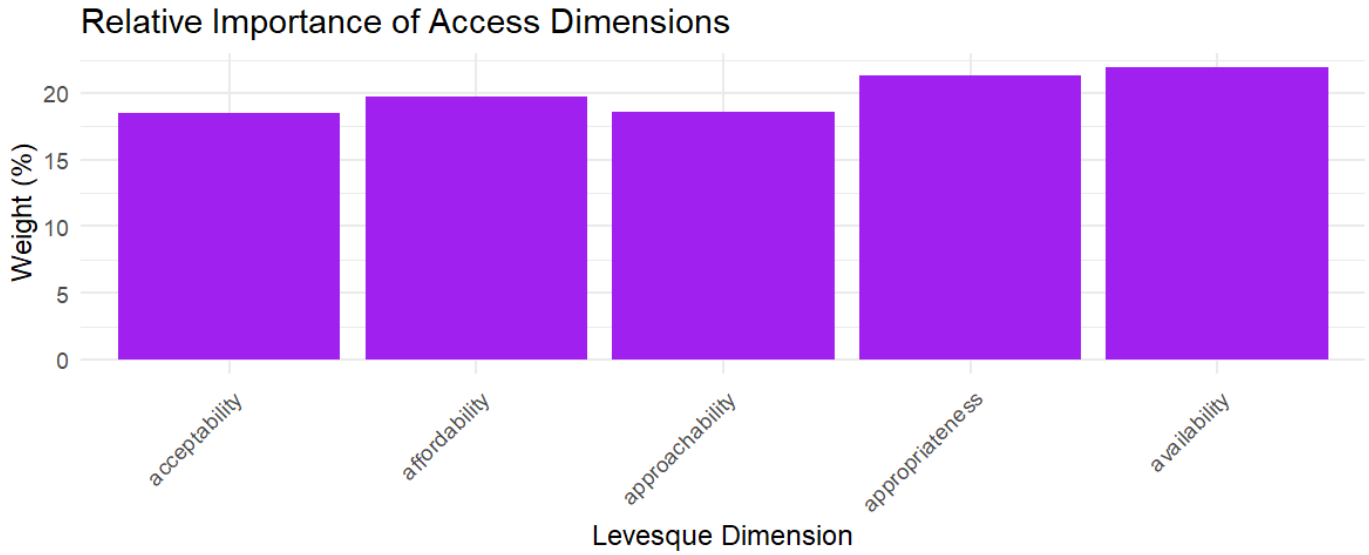

Figure 67: Relative importance of the Levesque access dimensions in Spain based on stakeholder weighting exercise

When the aggregated survey results were shown in the focus group, the interviewer reminded them that they rated appropriateness and availability highest overall. One respondent said they found it *"hard to score"* because the concepts are *"interdependent*" explaining: "*If they don't know us, we can do little. If we don't have time, we can't do much, even if we have the most beautiful powerful programmes in the health system … These are concepts that are linked to each other … It's very difficult to separate them in terms of scoring".* Another respondent focused on affordability, admitting they *"didn't know exactly what costs the applications had … as to answer with certainty whether the tool was efficient"*, and another participant stressed that while they might personally be able to pay for an app *"many migrants cannot*" so cost is a real barriers. Across the discussion, participants also implicitly broaden approachability to include language simplicity, easy navigation, audiovisual formats, and immediacy, as one participant stated: *"When you are in crisis … what you want is immediacy … you need a very friendly language … go straight to what the user really needs".*

Interventions

En Buena Edad – online platform & mobile app

The first service evaluated in Spain was En Buena Edad, a multilingual digital platform and mobile application developed to support healthy and active ageing among older adults[21]. The platform provides information and practical tools related to physical health, emotional wellbeing, social participation, and the use of technology in daily life. The service offers interactive resources, guidance

materials, and opportunities for engagement aimed at supporting autonomy, maintaining mental wellbeing, and strengthening social connectedness.

Figures 24 and 25 present the access profile of En Buena Edad across the five Levesque access dimensions. Figure 24 illustrates the unweighted profile, reflecting participants' original ratings across the dimensions, while Figure 25 displays the weighted profile incorporating the relative importance assigned to the access dimensions during the weighting exercise. The unweighted profile demonstrated variation across dimensions. En Buena Edad received scores of approximately 7.5 for both approachability and appropriateness, indicating generally positive perceptions in these areas. Availability and affordability received the highest ratings, both scoring above 8, suggesting that participants considered the service easily accessible and financially accessible. In contrast, acceptability received comparatively lower ratings, scoring only slightly above 5

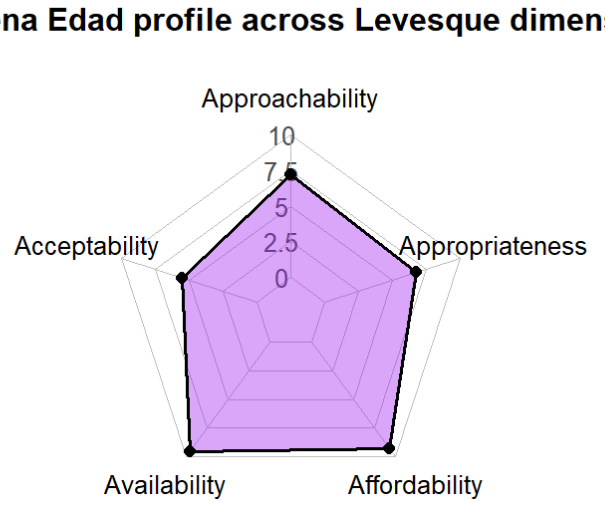

Figure 68: Unweighted access profile of En Buena Edad across the Levesque access dimensions

Following the weighting procedure, these differences became more pronounced. Acceptability decreased further in relative prominence, while availability emerged as the strongest dimension within the weighted profile. Approachability, appropriateness, and affordability clustered at relatively similar levels.

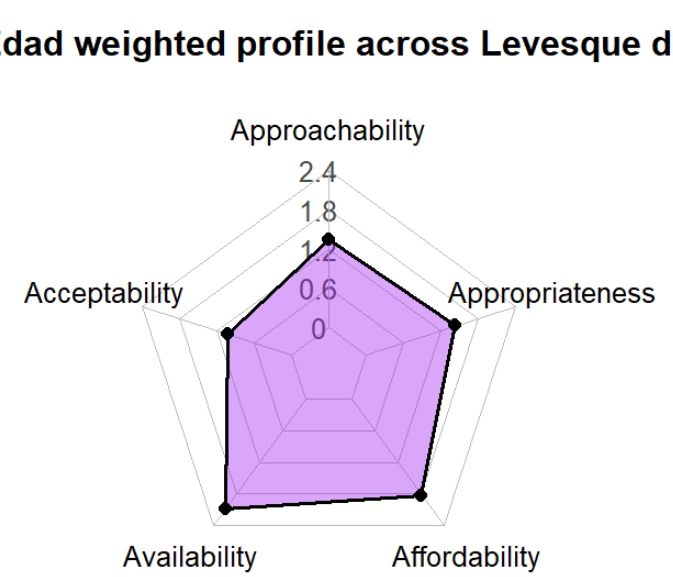

Figure 69: Weighted access profile of En Buena Edad across the Levesque access dimensions

In the focus groups the participants recognized the relevance of En Buena Edad for older adults but were skeptical about its practical use for the older populations they work with. One participant reflected that *"it's very difficult for an older adult to be able to access it … you need to explain a lot'´,* particularly for those who *"struggle"* with digital tools. Another participant, speaking specifically about older people in a socially excluded neighbourhood, stated that they *"would not recommend the one for older people"*, because the older adults they know *"would not access an explanation to solve their issues"* via a digital resource; they distinguished this from more active, digitally confident older people in other settings, for whom it might work.

Foundation Health Problems of Minorities

The second service evaluated in Spain was Foundation Health Problems of Minorities, a programme providing integrated health and mental health support for minority populations, with a particular focus on the Roma community[22]. The service is delivered by a multidisciplinary and multi-ethnic team that combines expertise from psychology, medicine, and social and cultural sciences.The programme functions as a bridge between individuals, communities, and health and social care systems, aiming to reduce cultural, linguistic, and structural barriers that may hinder access to care. Support is tailored to the needs and context of individuals and is primarily delivered through community-based approaches.

Figures 26 and 27 illustrate the access profile of Foundation Health Problems of Minorities across the five Levesque access dimensions. Figure 26 presents the unweighted profile based on the original participant ratings, while Figure 27 displays the weighted profile after accounting for the relative

importance assigned to each access dimension. Overall, the service received positive evaluations across all dimensions, with scores remaining consistently above 7.5. This suggests that participants perceived the service as broadly supportive of access to care across different aspects of accessibility. Availability and affordability received particularly strong ratings and scored higher than the other dimensions, indicating that the service was perceived as both accessible and feasible to use.

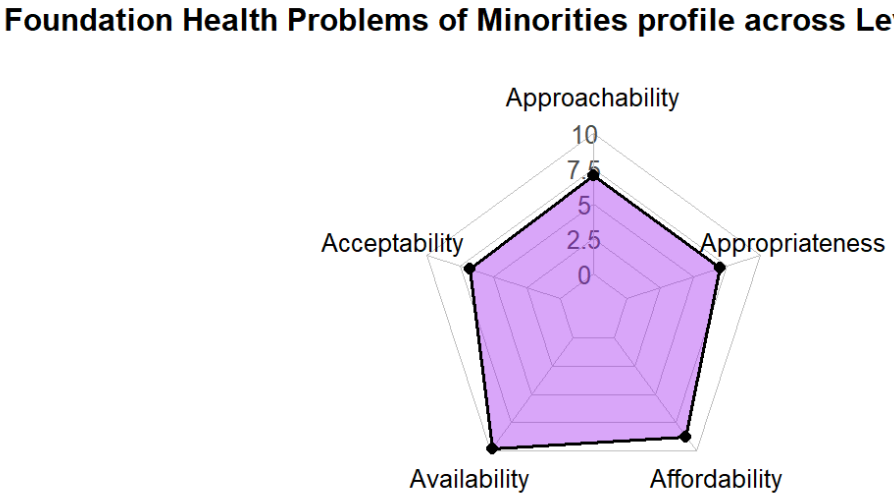

Figure 70: Unweighted access profile of Foundation Health Problems of Minorities across the Levesque access dimensions

A similar pattern was observed after applying the weighting procedure. However, differences between dimensions became somewhat more distinct, with dimensions such as availability and affordability becoming more prominent in the overall profile. These shifts demonstrate the influence of stakeholder priorities on the weighted results while maintaining the generally favourable perception of the service across the access dimensions.

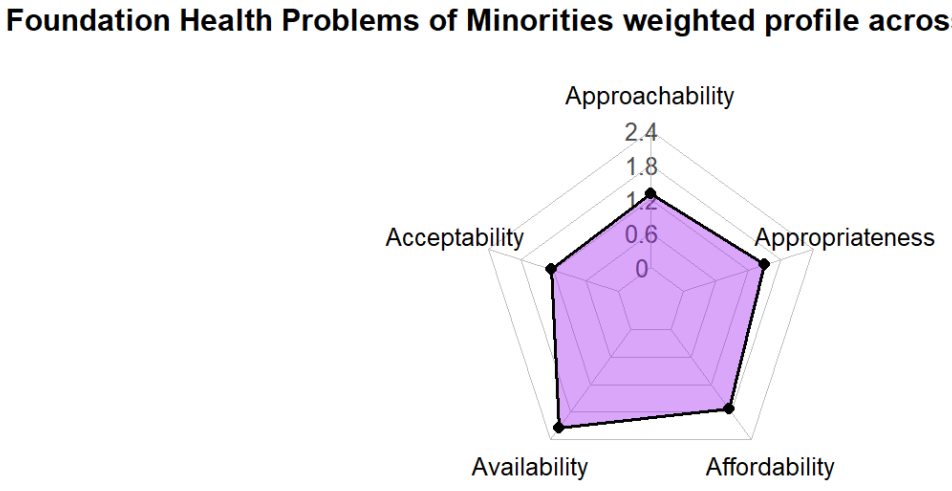

Figure 71: Weighted access profile of Foundation Health Problems of Minorities across the Levesque access dimensions

The foundation's service was not explored in depth in the focus groups, but was consistently mentioned together with Confederación Salud Mental España as one of the two most appealing, broad-scope programmes. One participant summarises that, among the examples: *"Confederación Salud Mental España … was the one that referred more to broader concepts – lifestyle, activities, diet healthy things, that bring you closer to healthy lifestyles and possibilities for changing habits"* and adds *´I'm not sure exactly if it was that one or the other from the foundation on health problems. It would be those two, which I think are more extensive and cover a bit more all aspects of life."* This breadth was seen as a key strength: both services address "*all aspects of life"* and not just clinical symptoms, which participants regarded as important for mental health promotion. At the same time, their general criticisms of the portals apply here. They stated that on some sites there is a lot of *"superfluous information"* such as long *"who we are"* sections that *"redirect attention"* so that for many users *"it's very possible they would abandon certain pages."* They insist that language needs to be *"very friendly"* and straight to the point, especially for people in crisis who *"want immediacy"* and "*clarity"* rather than *"so much fluff in the content"* and they argue that easy-to-read text and audiovisual formats are crucial for migrans and low-literacy users to be able to engage. So while the foundation's lifestyle-oriented content is perceived as appropriate and acceptable, participants implicitly warn that, without user-friendly design, its approachability and practical use will be limited.

Confederación Salud Mental España

The third service evaluated in Spain was Confederación Salud Mental España, a non-profit organisation that brings together regional mental health providers, associations, and initiatives across the country[23]. The organisation aims to promote the rights, recovery, and social inclusion of individuals experiencing mental health problems and their families. Rather than functioning as a direct treatment provider, the organisation primarily focuses on advocacy, training, awareness-raising activities, and support services. It plays an important coordinating role within the mental health field and contributes to the development and improvement of mental health policies and practices at both community and system levels.

Figures 28 and 29 present the access profile of Confederación Salud Mental España across the five Levesque access dimensions. Figure 28 displays the unweighted profile based on participants' original ratings, while Figure 29 presents the weighted profile after taking into account the relative importance assigned to the access dimensions. The unweighted profile showed greater variation across dimensions compared with some of the previously evaluated services. Approachability received the lowest score, around 5, suggesting that participants perceived greater challenges regarding the visibility, recognisability, or ease of identifying the service. Appropriateness received

moderately positive scores, ranging approximately between 6 and 6.5. In contrast, affordability, availability, and acceptability were evaluated more positively and scored around 7.5.

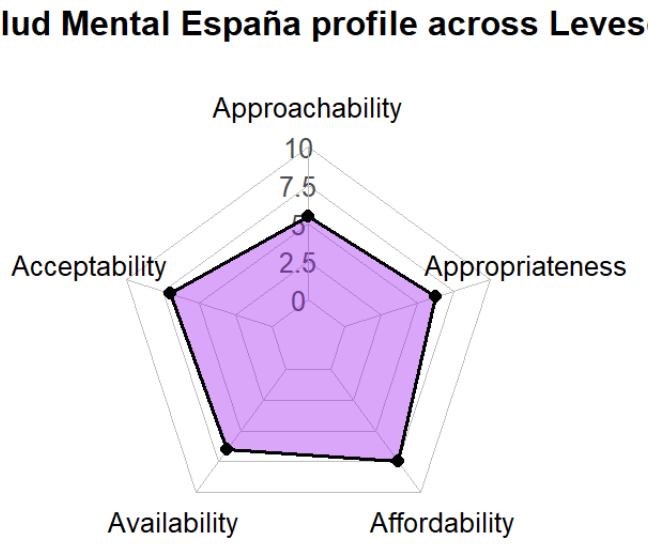

Figure 72: Unweighted access profile of Confederación Salud Mental España across the Levesque access dimensions

After incorporating the weighting procedure, differences between dimensions became less visible and the overall profile appeared more balanced. Scores across the weighted dimensions converged and remained relatively similar. This suggests that the weighting exercise reduced some of the contrast observed in the unweighted profile and resulted in a more even representation of the service across the different aspects of access.

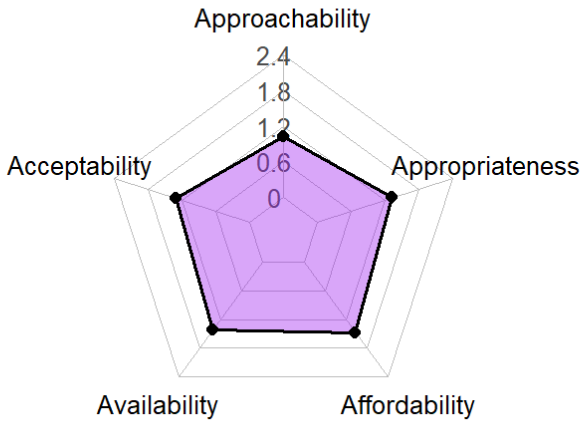

Figure 73: Weighted access profile of Confederación Salud Mental España across the Levesque access dimensions

Confederación Salud Mental España emerged as one of the most positively valued services, particularly because of its holistic, lifestyle focus. One respondent explained that Confederación Salud

Mental España was the service that *"referred more to broader concepts; lifestyle, activities, diet, healthy things that bring you closer to healthy lifestyles and possibilities for changing habits"* and notes that together with the health-problems foundation it is *"more extensive and covers a bit more all aspects of life."* When asked which service they would recommend, another participant immediately mentioned: *"the one from Confederación Salud Mental España"*. However, several participants described important access problems linked to the site's format and language. A participant working with users from the Roma-community said they *"miss an element of easy-to-read format"* and would like *"more visual supports"* to make it cognitively accessible. They critize the presence of long *"who we are"* blocks and other *"superfluous information that redirects attention"* and conclude that, for their users; *"it's very possible they would abandon certain pages".* Others emphasis that *"a more basic, clearer language"* is often *"more effective"* especially for migrants or people experiencing distress , who *"want immediacy"* and need the content to *"go straight to what the user really needs"* without excessive technical jargon or padding. They repeatedly stress that *"audiovisual wins": "what works a lot is audiovisual format more than text … quick video messages that hook you, TikTok style"* because *"we go for the comfortable option, let's be honest; you watch something before you read a text*".

Health mediators via the National Network of Health Mediators

The fourth service evaluated in Spain was Health Mediators via the National Network of Health Mediators[24]. This service provides mediation and navigation support for individuals in vulnerable situations and aims to facilitate access to mental health care as well as broader health and social services. Trained health mediators act as intermediaries between individuals, communities, and service providers, supporting communication and helping people navigate often complex systems of care.The service assists individuals with practical aspects of accessing care, such as arranging appointments, understanding information provided by professionals, and improving communication with healthcare and social services. In addition, mediators help address cultural, linguistic, and structural barriers that may impede access to support. Health mediators are generally state-appointed and receive specialised training.

Figures 30 and 31 present the access profile of Health Mediators via the National Network of Health Mediators across the five Levesque access dimensions. Figure 30 displays the unweighted profile, while Figure 31 presents the weighted profile after accounting for the relative importance assigned to each access dimension during the weighting exercise.

Overall, the service received highly positive evaluations across dimensions. Particularly strong scores were observed for acceptability and appropriateness, both receiving ratings above 9. This suggests that participants perceived the service as highly responsive to users' needs and considered it culturally appropriate and well aligned with the needs of vulnerable groups. The remaining dimensions were also positively evaluated, contributing to an overall favourable profile.

Health mediators via the National Network of Health Mediators profile across Levesque dimensions

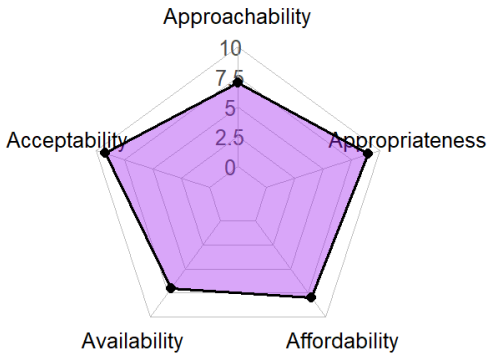

Figure 74: Unweighted access profile of Health Mediators via the National Network of Health Mediators across the Levesque access dimensions

A similar pattern was observed after applying the weighting procedure. Only limited changes were visible in the weighted profile, indicating that the influence of weighting had relatively little impact on the overall distribution of scores. The strong performance across dimensions remained largely stable.

Health mediators via the National Network of Health Mediators weighted profile across Levesque dimensions

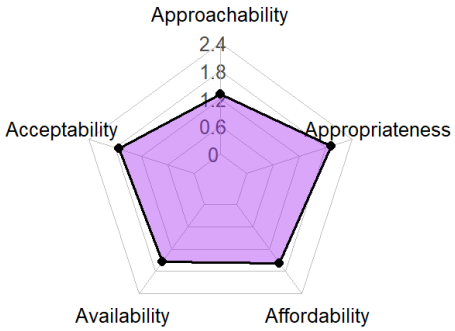

Figure 75: Weighted access profile of Health Mediators via the National Network of Health Mediators across the Levesque access dimensions

The national Health Mediators via the National Network of Health Mediators webpage was the highest-scoring service in the Spanish survey when mapped onto the Levesque framework. The interviewer explained that, overall, participants rated "*appropriateness and that the service is available"* as the most important dimensions. At the same time, the discussion of the Levesque dimensions showed they saw these concepts as intertwined and worry about blind spots.

Step by Step

The final service evaluated in Spain was Step-by-Step, a digital mental health intervention designed for individuals experiencing symptoms of depression[25]. The service is delivered online and consists of a structured programme based on behavioural activation and other psychological techniques. The intervention uses an interactive format, including illustrated stories and practical exercises. It also

incorporates psychoeducation, relaxation techniques, and activities aimed at strengthening social connections. The programme can be used independently or with support from trained non-specialist e-helpers who provide brief guidance by phone or messaging.

Figures 32 and 33 present the access profile of Step-by-Step across the five Levesque access dimensions. Figure 32 shows the unweighted profile based on the original service ratings, while Figure 33 presents the weighted profile after incorporating the relative importance assigned to each access dimension. In the unweighted profile, Step-by-Step received consistently positive scores across all dimensions, with all ratings above 7.5. Scores were also relatively similar across the five dimensions, suggesting that participants perceived the service as balanced in terms of approachability, acceptability, availability, affordability, and appropriateness.

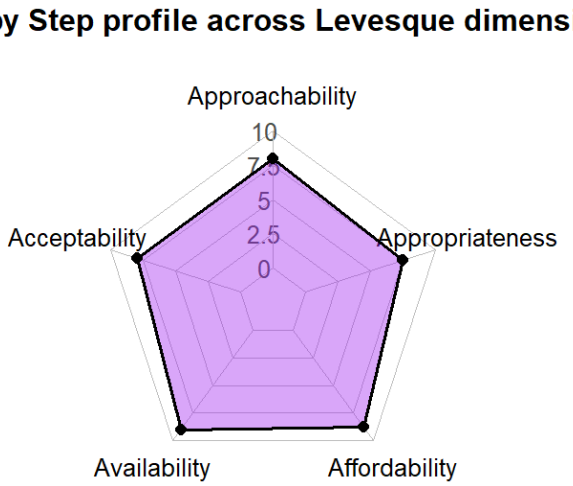

Figure 76: Unweighted access profile of Step-by-Step across the Levesque access dimensions

After applying the weighting procedure, some differences between dimensions became more visible. However, these differences remained limited overall, and the service continued to show a generally even and positive access profile.

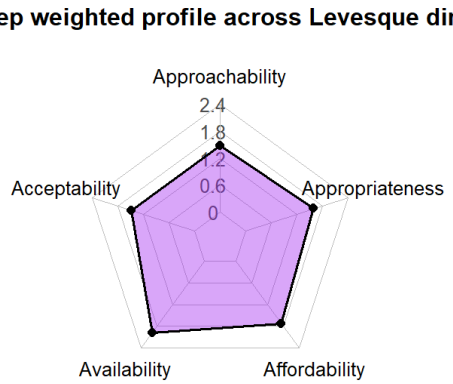

Figure 77: Weighted access profile of Step-by-Step across the Levesque access dimensions

Step by step was the digital intervention the group talked about most, and was frequently identified as the most concretely useful tool. The interviewer described it as an app that *"goes specifically to the treatment of mood, stress situations and, in particular, focuses a bit more on depression"* and one participant immediately pointed to its potential for self-management: *"being a mobile application … gives more autonomy, more capacity to the patient or user to manage that resources themselves. I think this strengthens autonomy and a proactive attitude in the patient, which is what we seek in many cases."* Another participant emphasizes its specificity: *"Step by Step is the only one that is a concrete tool. The others are like a bank of tools that allow you to access other resources, and it's very likely that you get lost and don't really know which resource you need. But Step by Step is a tool that directly has an intention, it's a specific resource, so I think it might also be the most useful."* When asked which service they would recommend, one respondent answered: *"I think the Step by Step one; as long as it has monitoring, that is, in a more hybrid model, would make sense to use".* One participant also commented on access and limitations in ways that map closely to Levesque's dimensions. They underlined that apps are generally *"more accessible"* than websites for many users, because *"you just press here and it's much easier",* particularly for people who are not used to searching online. At the same time, they stressed that success *"depends on how the resource is presented"*. For older adults and people in the Roma community, a participant insisted on the need for in-person guidance: *"previous education in the resource"* is *"fundamental"* just as with medication. Affordability is also a concern: a researcher says that they did not know: *"whether it would have a cost"* , and a migrant participant explained that although they can pay for an app: *" many migrants … find it difficult to pay for that*", especially when they are already struggling with adaptation and depressive symptoms.

Finally, there are questions about its role in acute situations. A participant with lived experience of depression remarked that in *"a strong anxiety crisis or major depressive peak"* they would not *"go into an application to solve that"* and that *" many things cannot be resolved only with an app, especially for mental health patients",* stating they would *"need someone to physically pull me out of that state"* and arguing that *"it has to be combined"* with face-to-face support.

4.4 France

Five mental health services were assessed in France to explore their perceived contribution to improving access to mental healthcare across the five dimensions of the Levesque framework.

Reflection on the access dimensions

Figure 34 illustrates how participants prioritised the different dimensions of access. Among the five dimensions, appropriateness was considered the most influential factor in improving access to mental healthcare, followed closely by acceptability. These findings suggest that participants placed particular value on services that effectively meet users' needs and are delivered in a manner that is acceptable and responsive to diverse populations. Although approachability also received relatively high ratings, affordability and availability were assigned somewhat lower importance scores.

Nevertheless, no dimension was considered unimportant, indicating broad recognition that access to mental healthcare depends on multiple interconnected factors.

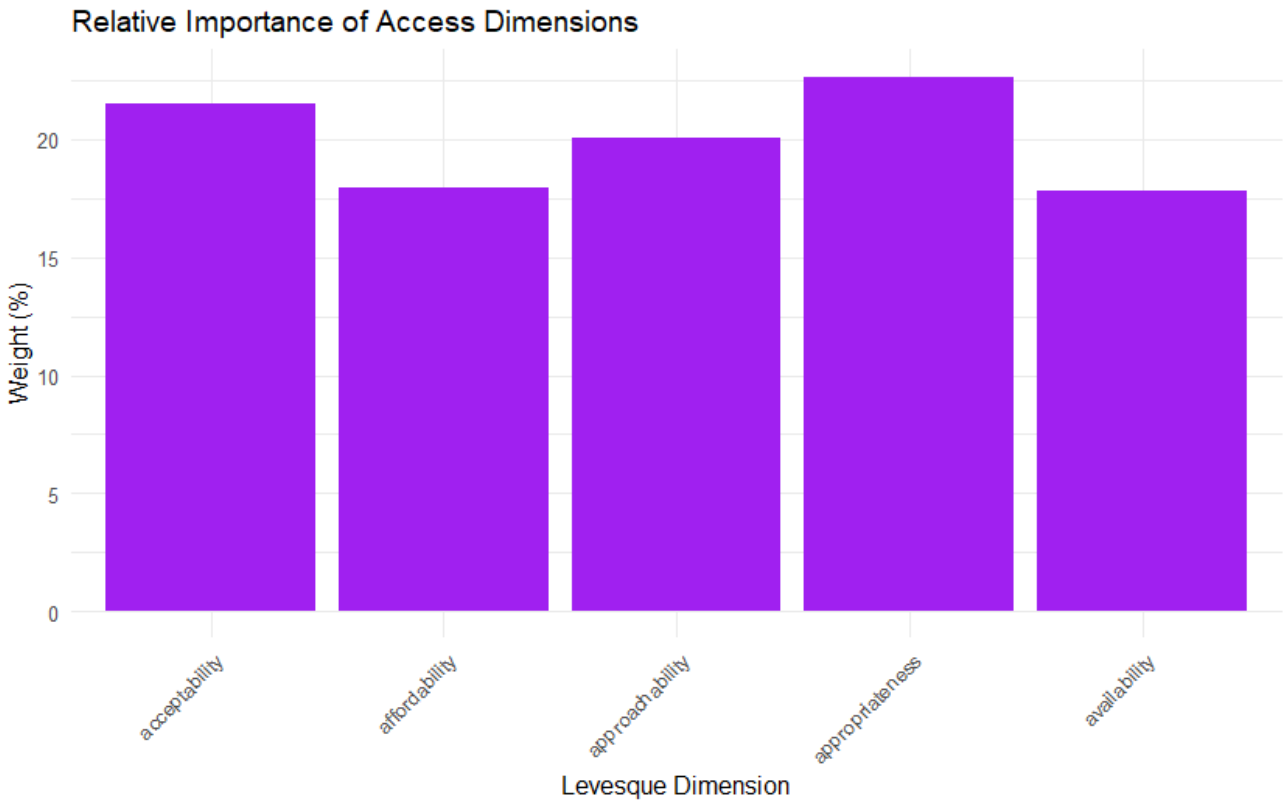

Figure 78: Relative importance of the Levesque access dimensions in France based on stakeholder weighting exercise

Interventions

AMKE IASIS

The first service evaluated in France was AMKE IASIS, an integrated community-based psychotherapy and home care service for individuals experiencing severe mental health problems[26]. The service is delivered by a multidisciplinary team and adopts a holistic approach that aims to address both the clinical and social needs of service users. The intervention includes the diagnosis and treatment of mental health conditions, nursing follow-up, psychological support, and education for patients and their families.

Figures 35 and 36 present the access profile of AMKE IASIS across the five Levesque access dimensions. Figure 35 shows the unweighted profile based on participants' original ratings, while Figure 36 presents the weighted profile after taking into account the relative importance assigned to each access dimension during the weighting exercise. The unweighted results revealed considerable variation across the dimensions. Approachability received the highest rating, scoring approximately

7.5, indicating that participants perceived the service as relatively easy to identify and access. Availability received a more moderate evaluation, scoring slightly above 5. In contrast, acceptability, affordability, and appropriateness received lower ratings, all scoring below 5.

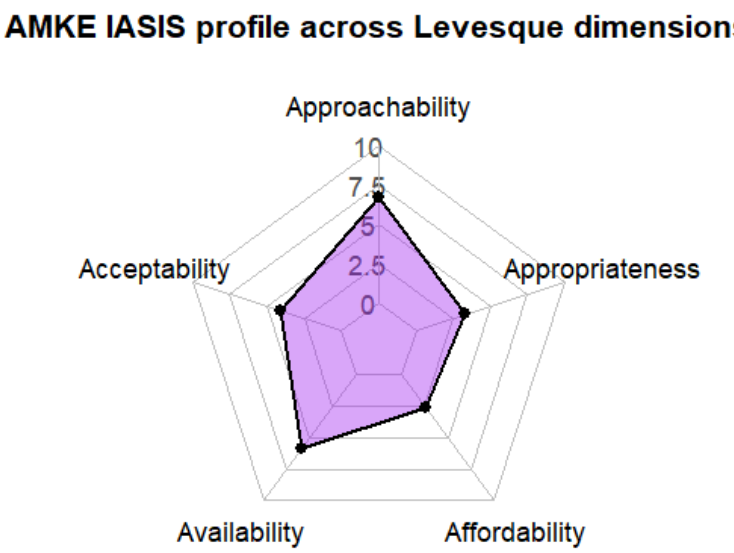

Figure 79: Unweighted access profile of AMKE IASIS across the Levesque access dimensions

After incorporating the weighting exercise, the overall pattern remained largely unchanged. Approachability continued to be the strongest-performing dimension, while acceptability, affordability, and appropriateness remained comparatively lower. Although the weighting procedure slightly altered the relative contribution of each dimension, it did not substantially change the overall profile of the service.

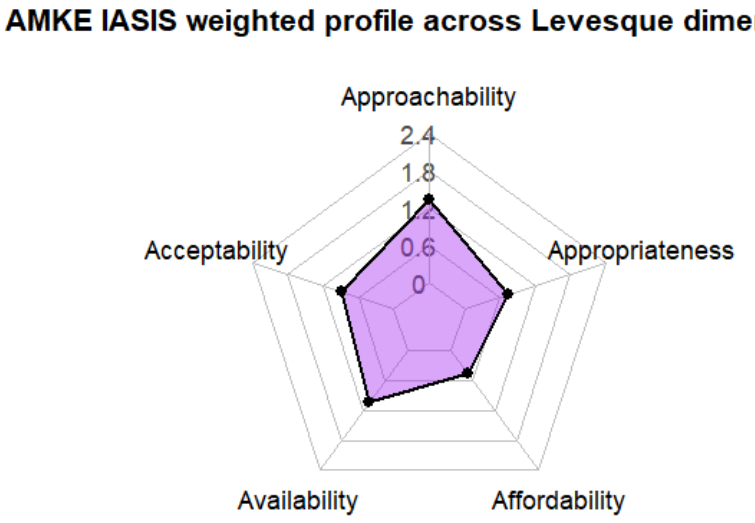

Figure 80: Weighted access profile of AMKE IASIS across the Levesque access dimensions

L'OMéDIT Normandie

The second service evaluated in France was L'OMéDIT Normandie, which provides a toolkit aimed at improving awareness, understanding, and appropriate use of psychotropic medications, including antipsychotic treatments[27]. The service is designed for both healthcare professionals and individuals receiving these medications. The toolkit includes a range of educational, informational, and decision-support resources intended to promote safe and informed medication use.

Figures 37 and 38 illustrate the access profile of L'OMéDIT Normandie across the five Levesque access dimensions. Figure 37 presents the unweighted profile based on participants' original ratings, while Figure 38 displays the weighted profile after accounting for the relative importance assigned to each access dimension. In the unweighted profile, L'OMéDIT Normandie performed strongest on acceptability and approachability, both receiving scores of approximately 7.5. These findings suggest that participants perceived the service as understandable, accessible, and responsive to users' needs and preferences. The remaining dimensions; availability, affordability, and appropriateness, received more moderate ratings, scoring around or slightly above 5.

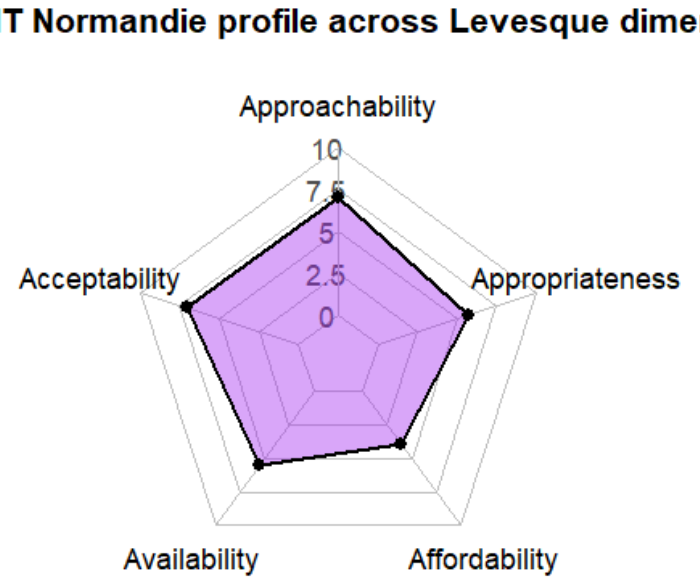

Figure 81: Unweighted access profile of L'OMéDIT Normandie across the Levesque access dimensions

After applying the weighting procedure, some shifts in the profile became visible. Affordability became less prominent within the weighted profile, reflecting the comparatively lower performance of this

dimension combined with the weighting exercise. In contrast, approachability, acceptability, and appropriateness converged and received relatively similar weighted scores.

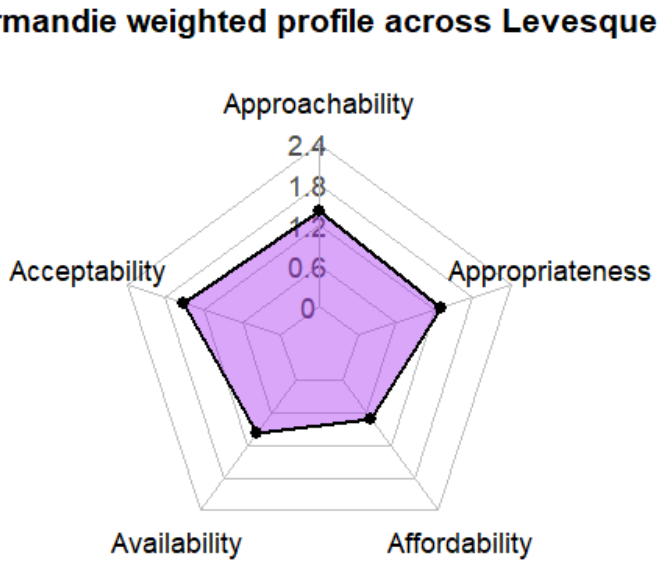

Figure 82: Weighted access profile of of L'OMéDIT Normandie across the Levesque access dimensions

EPAPSY (Association for Regional Development and Mental Health) - Early Intervention in Psychosis Units

The third service evaluated in France was EPAPSY, a specialised early intervention service for adolescents and young adults experiencing a first episode of psychosis, as well as their families. The service aims to promote early identification and timely intervention in order to improve outcomes and reduce the long-term impact of mental health problems. The programme is delivered by a multidisciplinary team and addresses the complex and multidimensional needs that may arise during a first psychotic episode. Support may include clinical assessment, treatment, psychological counselling, and family support.

Figures 39 and 40 present the access profile of EPAPSY across the five Levesque access dimensions. Figure 39 displays the unweighted profile based on participants' original ratings, while Figure 40 presents the weighted profile after taking into account the relative importance assigned to the access dimensions. The unweighted profile showed a remarkably balanced pattern across dimensions, with all five access dimensions receiving scores of approximately 7.5. This suggests that

participants perceived the service as performing consistently well across different aspects of access, without any single dimension standing out as either a particular strength or weakness.

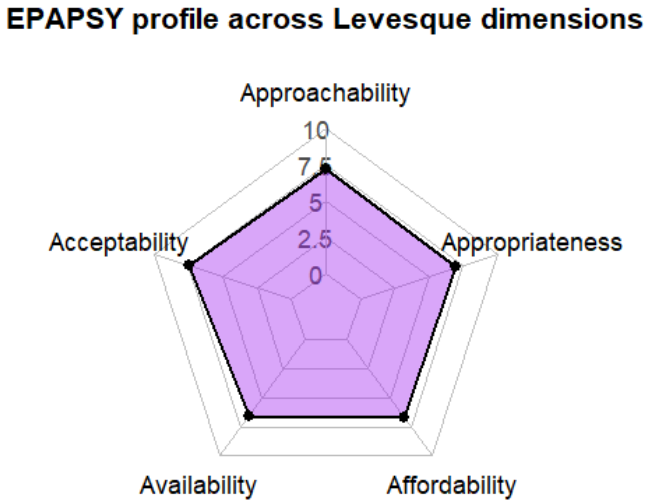

Figure 83: Unweighted access profile of EPAPSY across the Levesque access dimensions

Following the weighting exercise, differences between dimensions became more visible. Because the original ratings were relatively similar, the weighted profile more clearly reflected the priorities expressed by participants during the weighting exercise. In particular, acceptability and appropriateness became more prominent in the weighted profile, reflecting the higher importance assigned to these dimensions.

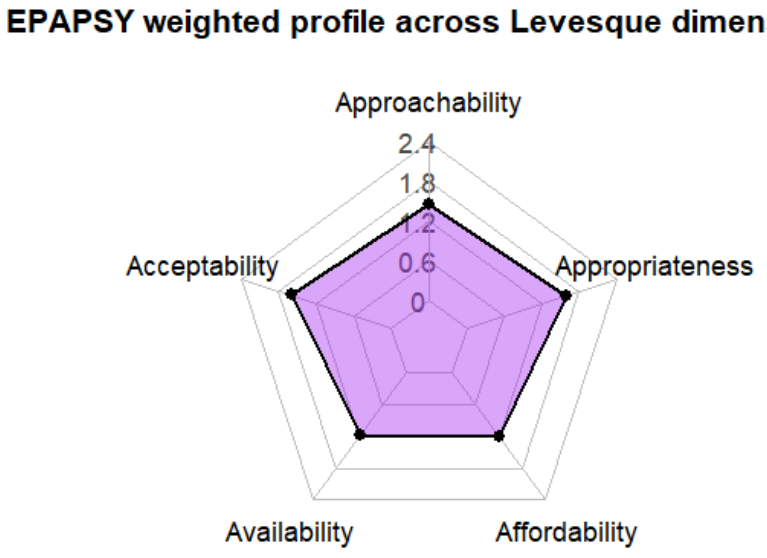

Figure 84: Weighted access profile EPAPSY across the Levesque access dimensions

Hara

The fourth service evaluated in France was Hara, a residential and day-care support service for individuals with intellectual disabilities and additional complex needs, including conditions such as autism, cerebral palsy, and Down syndrome[28]. The service is designed for individuals who require substantial support in their daily lives and aims to provide a stable and supportive environment tailored to long-term care needs. Hara offers structured accommodation, daily activities, and personalised support adapted to the specific needs of each individual. In addition to providing care and assistance, the service promotes participation in community life and seeks to reduce stigma through engagement with local residents and community initiatives. The overall objective is to enhance quality of life, foster social inclusion, and provide person-centred support for individuals with complex and enduring support needs.

Figures 41 and 42 present the access profile of Hara across the five Levesque access dimensions. Figure 41 displays the unweighted profile based on participants' original ratings, while Figure 42 presents the weighted profile after incorporating the relative importance assigned to the access dimensions during the weighting exercise. The unweighted profile indicated low ratings across all five access dimensions. Scores remained below 5 for each dimension, suggesting that participants perceived the service as making a more limited contribution to improving access to mental healthcare compared with the other services evaluated. No clear strengths emerged across the dimensions, with ratings remaining consistently low throughout the profile.

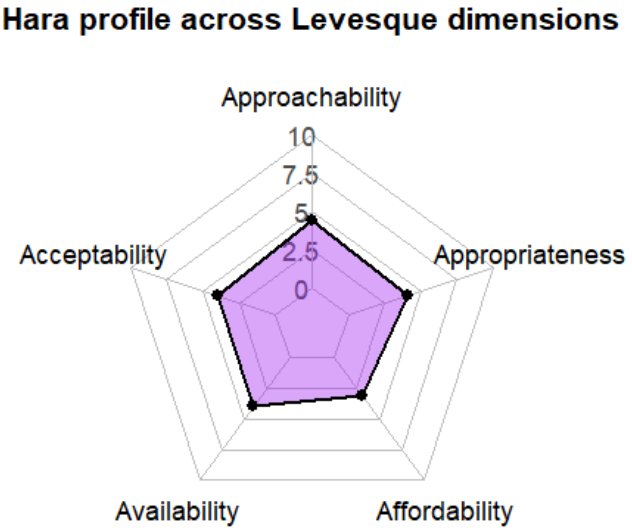

Figure 85: Unweighted access profile of Hara across the Levesque access dimensions

A similar pattern was observed in the weighted profile. Although the weighting procedure altered the relative contribution of the different dimensions, the overall assessment of the service remained largely unchanged. Scores continued to be low across all dimensions, indicating that the service was

perceived as having a comparatively limited impact on improving access to mental healthcare, even when stakeholder priorities were taken into account.

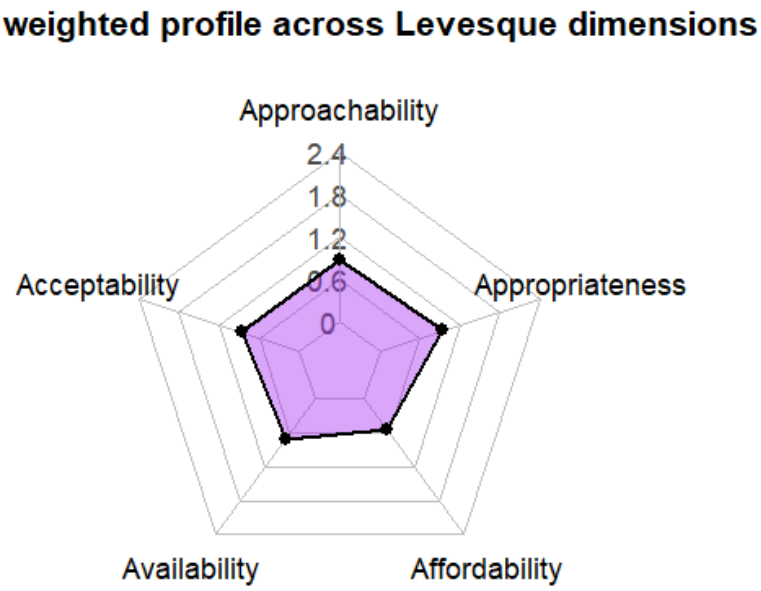

Figure 86: Weighted access profile of Hara across the Levesque access dimensions

Private Health Center Normandie

The final service evaluated in France was Private Health Center Normandie, a day-care and outpatient mental health service providing support for individuals experiencing mental health problems[29]. The centre offers a range of interventions, including individual counselling, psychotherapy, and peer support groups. Alongside more traditional therapeutic approaches, the service incorporates a variety of complementary activities, such as mediation groups, body-oriented practices, theatre, and art therapy.

Figures 43 and 44 present the access profile of Private Health Center Normandie across the five Levesque access dimensions. Figure 43 shows the unweighted profile based on participants' original ratings, while Figure 44 presents the weighted profile after incorporating the relative importance assigned to each access dimension. The unweighted profile demonstrated a relatively consistent pattern across all dimensions. Ratings were generally around 5, with only limited variation between approachability, acceptability, availability, affordability, and appropriateness.

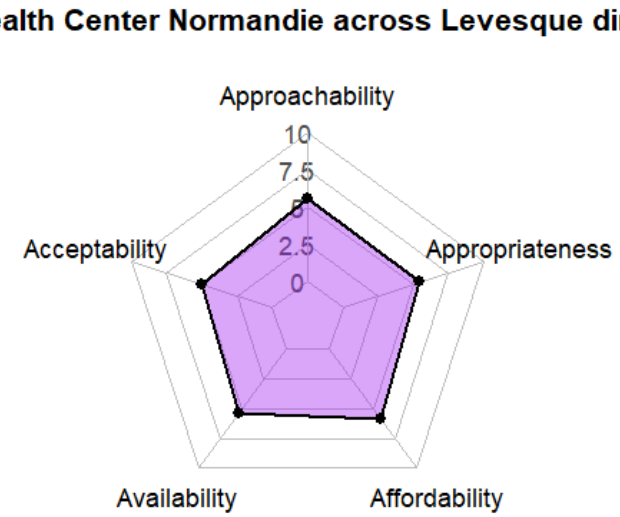

Figure 87: Unweighted access profile of Private Health Center Normandie across the Levesque access dimensions

Following the weighting exercise, modest differences between dimensions became more apparent. Nevertheless, these variations remained limited, and the overall profile continued to show a relatively even distribution across the access dimensions.

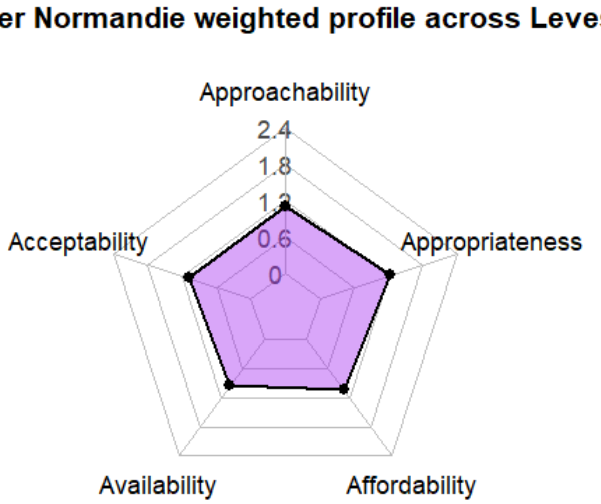

Figure 88: Weighted access profile of Private Health Center Normandie across the Levesque access dimensions

5. Discussion

This deliverable evaluated twenty mental health services across Ireland, Spain, Turkey, and France to assess their perceived contribution to improving access to mental healthcare for vulnerable populations. Using the Levesque framework and a mixed-methods approach combining service ratings, stakeholder weighting exercise, and qualitative discussion in focus groups, the evaluation generated evidence on service accessibility, stakeholder priorities, and factors influencing access to care.

5.1 Access to mental healthcare is multidimensional

The findings demonstrated that access to mental healthcare cannot be reduced to as single characteristic of a service. Across countries, stakeholders consistently emphasised that accessible services need to be visible, acceptable, available, affordable, and appropriate to users' needs. No service performed equally across all dimensions, and different services demonstrated different access profiles. The findings further showed that stakeholders viewed the dimensions as highly interconnected. During focus group discussions, participants repeatedly described the dimensions as *"pieces of a puzzle"*, arguing that weaknesses in one dimension may undermine strengths in others. For example, highly appropriate services may remain inaccessible if waiting lists are long, costs are prohibitive, or individuals are unaware that the service exists.

Table 2: Relative importance of the Levesque dimensions across countries

Country	Highest priority dimensions	Secondary priorities	Lower priorities
Ireland	Acceptability, Approachability	Availability, Appropriateness	Affordability
Spain	Availability, Appropriateness	Affordability	Acceptability, Approachability
Turkey	Availability, Affordability	Appropriateness	Acceptability, Approachability
France	Appropriateness, Acceptability	Approachability	Availability, Affordability

Although priorities differed between countries, appropriateness emerged as one of the most influential dimensions across all the settings. Stakeholders consistently emphasised the importance of services that effectively respond to users' needs and circumstances. Acceptability also emerged as a key consideration, particularly where services were expected to address stigma, cultural differences, and vulnerable populations The evaluation also demonstrated that each access dimension contributes differently to perceptions of service accessibility (Table 2). The findings suggest that appropriateness

and acceptability are particularly important for vulnerable populations, while affordability and availability remain critical prerequisites for ensuring that support can actually be reached and used.

Table 3: Evaluation of the services based on the Levesque dimensions

Dimension	Key findings
Approachability	Services providing clear information, simple navigation, digital access, and community visibility were rated highly. Complex websites, limited awareness, and difficult entry pathways reduced scores
Acceptability	Culturally responsive, stigma-sensitive, and community-based services consistently performed well. Services tailored to specific populations received particularly strong ratings
Availability & Accommodation	Services embedded within communities, schools, primary care, or outreach structures were viewed positively. Geographic barriers, waiting times, and workforce shortages reduced perceived accessibility
Affordability	Low-cost, community-based, and publicly supported interventions were generally perceived positively. Financial constraints, transportation costs, and indirect costs remain important barriers in several contexts
Appropriateness	This dimension received the highest weighting in several countries and was frequently highlighted during focus groups. Stakeholders valued services that were tailored, person-centred, coordinated, and responsive to complex needs.

5.2 Comparison of the evaluated services

The evaluation identified substantial variation in perceived accessibility across services. Several interventions demonstrated consistently strong performance across multiple dimensions, while others showed more mixed or limited profiles. Table 3 summarises the perceived strengths and limitations of the evaluated services

Table 4: Main strengths and limitations of the evaluated services

Country of evaluation	Service	Main strengths	Main limitations
Ireland	Spunout Navigator	Highly approachable; Easy digital access	Limited influence on structural barriers such as waiting lists
	Gesundheitstreffpunkt Mannheim	Peer support and empowerment	Limited information available to fully assess implementation
	We Matter Too	Youth engagement; Innovative	Lower acceptability compared with other dimensions

	Plus e.V.	Strong support for LGBTQIA+ refugees and migrants; Culturally sensitive	Complex implementation context and structural barriers
	Friendship Bench	Affordable; Promotes social connectedness	Potential activation barriers for service uptake
Turkey	Family physicians in MHC	Familiar access point Supports early identification	Concerns regarding provider capacity and stigma
	CAMHI	School-based prevention; Broad reach	Lower appropriateness compared with other dimensions
	Hatay Refugee Response operation	Multidisciplinary; Outreach-based; Strong scores across all dimensions	Resource-intensive models
	StrongMinds	High affordability and availability; Free of charge Scalable intervention	Mechanical feeling; Limited potential to change thinsg on its own
	Thinking Healthy Programme	Preventive; Empowering of women and mothers	No major weaknesses identified
Spain	En Buena Edad	High availability and affordability	Sceptical about practical use for older populations; Lower acceptability ratings
	Foundation Health Problems of Minorities	Strong cultural responsiveness; Addresses all aspects of life	Approachability and practical use will be limited without clarity
	Confederación Salud Mental España	Strong advocacy and information provision	Lower approachability due to information complexity
	Health mediators via the National Network of Health mediators	Excellent acceptability and appropriateness; Addresses structural barriers	Questions regarding sustainability and efficiency
	Step by Step	Flexible digital delivery; Broad reach potential	Dependent on digital access and literacy
France	AMKE IASIS	-	Lower scores for affordability and appropriateness
	L'OMéDIT	Strong acceptability and approachability	More moderate affordability and availability
	EPAPSY	Balanced performance	Few distinctive strengths relative to other services

	Hara	-	Consistently low accessibility ratings
	Private Health Center Normandie	Balanced and personalised support	Moderate performances across all dimensions

Several services stood out as particularly promising examples of accessible and equitable mental healthcare: Health Mediators, Hatay Refugee Response Operation, Thinking Healthy Programme, StrongMinds, Friendship Bench, Plus e.V. and EPAPSY. A common feature across these services is their ability to combine person-centred care with practical accessibility. Services embedded in communities, delivered through trusted intermediaries, or specifically tailored to vulnerable populations were consistently perceived as more accessible than generic service models.

5.3 Implications of this Deliverable

The findings generated through this evaluation provide important guidance for subsequent activities within EQUICARES, particularly Work Packages 3 and 4. Across countries, stakeholders consistently emphasised that accessible mental health services should be community-based, culturally responsive, person-centred, and tailored to the needs of specific population groups. Beyond these general characteristics, the evaluation identified several practical considerations that may inform the development of digital tools and innovative service models within the project. For Wp3, which focuses on the development of the AI chatbot and digital support tools, stakeholders repeatedly highlighted the importance of simplicity, clarity, and accessibility. Across multiple focus groups, participants emphasised that users often require practical and immediate guidance rather than extensive background information. Long texts, complex navigation pathways, and excessive information were frequently described as barriers to engagement. Several participants noted that individuals experiencing psychological distress, migrants, people with lower literacy levels, and some older adults may struggle to engage with text-heavy digital resources. Easy-to-read language, clear signposting, intuitive navigation, and the use of visual or audiovisual content were therefore identified as important characteristics of accessible digital mental health support. These findings suggest that the AI chatbot should prioritise concise communication, practical information, and user-centred design principles.

The findings also provide valuable insights for WP4 and pilot partners involved in the development and implementation of innovative mental health solutions. Stakeholders consistently valued services that were embedded within communities, delivered through trusted intermediaries, and capable of addressing social as well as clinical needs. Services such as health mediation initiatives, outreach programmes, peer-support approaches, and culturally adapted interventions were perceived as

particularly effective in improving access among vulnerable populations. The results therefore suggest that future innovations should not only focus on increasing service availability but also on strengthening acceptability, cultural responsiveness, and appropriateness for diverse user groups. Furthermore, pilot partners may benefit from adapting successful service characteristics identified in this deliverable to local contexts and population needs.

6. Conclusion and impact

This deliverable evaluated twenty mental health services across Ireland, Spain, Turkey, and France using the Levesque framework and a mixed-methods approach combining service ratings, stakeholder weighting exercises, and focus group discussions. The findings demonstrate that access to mental healthcare is multidimensional and that accessible services must not only be available and affordable, but also acceptable, appropriate, and available. Across countries, stakeholders consistently valued services that were community-based, culturally responsive, person-centred, and tailored to the needs of vulnerable populations. Services delivered through trusted community actors, outreach mechanisms, health mediation approaches, and integrated support structures were generally perceived as more accessible than generic service models. At the same time, the evaluation highlighted persistent barriers related to complexity, stigma, insufficient tailoring, workforce limitations, waiting times, and digital accessibility.

The deliverable contributes to a broader understanding of how equitable access to mental healthcare can be assessed and strengthened across different contexts. By combining quantitative service assessments with stakeholder perspectives, the evaluation identified both promising practices and remaining challenges that can inform future service development, implementation, and policy learning. Within EQUICARES, the findings provide an evidence base for the development of the AI chatbot, the design of innovative service solutions, the identification of promising practices for the EQUICARES Atlas, and future dissemination and knowledge-exchange activities. Ultimately, the results contribute to the project's overarching objective of reducing inequalities in access to mental healthcare and supporting the development of more accessible, equitable, and responsive mental health systems.

6.1 Limitations

Several limitations should be considered when interpreting the findings. First, the evaluation relied on stakeholder perceptions rather than direct service utilisation or effectiveness data. Consequently, the results reflect perceived accessibility rather than objective measures of service performance. Second, the services were assessed in different national and organisational contexts, which may influence how access dimensions were interpreted by participants. Third, although the mixed-methods approach provided rich insights, the number and composition of participants varied across countries and focus groups. Finally, some services were evaluated based on publicly available information rather than direct experience of service delivery, which may have affected the depth of assessment.

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8. Appendix A – Questionnaire

EQUICARES T2.4 - Ireland

Q1 This survey aims to assess different mental health services in terms of their contribution to equitable access to care.
You will be asked to:

- Evaluate the importance of different aspects to mental healthcare
- Score a set of services based on how welly they support access to care

The assessment is based on five key dimensions of access:

- Approachability
- Acceptability
- Availability & accommodation
- Affordability
- Appropriateness

You may not be familiar with all services included in this survey. For each service, a short description is provided. Please base your responses on your experience, perspective, or best judgement

There are no right or wrong answers. We are interested in your personal perspective.

To get an idea of who is filling in the questionnaire, we would like to know which of the following best describes you?

Q2 *Imagine a situation where mental health services perform very poorly across all aspects of access.*

Now imagine that only one aspect could be improved from the worst possible level to the best possible level.

Which improvement would make the biggest difference in improving access to mental healthcare, especially for people who may face barriers (e.g., vulnerable or underserved groups)?

Please rate how important each aspect is using a scale from 0 (not important) to 10 (extremely important). Higher scores should be given to aspects where improvement would have the greatest impact.

Q3 The following aspects describe different ways in which services can support access to mental health care.

Please consider the definitions below when answering:

- **Approachability:** Health services are organized, presented, and communicated in ways that make them visible, understandable, and perceived as relevant and trustworthy by the population.

  Examples: clear information about where services are located, what support is available, who can use them, and how to seek help; outreach activities; information shared in plain language through schools, community groups, or social media.

- **Acceptability:** The service fits cultural values, preferences, and reduces stigma.

  Examples: respectful and non-judgmental staff attitudes; protecting privacy and confidentiality; services that are sensitive to gender, religion, language, and cultural background; care that makes users feel safe, welcomed, and understood.

- **Availability & Accommodation:** Health services can be physically and temporally reached by people in need and are organized in ways that fit people's daily lives, mobility, and practical circumstances.

  Examples: services located within reasonable travel distance; opening hours that work for school, work, or caregiving responsibilities; short waiting times; appointment systems that are easy to use; options for remote or outreach-based care where relevant.

- **Affordability:** Health services are priced, financed, and organized in ways that minimize the financial burden on users, including both direct costs of care, such as consultation, diagnostic, and medication fees, and indirect costs such as transportation.

  Examples: low-cost or free consultations; insurance coverage or fee waivers; affordable medicines; transport support; and minimizing repeated visits that increase travel or time costs.

- **Appropriateness:** The service meets users' needs, including both medical needs, such as benefiting from treatment and improvement in their condition, and social needs, such as

continuity of schooling, continuity of employment, access to other necessary forms of support, and family support, while also providing appropriate quality of care.

Examples: care that matches the person's condition and circumstances; treatment that leads to improvement; referral to other needed services; follow-up support; and care plans that help users continue school, work, or family responsibilities where possible.

	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	8 (8)	9 (9)	10 (10)
Approachability (1)	○	○	○	○	○	○	○	○	○	○
Acceptability (2)	○	○	○	○	○	○	○	○	○	○
Availability & Accomodation (3)	○	○	○	○	○	○	○	○	○	○
Affordability (4)	○	○	○	○	○	○	○	○	○	○
Appropriateness (5)	○	○	○	○	○	○	○	○	○	○

Q4 *Below and on the next pages, you will find descriptions of different mental health services (5 in total).*

These services may be designed for different population groups. Even if a service is not directly relevant to your own situation or experience, your perspective and expertise remain valuable. Please rate how well each service supports access to mental health care across the following dimensions.

Base your answers on your personal experience, professional knowledge, or overall impression. If you are not familiar with a service, please rely on the description provided.

Q5 **Service:** Spunout Navigator

Description:
This service provides an online tool that offers personalised information on mental health support options. It is designed for individuals experiencing mental health difficulties and aims to guide users towards appropriate services based on their needs.

The tool is accessible online and can be used independently without referral. Its main objective is to support users in identifying suitable care options and improving navigation within the mental health system.

Question:
Please rate how well this service supports access to mental health care across the following aspects.

	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	8 (8)	9 (9)	10 (10)
Approachability - People are able to find and recognize this service and understand what it offers (1)	○	○	○	○	○	○	○	○	○	○
Acceptability - The service is respectful and appropriate for different groups (2)	○	○	○	○	○	○	○	○	○	○
Availability & Accommodation - The service is available and reachable when needed (3)	○	○	○	○	○	○	○	○	○	○
Affordability - The service is financially accessible (4)	○	○	○	○	○	○	○	○	○	○
Appropriateness - The service provides care that meets people's needs, including quality of care, timeliness, continuity, coordination between services, and the adequacy of treatment. (5)	○	○	○	○	○	○	○	○	○	○

Q6 **Service:** Gesundheitstreffpunkt Mannheim

Description: This service provides access to a wide range of self-help groups and peer-to-peer support networks for individuals experiencing health conditions, mental health challenges, or difficult

life situations. It brings together people with similar experiences to share knowledge, offer mutual support, and reduce feelings of isolation.

The service is community-based and participatory, meaning that many of the groups are organized and led by peers rather than healthcare professionals. Activities typically include regular group meetings, information exchange, and support in navigating health and social care services. The aim of the service is to strengthen empowerment, social connectedness, and individuals' ability to manage their own health and wellbeing. Participation is voluntary, generally free of charge, and does not require a formal referral.

Question:
Please rate how well this service supports access to mental health care across the following aspects.

	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	8 (8)	9 (9)	10 (10)
Approachability - People are able to find and recognize this service and understand what it offers (1)	C	C	C	C	C	C	C	C	C	C
Acceptability - The service is respectful and appropriate for different groups (2)	C	C	C	C	C	C	C	C	C	C
Availability & Accommodation - The service is available and reachable when needed (3)	C	C	C	C	C	C	C	C	C	C
Affordability - The service is financially accessible (4)	C	C	C	C	C	C	C	C	C	C
Appropriateness - The service provides care that meets people's needs, including quality of care, timeliness, continuity, coordination between services, and the adequacy of treatment. (5)	C	C	C	C	C	C	C	C	C	C

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Q7 **Service: We Matter Too**

Description:
This service provides community-based mental health support for young people, using culturally relevant approaches to promote awareness and reduce stigma related to mental health. It uses creative methods such as hip-hop and rap music to encourage open discussions about mental health and emotional well-being. In addition to awareness activities, the service delivers brief psychosocial support interventions for young people experiencing mild psychological distress. These interventions are provided in community settings by trained facilitators, including trusted local community members such as barbers.

The service also includes activities aimed at strengthening life skills and economic opportunities, such as entrepreneurship support. The overall aim is to improve access to mental health support by reducing stigma, increasing community engagement, and offering low-threshold support in familiar environments.

Question:
Please rate how well this service supports access to mental health care across the following aspects.

	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	8 (8)	9 (9)	10 (10)
Approachability - People are able to find and recognize this service and understand what it offers (1)	C	C	C	C	C	C	C	C	C	C
Acceptability - The service is respectful and appropriate for different groups (2)	C	C	C	C	C	C	C	C	C	C
Availability & Accommodation - The service is available and reachable when needed (3)	C	C	C	C	C	C	C	C	C	C
Affordability - The service is financially accessible (4)	C	C	C	C	C	C	C	C	C	C
Appropriateness - The service provides care that meets people's needs, including quality of care, timeliness, continuity, coordination between services, and the adequacy of treatment. (5)	C	C	C	C	C	C	C	C	C	C

Q8 **Service:** Plus e.V. - LGBTQIA+ support for refugees

Description:
This service provides counselling, community-based support, and psychosocial assistance for LGBTQI+ refugees and migrants from diverse cultural backgrounds. It aims to address mental health needs as well as social challenges related to displacement, identity, and integration. The service is tailored to a specific population group that may face multiple barriers to accessing care, including stigma, language differences, legal uncertainty, and limited access to appropriate services. Support may include individual counselling, peer support, and guidance on accessing health and social care systems. The service is typically delivered through community-based organisations and aims to provide safe, inclusive, and culturally sensitive support. Access is often low-threshold and may not require formal referral.

Question:
Please rate how well this service supports access to mental health care across the following aspects.

	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	8 (8)	9 (9)	10 (10)
Approachability - People are able to find and recognize this service and understand what it offers (1)	○	○	○	○	○	○	○	○	○	○
Acceptability - The service is respectful and appropriate for different groups (2)	○	○	○	○	○	○	○	○	○	○
Availability & Accommodation - The service is available and reachable when needed (3)	○	○	○	○	○	○	○	○	○	○
Affordability - The service is financially accessible (4)	○	○	○	○	○	○	○	○	○	○
Appropriateness - The service provides care that meets people's needs, including quality of care, timeliness, continuity, coordination between services, and the adequacy of treatment. (5)	○	○	○	○	○	○	○	○	○	○

Q9 **Service:** The Friendship Bench

Description: This service provides community-based mental health support for individuals experiencing symptoms of depression and emotional distress. It creates safe and accessible spaces within communities where people can talk about their problems and receive support.

The service is delivered by trained lay health workers, who provide structured support using approaches such as problem-solving therapy and behavioural activation. Sessions typically take place in informal, community-based settings. The aim of the service is to reduce barriers to accessing mental health care by offering low-threshold, accessible support and strengthening social connectedness. Access does not usually require formal referral and is designed to reach individuals who may otherwise not receive care.

Question: Please rate how well this service supports access to mental health care across the following aspects.

	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)	6 (6)	7 (7)	8 (8)	9 (9)	10 (10)
Approachability - People are able to find and recognize this service and understand what it offers (1)	○	○	○	○	○	○	○	○	○	○
Acceptability - The service is respectful and appropriate for different groups (2)	○	○	○	○	○	○	○	○	○	○
Availability & Accommodation - The service is available and reachable when needed (3)	○	○	○	○	○	○	○	○	○	○
Affordability - The service is financially accessible (4)	○	○	○	○	○	○	○	○	○	○
Appropriateness - The service provides care that meets people's needs, including quality of care, timeliness, continuity, coordination between services, and the adequacy of treatment. (5)	○	○	○	○	○	○	○	○	○	○

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Erasmus School of Health Policy & Management

KOÇ ÜNİVERSİTESİ

SEERC SOUTH-EAST EUROPEAN RESEARCH CENTRE

GIVMED Share medicine Share life

AMALIPE Center For Interethnic Dialogue and Tolerance

LADAPT

LGBT IRELAND For Inclusion For Equality For Everyone

FISEVI Fundación para la Gestión de la Investigación en Salud de Sevilla

ZI Zentralinstitut für Seelische Gesundheit

Q-PLAN INTERNATIONAL

JIGSAW Young people's health in mind

EHTEL Collaborating for Digital Health and Care in Europe

diesis network

EUCOMS The European Community based Mental Health Service Providers Network www.eucoms.net

EASPD European Association of Service providers for Persons with Disabilities

SQUAREDEV

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