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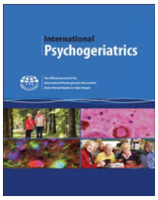

Review Article

Solutions to inequalities in dementia diagnosis and care: A systematic review

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ABSTRACT

Background: People with dementia and their carers often face barriers during diagnosis and accessing post-diagnostic care, causing avoidable inequalities in health outcomes. Without any previous synthesis to date to help improve people with dementia's health outcomes, the aim of this systematic review was to identify and synthesise existing solutions to increase equity in dementia diagnosis and care.
Methods: A search was conducted across five databases in March 2025. All abstracts and full texts were independently screened by two researchers, with a third researcher sorting through any conflicts. Data were extracted by two public advisor researchers and reviewed by a senior research team member, who synthesised the data into solutions on individual, community, and system and infrastructure levels.
Findings: Forty-three studies (42 from High Income Countries) comprising solutions from 13 countries, were included in this systematic review. The majority of studies focused on access to care, with most solutions centering on system-level change. Only one study was conducted in two middle-income countries. Evidence is diverse and minimal for most types of solutions, with a lack of cost-effectiveness data. There are clear indications for key solutions including dementia link workers, communities of practice and wider networks, as well as one-stop memory clinics providing same day diagnostic assessments in rural countries or regions.
Conclusions: Whilst this review highlights a diversity in solutions, more research needs to be conducted that uses clear measurements of health and social care usage and health economics. Importantly, research needs to be undertaken across different countries, particularly lower- and middle-income countries.

Introduction

Although dementia is a recognised global public health problem, with prevalence continuously rising [4], many people with dementia and their carers face substantial barriers in accessing diagnosis and care [22]. With over 57 million people living with dementia globally (ADI, 2023), people with dementia and their carers often experience unmet needs, including insufficient care, support and a lack of training and information about the condition [40,55]. This is particularly challenging in lower- and middle-income countries (LMICs), which generally have less available health care services and higher levels of stigma associated with the condition [53]. However, people with dementia in high-income countries (HICs) can face similar challenges in accessing diagnosis and care. This can be especially influenced by socio-economic factors and level of rurality [38,64].

The Dementia Inequalities Model [21] organises the factors leading to unequal health outcomes in dementia into three levels: individual, community, and society and infrastructure level. On an individual level, people with dementia can face inequalities in accessing a diagnosis or care based on their personal characteristics, such as age, gender, ethnicity, socio-economic background or geographical location, as well as dementia subtype [17,66]. On a community level, people with dementia may experience difficulties if they lack an unpaid carer, or if dementia is highly stigmatised in their community/family [8]. On a society and infrastructure level, people with dementia can struggle due to a lack of health and social care service integration, lack of workforce knowledge, and limited third sector support

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(e.g. [5]). Being from a minority ethnic background is often also linked to stigma within the community, leading to delays or general reluctance in approaching a health care professional for help [8]. To overcome these challenges and create equal opportunities for anyone, multiple solutions need to be developed and implemented.

Whilst there has been a focus on trying to find non-pharmacological and pharmacological interventions that help delay or manage the symptoms of dementia, little attention has been paid to how the delivery of care and receiving a diagnosis might become more inclusive and accessible. People with dementia can substantially benefit from increasing accessibility to correct and timely diagnosis and to suitable day, home, residential or other community-based care. Alty et al. [3] describe an example of increasing geographical equity in access for people with dementia by implementing a 'one-stop' memory clinic in rural Australia, where all assessments and the diagnosis took place within the same day for 98.5 % of participants. This novel model reduced the need for people to travel to several appointments and significantly addressed rural health inequalities in access to diagnosis, by reducing the average waiting time from referral to diagnosis by two months. Examples of increasing equity in access to care in Germany and other countries include the introduction of dementia link workers who connect people with dementia and their carers to services and support from the point of diagnosis [30,52].

A detailed exploration and synthesis of the existing literature on solutions to different types of inequalities in dementia is urgently required to promote generalisation of these solutions to other settings and subgroups where possible. The aim of this systematic review was to critically evaluate the existing evidence on solutions to reduce inequalities in dementia diagnosis and care. Findings from this review will be useful to inform how different barriers might be addressed so that existing interventions and systems for people with dementia can become more inclusive and accessible to reduce inequalities in health outcomes.

Methods

Search strategy

Five data bases (Pubmed, PsycINFO, CINAHL, Scopus, Web of Science) were searched in February 2024 with searches re-run in March 2025, using the following search strategy:

Dementia AND (diagnos OR care OR access OR use) AND (facilitator OR solution) AND (therapy OR intervention OR service)*

The review protocol was prospectively registered on PROSPERO [Ref:CRD42024504882].

Inclusion and exclusion criteria

Studies were eligible for inclusion if they were published in English or German, the spoken languages of the research team; published from 2010 onwards; and focused on an intervention or mechanism that reduced inequalities in access to diagnosis or care for people with dementia. No restrictions were placed on country of the intervention. Papers were excluded if they were published before 2010; published in a language other than English or German; did not contain original data (i.e. letter, editorial, systematic review, opinion piece); did not focus on an intervention or solution to increase greater equity in dementia diagnosis or care.

Study selection

Each title and abstract of retrieved records was assessed by two research team members against the inclusion criteria to exclude articles that did not meet the inclusion criteria in Stage 1. The task was shared among five researchers, ensuring that each title was assessed by two reviewers. The selected records were read in full text in Stage 2 independently by two researchers (CG, AV, CT, BWH), and articles that met the inclusion criteria were included in the review. Any discrepancies at stage 1 or 2 were resolved in discussion with the wider research team. We followed PRISMA guidance in screening and selecting articles.

Data extraction and synthesis

Data from each study were extracted by a public advisor researcher (JH, FR) and checked by a research team member. Data were extracted about country, study methodology, population and sample size, type of intervention, outcomes of intervention, health inequalities addressed. Data were synthesised by focusing on the different types of interventions or solutions used; the different types of health inequalities addressed; and their level of success in increasing inclusion and access to care for people with dementia and unpaid carers. Specifically, interventions were grouped into the three levels of dementia inequalities as reported in the Dementia Inequalities Model [21], by clustering solutions into addressing individual, community-, and societal- and infrastructure-level inequalities. Due to the mixed nature of the methodologies included in this review, data were synthesised narratively by two researchers (CG, CT).

Quality ratings

Study quality for all studies was assessed using the Mixed-Methods Appraisal Tool (MMAT, [31]). This was based on a substantial number of mixed-methods papers included in this review. Where a study was either qualitative or quantitative, the relevant section of the MMAT was used. Using one single tool for multiple methodologies employed across the different included studies allowed for greater comparison of the quality of each study. Quality ratings did not influence study selection but were used in guiding the discussion of findings and drawing conclusions.

Results

Overview of included studies

After screening 8140 abstracts and 134 full texts, 43 studies were included in this review. Fig. 1 shows the PRISMA flow chart of included studies. The majority of studies used mixed-methods (n = 17), followed by quantitative (n = 13) and qualitative (n = 13) studies. Included studies covered 13 countries, including USA (n = 12), UK (n = 7), Australia (n = 6), Canada (n = 6), Germany (n = 5), and one each from Japan, Taiwan, Sweden, Denmark, Austria, Netherlands and one cross-country study from Brazil and India. Thus, only one study [16] was conducted in a lower middle-income country (India) and an upper middle-income country (Brazil), with all other 42 studies conducted in HICs.

Table 1 shows details of each included study, organised by types of solutions into individual-level, community-level, and society- and infrastructure-level, as well as separated into those focusing on diagnosis (n = 15), post-diagnostic care (n = 35) and both diagnosis and care (n = 7). The majority of studies reported on solutions to society-level inequalities (n = 24), specifically to care, with 14 and 9 studies reporting on solutions to individual- and community-level inequalities, respectively.

Reducing individual-level inequalities

Diagnosis

Only one study reported on interventions addressing individual-level inequalities in diagnosis. Ali et al. [2] evaluated an online multilingual dementia information session for English-, Arabic-, and Vietnamese-speaking communities in Australia. During in-session quizzes, participants demonstrated understanding of dementia and its symptoms, and post-session survey responses from seven participants showed improved knowledge, attitudes, and confidence in communicating with people living with dementia.

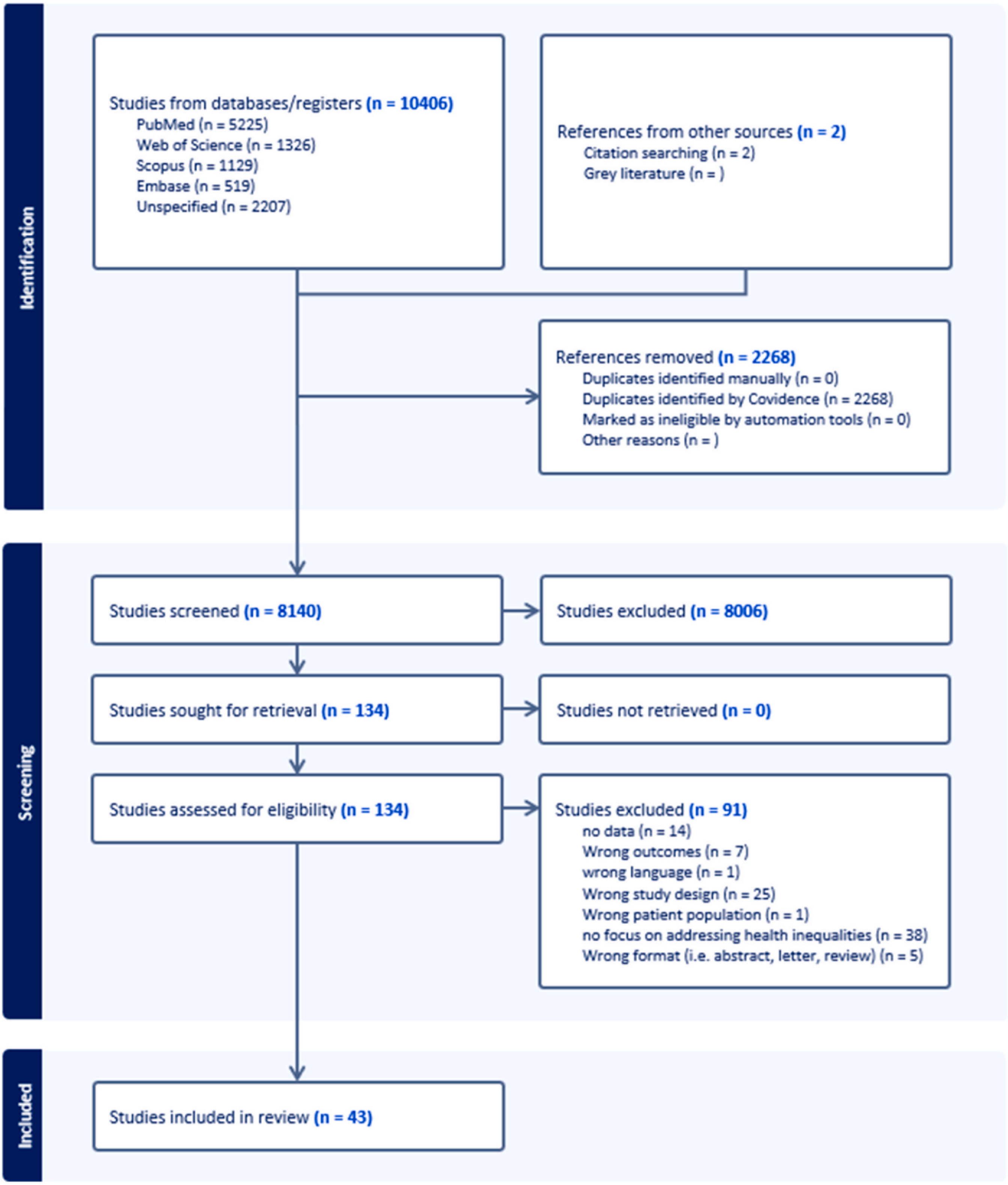

Fig. 1. PRISMA flowchart.

Care

Thirteen studies reported on interventions targeting individual-level inequalities in dementia care, including one health education intervention [32], eight culturally or linguistically tailored interventions designed for specific communities (e.g., [15,47], and four digital interventions aimed at improving care, decision-making, or social support (e.g., [48,65]). The health education intervention was delivered by nurse practitioners to family carers in Taiwan and focused on improving carers' ability to manage behavioural problems, increasing their confidence in providing care, and offering individualised education on the stages of dementia [32]. Participants who received the intervention showed significant improvements in preparedness, competence, and awareness and utilisation of community resources compared with the control group.

Table 1
Characteristics of included studies.

Author (year)	Country	Type of study	Intervention	Participants	Types of inequalities addressed	Inequality level	Outcomes
Diagnosis							
Alty et al. [3]	Australia (Tasmania)	Observational study	• One-stop single-visit interdisciplinary clinic offering medical, cognitive, physiotherapy & imaging assessments • Same day diagnosis and treatment plan	• Adults referred by GPs (n = 130) • 36.8 % from rural/remote areas	• Rural/remote residents to improve access	Society and infrastructure	• 98.5 % received same day diagnosis • Referral to diagnosis time halved (78 vs 133 days) • 90 % of patients satisfied • 36.8 rural attendance suggests reduced geographic inequity
Casey et al. [12]	Australia	Surveys • before • after • 6–9 months after	• National GP dementia training programme • Covered diagnosis, management, legal issues and resources • Accredited for GP development	GPs • Baseline (n = 1303) • Post programme (n = 1017) • Follow-up (6–9 months) n = 138	• GPs from regional, remote and urban areas • Skills equality: GPs with advanced to early career experience	Society and infrastructure	• Short-term increases in dementia awareness (+0.9), practice (+1.3), knowledge (+2.2), confidence (+2.1) • Most sustained at 6–9 months, with minor declines • High satisfaction (> 90 %) & strong relevance rating
[36]	Canada	Mixed methods: • Pre-post training surveys • interviews	• Implementation of Primary Care Collaborative Memory Clinics (PCCMCs) in non-professional primary care settings, supported by community partnerships.	• n = 122 providers (pre-survey) • n = 71 (post survey) • n = 40 interviews across 14 primary care practices	• Workforce and resource inequalities - bringing memory clinics to less resourced primary care settings	Society and infrastructure	• increased referrals and assessments • shorter wait times • identification of enablers (training.co-ordination)
[]et al. [39]	UK	Cluster-randomised controlled trial	• A GP outreach strategy • sending personalised letters & evidence-based leaflets to patients 70 + without dementia diagnosis – aiming to prompt memory concern presentation to GPs	• n = 6387 patients in 11 intervention practices • n = 8171 in 11 control practices	• Addressing low awareness of dementia symptoms & barriers to seeking help from GPs	Society and infrastructure	• More patients presented to GPs with memory problems • did not increase dementia diagnoses or reduce severity at diagnosis.
Mason et al. [41]	UK	Observational study	• Financial incentives for GPs to record dementia diagnosis	• General Practices (n = 7142) 2006–2016	• Disparities in dementia diagnoses across primary care practices	Society and infrastructure	• Significant reduction in under diagnosis • Recorded dementia cases rose from 51.8 % to 68.8 % of expected rates (2013–2016) • Estimated 40,767 more people registered nationally
Medina et al. [43]	USA	Pre-post assessment surveys	• Boot camp Translation (BCT) • process where local Hispanic/Latino community members co-designed culturally appropriate messaging about Alzheimer's disease	• n = 39 Hispanic/Latino community members from 3 cities	• educating and motivating Hispanic/ Latino communities • addressing health literacy and cultural barriers	Individual / Community	• Participants showed improved understanding of Alzheimer's • created actionable, culturally tailored dementia messages
Satoh et al. [54]	Japan	• Surveys • Clinical Screening data	• Dementia IT Screening System (DITS) • program linking family doctors with dementia specialists via an IT platform, using local social resources to enable early diagnosis.	• n = 158 older adults screened through family doctors	• limited access to dementia specialists • delays in diagnosis in community settings	Society and infrastructure	• DITS improved collaboration between family doctors and specialists • increased early dementia referrals
Turner et al. [63]	USA	Observational study • Survey/ questionnaires	• Interdisciplinary memory clinic • Cognitive screening • Streamlined referrals	• Patients (n = 100) • Primary care/memory clinic staff (n = unspecified)	• Long wait times for assessment • Improving early access	Society and infrastructure	• Reduced wait times • Earlier diagnosis • Improved care coordination & patient satisfaction
Diagnosis and care							
Ali et al. [2]	Australia	Mixed methods: • Post session surveys • group quizzes • focus groups	• Dementia alliance co-created online multilingual dementia information session	• n = 114 English, Arabic and Vietnamese aged over 18. • 68 English • 13 Arabic • 33 Vietnamese	• Dementia knowledge within multi-cultural societies	Individual	• Online dementia session successfully supported participants' understanding dementia causes, impacts and strategies

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Table 1 (*continued*)

Author (year)	Country	Type of study	Intervention	Participants	Types of inequalities addressed	Inequality level	Outcomes
Brown et al. [9]	Australia	Semi structured group interviews	• Tele health service implemented-for YOD • Video calls were used to extract information	• n = 7 metropolitan clinicians • n = 16 rural clinicians	• Geographic barriers for rural people • Gaps in expertise and services	Society and infrastructure	• provided access to specialised education and training • Improved quality of care by providing access to collaborative/specialised care
de Carvalho et al. [16]	Brazil & India	Mixed methods pre/post test single-group feasibility study	Dementia awareness course for carers	• n = 70 family caregivers Brazil = 34 India = 36 • n = 54 completed	Knowledge & awareness of Dementia and Stigma in 2 countries	Individual & Community	• Improved attitudes and carer competence • Acceptability, feasibility, attitude change
[24]	UK	Semi-structured interviews	• Engagement with Liverpool Dementia & Aging Research Forum – bringing together people with dementia, unpaid carers, academics, clinicians, service providers. • To provide an inclusive space for sharing knowledge, building partnerships through events and activities	• n = 17 • 13 were female and white British • 7 were unpaid carers for PwD	Community focussed bringing different stakeholders together to exchange different experiences	Community	• Improved skills, knowledge, networking, empowerment • ethnic diversity was limited • people accessing services better
Morgan et al. [46]	Canada	• Focus Groups • interviews	• A Rural Health Care Model for Dementia, co-developed via a five-step, community-based process to implement team-based care, decision support tools and specialist-provider support	n = 23 rural primary care providers across 3 teams including Medical professionals, case managers and Alzheimer Society staff	• Geographic and resource disparities • Limited access to specialist dementia care in rural communities	Society and infrastructure	• improved co-ordination of care • better provider education
Morgan et al. [46]	Canada	• Focus Groups • Semi structured interviews	• 1-day memory clinic • Team based dementia assessments • Sharing tools embedded into medical records (EMR) • Case conferences • Alzheimer Society coordinator	Health Care Professionals (n = 25)	• Rural & remote areas • Reducing gaps in diagnosis & care	Society and infrastructure	• Improved access for rural care • Earlier diagnosis
[50]	USA	Mixed-methods descriptive study	Wisconsin Alzheimer's Institute (WAI) Dementia Diagnostic Clinic Network connected 38 memory clinics to share resources, education and quality improvement support.	• clinics (n = 38) patients across 21 counties • Patients (n = 4710) 92 % 65 + over 60 % female. 92 % white	• inequalities due to rural and underserved areas. • workforce training gaps	Society and infrastructure	• established a network of memory clinics • Training improved knowledge, skills & confidence • data provided valuable evidence.
Care							
Alexander et al. [1]	USA	Mixed-methods: • pre post surveys • in depth interviews	Psychoeducation course designed for black carers	• Black dementia carers enrolled • n = 75 • n = 32 carers completed course	• Addressed lack of support options for black carers • Support disparities	Individual / Community	• 32 Black care givers completed the course • Care givers mastery increased by 0.45 points
Berridge et al. [7]	USA	Mixed-methods: • Pre-post design with surveys, questionnaires • Follow-up interviews	Web app Intervention to help people with dementia and carers plan how to use tech at home (like monitoring devices, alerts)	n = 29 dementia care dyads	Lack of knowledge in people affected by dementia	Individual	• participants reported it helped them have meaningful conversations about using technology
Cha et al. [13]	USA	Mixed-methods: • Surveys • questionnaires • Semi -structured interviews	Care to Plan (CtP) web tool support for carers	Carers (n = 20)	Lack of knowledge about services	Individual	• 85 % of carers found CtP helpful • 90 % would recommend it as it enhanced access to services
Dassel et al. [15]	USA	Focus Groups	• Creation of a Spanish version of the LEAD guide (Life-Planning in Early Alzheimer's and other Dementias. • To help PwD and their families plan for future care	• Spanish-speaking Latino people with dementia and carers (n = not specified)	• Language • health literacy • cultural accessibility	Individual	• Produced culturally acceptable guide for advanced care planning

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Table 1 (*continued*)

Author (year)	Country	Type of study	Intervention	Participants	Types of inequalities addressed	Inequality level	Outcomes
Eichler et al. [18]	Germany	Observational study • Survey/ questionnaires	Intervention management System (IMS) used by GPs and care managers • To identify dementia patients' needs • To generate care recommendations (services & treatments) • Developed within DelpHi-MV trial	• GPs & dementia care managers • Survey respondents (numbers not given)	Service access inequality for care support	Society and infrastructure	• 85 % increase in recommended interventions • Higher user satisfaction
Gaugler et al. [20]	USA	Mixed methods study: • Questionnaires • semi structured interviews	Care to Plan (CtP) online tool was evaluated in health care system	• n = 43 carers • 32 (74.4 %) female • 11 (25.6 %) male	• Lack of knowledge about services • Lack of information	Society and infrastructure	No significant effects
Goeman et al. [25]	Australia	Co-design study: • focus groups • Stakeholder workshops	On-line Vietnamese Dementia Talking Book designed with community members	• n = 59 Vietnamese community members & 11 Stakeholders in design. • n = 22 Vietnamese community members in evaluation	• Language barriers • Health literacy inequalities in culturally and linguistically diverse communities	Individual	• Enhanced the knowledge of the Vietnamese community and understanding of dementia • improved navigation of accessing services.
Guterman et al. [26]	USA	Secondary health economic analysis	Care Ecosystem (link worker model)	N = 460 people with dementia	Access to care	Society and infrastructure	Significant cost reductions post intervention, leading to an average of $526 savings monthly across 12 months
Haydon et al. [27]	Australia	Mixed-methods: • Surveys • Post feedback surveys	Dementia ECHO – a telemonitoring programme delivering specialist led video conference sessions & case discussions	• n = 94 health professionals • 30 completed pre-programme survey • 44 responded to post survey	• Rural & indigenous service disparities • Professional isolation	Society and infrastructure	• improved dementia knowledge (88.4 %) • increased confidence to provide dementia care (83 %) • reduced isolation (88 %).
Heinrich et al. [28]	Germany	Mixed methods: • Semi-structured interviews • Surveys/ questionnaires	• Evaluation of how Dementia Care Networks manage and share information with carers	• Health care & community-based professionals from 13 regional Dementia Care Networks (n = 68)	• Service access equality	Society and infrastructure	• Personalised, direct methods (via case managers/GPs) more effectively reached carers than passive methods (leaflets or websites) • Information sharing systems helped carers better access dementia services.
Heinrich et al. [29]	Germany	Mixedmethods: • Semi-structured interviews • Survey/ questionnaires	• How Demetia Care Networks (DCNs) evaluate whether carers have received/understood information	• Representatives from 13 regional DCNs (n = 68)	• service access inequality • ensuring carers actually received & understood support available	Society and infrastructure	• many networks lacked tools to check if carers understood information • Direct contact follow-ups were more successful. • highlighted gap between info supplied and confirmation it was understood/acted on
Heinrich et al. [30]	Germany	Mixed methods: • Semi-structured interviews • Quantitative data	• Trained dementia care nurses visited PwD /carers to offer case management support and service co-ordination	People with dementia (n = 113)	• Service access • aimed to reduce barriers by proactively bringing support to families at home.	Society and infrastructure	• Uptake of services increased by 19 % suggesting improved access and engagement
Huang et al. [32]	Taiwan	Survey/questionnaires (pre/post)	Nurse led health education program for people with dementia and their carers • Outpatient education sessions • On behaviour management, care preparedness, community resources	250 dyads	• Service access – strengthening care quality and resource use within patient settings	Individual	• Better support for carers – boosting their preparedness, competence and resource awareness

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Table 1 (*continued*)

Author (year)	Country	Type of study	Intervention	Participants	Types of inequalities addressed	Inequality level	Outcomes
Kagwa et al. [34]	Sweden	Semi-structured interviews	• Tested STAV (mobile app giving Support to Family Carers), tailored to each carer's situation • social care workers used app to interact with carers. • chat support, mindfulness exercises,digital diary, web	• Social care professionals (n = 11) • Family carers (n = 19)	• Service access inequality • Facilitated flexible, remote support	Society and infrastructure	• Improved access to professional support • Allowed flexible & continuous communication • Reduced feeling of isolation especially where in-person help was limited
Kontos et al. [35]	Canada	• semi-structured interviews • focus	• Screening of research-based film **Cracked: New Light on Dementia** • Designed to challenge stigma & highlight relational caring	• n = 16 formal carers • n = 8 family carers • n = 8 public	• social stigma • negative stereotypes • lack of recognition of relational frameworks	Community	• reduced stigma • fostered understanding of dementia • emphasised importance of relational caring.
Lee et al. [37]	USA	• semi-structured interviews	• 12-week home-based intervention by trained bi-lingual Community Health Workers (CHWs) • education strategies & emotional support • navigation to community resources through home visits	unpaid carers (n = 57)	• ethnic and linguistic inequalities (for Korean, Vietnamese, Latino, Hispanic & white carers) • CHWs helped carers navigate services	Individual	• improved carer self-efficiency • enhanced communication with people with dementia • greater access to community resources • reduced carer's isolation through trusting CHW relationships
McConnell et al. [42]	UK	Mixed methods: • Interviews • observations • document analysis	• A member-led dementia empowerment service led by people with dementia via Dementia NI • Aimed at fostering participation, independence & empowerment	• n = 15 people with dementia • n = 3 staff • n = 5 board members	• limited representation and control by people with dementia in service design and decision-making	Community	• Members reported improved quality of life and feeling valued • People with dementia treated as equal partners • staff provided support without taking over • Reduced stigma in part
Morgan et al. [44]	Canada	• Focus Groups • Semi-structured interviews	• Alzheimer Society Coordinator embedded within PHC team • Support & education for families • Early connection to Alzheimer Society • Team meetings and care planning	• Health professionals & Alzheimer Society staff (n = 12) • Unpaid carers (n = 13)	• Rural & remote settings • Earlier & more consistent intervention	Society and infrastructure	• Improved continuity & coordination of care • Families connected sooner & felt less isolated.
Nielsen et al. [47]	Denmark	• Surveys • Pre-post questionnaires	A culturally tailored dementia information programme delivered in minority ethnic communities (language and culture adapted sessions	Medicare beneficiaries in the community with dementia aged 75 + (n = 48,474)	• Inequalities based on services offered where they lived • Lack of support services available in certain areas	Individual	• Significant increased knowledge • more positive beliefs about dementia, • stronger intentions to seek help
O'Connell et al. [48]	Canada	Semi-structured interviews	• Support group for rural spouses of early-onset dementia individuals - developed and delivered by memory clinic psychologists via video conferencing • Create a replicable template for rural delivery	• Rural spouses of individuals with early-onset dementias (n = 10)	• Addressed rural access issues	Individual/ Community	• High acceptability • Peer connection reduced isolation • Video conferencing bridged distance • Developed template for scaling similar support in rural settings
Piercy et al. [49]	UK	Mixed methods: • Interviews • questionnaires	An integrated post-diagnostic support service providing person-centred co-ordination, home visits, information & support	• 20 people with dementia • 20 family carers • 7 DAs	• Gaps in continuity of care • Limited access to co-ordinated post-diagnostic care	Society and infrastructure	• a joined-up approach to allow better access • improved satisfaction with services • stronger continuity of care
Plunger et al. [51]	Austria	• Workshops • focus groups • semi- structured interviews	Dementia Friendly pharmacy programme that transformed community pharmacies into accessible, supportive spaces for people with dementia and their carers	n = 41 pharmacists and technicians	• Access barriers due to stigma • Community awareness gaps	Community	• Pharmacy staff reported enhanced dementia awareness counselling skills • motivation to participate in advocacy • Successful community networking

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Table 1 (*continued*)

Author (year)	Country	Type of study	Intervention	Participants	Types of inequalities addressed	Inequality level	Outcomes
Possin et al. [52]	USA	Randomised Control Trial using questionnaires	Care Ecosystem – telephone-based collaborative dementia care delivered by dementia care navigator	780 dyads	● Lack of knowledge about dementia and services	Society and infrastructure	● Reduced emergency department visits ● Improved PwD quality of life ● Reduced carer depression and burden
Scher & Greenfield 2023	USA	Semi-structured interviews	Local Dementia-friendly Community Initiatives: training, memory cafes, advocacy, public space adaptations	Community leaders (n = 23)	How variations in funding and partnerships affected local implementation of dementia initiatives	Community	● Equity improved with greater funding ● Wider community partnerships led to broader, more inclusive impact
Spencer et al. [59]	UK	Mixed methods: ● Surveys ● Interviews ● routine data analysis	● PriDem intervention: delivery of personalised dementia care planning in primary care ● Coordinated by Clinical Dementia Leads (specialist nurses)	● n = 855 people with dementia (records) ● n = 21 carers ● n = 90 health/social care professionals ● n = 12 Clinical Dementia Leads	● Gaps in post-diagnostic support a ● Unequal access to personalised dementia care in primary care	Society and infrastructure	● Increase of personalised care plans in primary care from 37.4 % to 64.7 % ● Improved quality of care delivery
Thyrian et al. [62]	Germany	● Surveys ● Questionnaires ● Longitudinal observational study	Dementia Care Networks: regional, multi-professional networks offering co-ordination, counselling and support for PwD.	● n = 560 PwD ● n = 373 carers	● Unequal access to services ● Regional differences in service availability	Society and infrastructure	● Use of outpatient services increased ● fewer hospital stays ● Better access to coordinated support
Van Mierlo et al. [65]	Netherlands	Randomised controlled trial ● Survey ● questionnaires ● Semi-structured interviews	DEM-DISC: web-based advice providing services for carers and case managers	● Unpaid carers (n = 73) ● Case Managers (n = 27) ● 10 stakeholders interviewed	● Aimed to equalise access to support and services via digital tools	Individual	● Carers using DEM_DISC showed increased sense of competence & more support needs met ● Improved equity in care
Webster et al. [67]	UK	Mixed Methods: ● Survey/ questionnaires ● Semi structured interviews	● Culturally adapting START (STrATegies for RelaTives of people with Dementia) for Black & South Asian dementia carers ● 8 sessions, English and Urdu delivered	● Phase 1 (adaption interviews) South Asian carers (n = 15) & Black carers (n = 11) ● Phase 2 (delivery) South Asian carers (n = 13) & Black carers (n = 8) ● 21 consented/12 completed 5 or more sessions	● Lack of culturally appropriate support for Black and South Asian dementia carers.	Individual	● Carers completed most sessions and continued to use ● Immediate reductions in anxiety/ depression scores (HADS dropped from 14.1 to 11.3 post-intervention ● Demonstrated that cultural tailored START benefitted carers

Eight studies focused on reducing cultural and linguistic inequalities by designing or adapting interventions for under-served communities and found that culturally aligned materials and trusted facilitators improved carers' ability to access and navigate services. For example, Goeman et al.'s [25] Dementia Talking Book, tailored to the Vietnamese community in Australia, increased knowledge of how to access and navigate available services. Similarly, Lee et al.'s [37] home-based intervention, delivered by community health workers with cultural knowledge and experience reflecting that of the carers, improved carers' connection and access to community resources. Tailored interventions also enhanced dementia literacy and caregiving capacity. An adapted programme for Black and South Asian carers in the UK helped participants reframe behavioural symptoms as illness-related and adopt effective communication strategies [67]. In Brazil and India, a culturally adapted dementia awareness course for carers resulted in significant improvements in attitudes towards dementia and positive changes in caring behaviours [16]. Some of these tailored interventions translated into greater carer mastery and self-efficacy, with Alexander et al. [1] finding Black carers' levels of mastery increased after a tailored psychoeducation course. Studies also reported reductions in burden, role strain, depression, and anxiety among carers following adapted interventions [1,67].

Four studies employed digital tools to improve care planning, decision making, service navigation, or social support. In the Netherlands, DEM-DISC, a web-based intervention providing information about health and care services, was found to improve carers' competence and frequent users experienced more needs being met after six months compared with controls [65]. Similarly, Care to Plan, a web-based tool in the US, improved service navigation among carers [13], whilst the web-application Let's Talk Tech supported dyads of people with dementia and carers in making informed decisions about technology use at home, improving decision-making preparedness, understanding, and communication about technology [7]. For rural carers of people with atypical or early-onset dementia, a telehealth videoconference group reduced isolation and facilitated peer learning and practical problem-solving, though virtual interactions could feel more distant than in-person meetings [48]. Additional barriers to digital interventions included time constraints, service costs, and digital literacy challenges [13].

Reducing community-level inequalities

Diagnosis

Only two studies reported on solutions to community-level inequalities in diagnosis, focusing on improving understanding of dementia through participatory and network-based approaches [24,43]. In the USA, Medina et al. [43] used Boot Camp Translation to co-develop culturally responsive Alzheimer's disease messaging with Hispanic/Latino community members across three sites, resulting in significant improvements in subjective understanding and objective knowledge. In the UK, Giebel et al. [24] evaluated the Liverpool Dementia and Ageing Research Forum, a community of practice connecting people with dementia, carers, professionals, and researchers. Participation enhanced attendees' knowledge of dementia, including rare sub-types, and improved professionals' understanding of symptom nuances. However, participants in qualitative interviews highlighted the need for greater sociodemographic diversity within the forum.

Care

Seven studies addressed community-level inequalities in care, through raising awareness and challenging stigma (e.g., [35]), building community networks (e.g., [42]), and developing dementia-friendly communities and services (e.g., [51]). One study in Canada evaluated a research-based film depicting the stigma of living with dementia [35]. The film was found to counter tragedy discourse by helping audiences see the person behind the diagnosis and prompted family carers and professionals to adopt more supportive approaches to interactions. Three other studies highlighted the value of peer-led, professional, and community-based networks in reducing stigma and building capacity. McConnell et al. [42] evaluated Dementia Northern Ireland, a member-led organisation of people with dementia. Members reported being driven by a desire to challenge stigma and participated in several awareness-raising initiatives that improved understanding of dementia across communities and organisations. Similarly, engagement with a community of practice connecting people with dementia, carers, professionals, and researchers in the UK improved understanding of dementia care pathways, facilitated access to resources, and informed service improvements [24].

Two studies focused on creating dementia friendly communities (DFCs) and services [51,56]. In Austria, Plunger et al. [51] reported on a DFC pharmacy programme in which staff training and small-scale initiatives facilitated improved counselling and local community networking. Scher and Greenfield's [56] analysis of DFC initiatives in the USA identified common activities such as training, community outreach, service development, and improvements to existing resources. These initiatives were most effective when supported by funding and partnerships.

Reducing Societal- and infrastructure-level inequalities

Diagnosis

Ten studies (11 papers) focused on interventions to reduce society- and infrastructure level barriers for people with dementia to accessing a (timely) diagnosis. Three studies explored "one-stop-shops" for dementia diagnosis - two in rural Canada and Australia. Alty et al. [3] evidenced how a one-stop memory clinic in Tasmania led to just under 100 % of the 130 adults being assessed for their memory receiving a same-day diagnosis. This reduced the time from referral to diagnosis to an average of 78 days in Tasmania compared to 133 days. Similarly, [46] evidenced earlier diagnosis and improved access to diagnosis in rural Canada by implementing a rural primary health care model for dementia. In the US, a similar fast-tracked assessment in a primary care setting provided recommendations on the same day [63]. However, whilst the authors provided details as to the types of diagnoses made for older adults presenting to Rapid Access Memory Program, no data were collected on the reduction of average waiting times for people with dementia, unlike Alty et al. [3].

Three studies explored how to support GPs and ways to reach out to people of a specific age [12,39,41]. Livingston et al. [39] evidenced how GPs from 11 general practices in the UK outreaching to 6387 patients aged 70 + without a dementia diagnosis led to increased GP presentation by people aged 70 + with memory concerns. However, no increases in dementia diagnosis were recorded. Whilst this model significantly increased GP presentation for memory problems, it is unknown whether these memory problems were subjective or could have been measured objectively, such as via established cognitive tests, which may explain the lack of changes in subsequent diagnosis rates. In contrast, providing financial incentives to GPs in England to record more dementia diagnoses led to a significant increase in dementia diagnosis rates from 51.8 % to 68.6 %, with over 40,000 more cases reported [41]. The study benefits from having utilised data from over 7500 English general practices. Focusing on training instead, providing targeted dementia training for GPs in Australia provided positive impacts on improving dementia knowledge and skills [12]. However, long-term impacts of knowledge improvement interventions were missing, so that only financial incentives [41] have acted as an evidenced solution to increasing diagnosis rates when focusing on GPs.

Another three studies focused on increasing connectivity in health care and increasing workforce knowledge. In Japan, Satoh et al. [54] provided GPs with a personnel link to ordering dementia screening from a Dementia Network Promoter leading to increased early dementia referrals. The dementia specialist would conduct targeted screening and report back to the GP, providing recommendations as to whether the patient should be referred to a memory clinic for full assessment. Whilst this clinical role – the dementia specialists – was found to be beneficial for referrals, there was no control arm. Another study in the US showed that a network of 38 memory clinics led to improved workforce knowledge [50]. This community of practice, bringing together health care professionals in Wisconsin, improved knowledge about dementia in the health care workforce. This was facilitated by a full-time programme manager who actively recruits and engages with sites, thus generating wider engagement. Lee et al. [36] also reported on a network of linked up memory clinics in Ontario, Canada, and evidenced improved training and knowledge in the workforce compared to pre-network.

Care

Fifteen studies (17 papers) reported on interventions to reduce inequalities or causes of inequalities for accessing post-diagnostic care. Four studies focused on remote care delivery and data system approaches. In rural Australia, Brown et al. [9] evidenced clinicians' experiences of implementing a telehealth service for people with young-onset dementia. Focus group data from metropolitan and rural clinicians showed how clinicians felt they could offer more options to rural-residing people with dementia this way, whilst also being mindful of digital barriers. Gaugler et al. [20] evidenced no impact of an online tool to provide recommendations for care services to 43 unpaid carers in the US. This may have been due to the low number of participants, whilst personal and socio-economic backgrounds of participants in the US care system also need to be considered as important factors associated with access to care. In contrast, a different type of care decision and information tool trialled in Germany resulted in an 85 % increase in care recommendations to GPs for people with dementia [18]. Using a different approach of telecommunications, Kagwa et al. [34] evidenced how a mobile app improved communications from unpaid carers to social care professionals about any queries and support needs in Sweden, showing how telecommunications can aid in the post-diagnostic process in a number of ways.

Research from Germany, the UK, Canada, and the US has evidenced solutions to the disconnect between health and social care services by improving service linkage either on a larger scale or with individual link workers [26,28,29,30,44,49,52,62]. Dementia Care Networks connect key stakeholders in dementia, including people affected by the condition, health care professionals, and carers in the community [28]. They act as a community of practice focusing on connecting key stakeholders, aiming to increase knowledge and to facilitate access to care. Using semi-structured interviews and focus groups [28,29], evidenced how Dementia Care Networks in 13 German states led to increased knowledge mobilisation and people affected by dementia understanding more about the condition and available services. Beyond knowledge mobilisation, Dementia Care Networks were evidenced to lead to improved access to coordinated support by providing counselling and care coordination [62].

Five studies evaluated the effects of the role of either non-clinical or clinical dementia link workers. In Germany, trained dementia care nurses visited people with dementia in their homes, leading to a 19 % increase in uptake of post-diagnostic support [30]. In the US, Possin et al. [52] and Guterman et al. [26] reported the positive impacts from a RCT of the Care Ecosystem intervention, with primary contact via a non-clinical dementia link worker based in a multidisciplinary team, on people with dementia's quality of life and carer well-being. This study provided the only evidence of significant reductions in emergency department visits and a cost-effectiveness analysis. In Canada, an intervention embedding charity staff in primary care teams in rural areas was shown to improve the link-up to care and support services from the point of medical diagnosis (Morgan et al., 2022). Based on a small number of interviews with link coordinators and clinic team members (n = 9), this link worker role successfully facilitated access to services and provided emotional support to the carers. However, evidence is limited, with no quantitative evidence about service utilisation compared to usual care. In the UK, using service use data and focus groups of a model comprising clinical (Admiral Nurses) and non-clinical link workers (Dementia Advisors) provides strong support for a combined link worker model, with positive impacts on people with dementia and carers [49]. Carers had a better understanding of dementia, received information and access to care services, and were able to cope better.

On a more holistic level of system integration, Spencer et al. [59] reported the positive impacts of piloting the PriDem intervention across seven general practices in England. This model of care comprised embedding specialist nurses in primary care practices with a focus on direct patient care, staff training and mentoring and service co-ordination. Via medical record review, Spencer et al. [59] showed that the PriDem model effectively increased the implementation of personalised care plans for people with dementia from 37.4 % to 64.7 %, which were more holistic in content with a focus on social aspects.

One study focused on increasing workforce knowledge about dementia. In Australia, Haydon et al. [27] reported how the Dementia ECHO programme increased dementia knowledge and skills in First Nations-led health services in rural areas using telementoring. By measuring pre- and post-session knowledge and wider feedback, knowledge, skills, and capacity grew whilst professional isolation was reduced.

Quality assessments

Overall, the included studies demonstrated high methodological quality across designs. Most qualitative and mixed-methods studies scored highly (6–7/7), indicating clear research questions, appropriate study design, and strong coherence between data collection, analysis and interpretation. Quantitative studies showed slightly more variability, with some studies rated as moderate quality due to unclear reporting of sampling representativeness, response bias and completeness of outcome data. Appendix A includes an overview of quality ratings for each study.

Discussion

This is the first systematic review synthesising evidence on solutions to inequalities in accessing diagnosis and care for people with dementia and their unpaid carers. Interventions from 13 different countries worldwide were included, with a range of different approaches targeting individual, community, society and infrastructure levels to create more equitable access to diagnosis and care for those affected by dementia. Evidence on effectiveness was mixed, with few solutions evidenced more than once. However, various interventions pointed to promising ways that can help increase access to care for people with dementia. These included a range of methods such as networks, link workers, dementia-friendly communities, campaigns to reduce stigma, and digital health literacy training. Solutions to reduce inequalities to accessing diagnosis were fewer.

Most evidence emerged on a society and infrastructure level, with fewer interventions on an individual and community level. Creating networks of memory clinics and stakeholders [22,62], as well as key connecting roles such as link workers and care navigators [49,52] were found to be effective ways to increase connectivity between health and social care professionals and/or between people with dementia and carers and care services. Evidence from Canada, Germany, UK and USA creating meaningful integrative networks and communities of practice, as well as link worker roles, demonstrates perhaps the most evidenced solution on an infrastructure level and overall to date, with evidenced impacts on both the person with dementia and their carer (i.e. [52]). In contrast, relatively few interventions focused on individual-level barriers. Those that did tended to employ culturally or linguistically tailored approaches, which were consistently found to improve dementia literacy, service navigation, and carer self-efficacy [25,37]. These studies targeted specific groups such as the Vietnamese community in Australia [25], and Black and South Asian carers in the UK [67]. However, there remains a need to extend this work to other cultural and linguistic groups facing inequalities, to ensure that interventions are inclusive and respond to the diverse needs of people affected by dementia globally.

To ensure that interventions are incorporated into national policy and care delivery, evidence on both clinical and cost-effectiveness is critical. Based on included evidence, link workers are the only solution to date that reduces inequalities in access to dementia care and provides a cost-effective solution compared to standard care in the US care system [26]. Future research needs to embed health economic evaluations, whilst also measuring the effects of an intervention on reducing avoidable health care utilisation and cost effectiveness in countries other than the US, which has a unique health care model. Accessing timely social care is linked to reduced, avoidable, health care visits [60]. With a greater focus on quantifiable outcomes and measures of impact, these included and highlighted solutions to reducing health inequalities are more likely to be implemented in national care practice and policy guidance.

Reducing stigma in the community is a major approach to enabling people with suspected dementia to approach their GP and to be open about their diagnosis and thus be more likely to receive community-level support in their post-diagnostic journey. Considering this review only included a selection of stigma-reducing interventions aimed at increasing equity, identified in the comprehensive searches, it is important to highlight that stigma, similarly to dementia link workers, has its own rich evidence base which is substantial enough to be captured in standalone systematic reviews [23,6]. Bacsu et al. [6] for example categorised stigma-reducing interventions into education, contact, protest, and mixed, highlighting various approaches attempting to reduce societal stigma. Evidence from this review shows a diversity in stigma-reducing interventions as a solution, with positive impacts yet different methods employed.

DFCs were also found to be effective on a community level, albeit with minimal evidence included in this review. There are many existing systematic, scoping and realist reviews available on the topic of DFCs, with many not focusing on increasing equity in access, but instead on improving quality of life or making DFCs more inclusive [14,58]. Hung et al. [33] for example reported on strategies for creating DFCs, which involved public education to reduce stigma and raise awareness as a core feature. Whilst in England DFCs are very common [10], a large-scale evaluation of DFCs has shown limited evidence on effects of DFCs for people with dementia. Future research on DFCs needs to employ more rigorous outcome measures, including access to health and social care services to ensure studies capture how this important community approach can offer solutions to maximising access to care.

Several studies employed technology-based interventions to address inequalities, showing promise in improving carer competence, care planning, service navigation, and decision-making [65,7]. While these interventions are well-intentioned, they can also introduce barriers to engagement, particularly in relation to digital access and literacy, which may limit their effectiveness [13]. Broader research on digital technology use indicates that people with dementia and carers often encounter difficulties engaging with digital tools, including cognitive fatigue, limited digital literacy, challenges remembering how to use devices, unintuitive interfaces, and the affordability of digital technologies [11,61]. These findings suggest that although technology-based approaches have considerable potential to enhance care, they are not universally accessible and may inadvertently reinforce existing inequalities if certain groups are unable to benefit. Therefore, digital interventions should not be regarded as standalone solutions but rather complemented by accessible offline approaches and designed with attention to digital literacy and inclusivity to promote equity across diverse populations.

It is important to stress that the included evidence paints a fairly Western picture of solutions, as only one study [16] included evidence from India and Brazil. Whilst this may have been a result of the included published languages (English and German), English is the global language of academia and thus research conducted in languages spoken in LMICs tends to be published in English. Thus, based on the comprehensive screening of peer-reviewed publications, very little evidence exists in LMICs. This is not surprising though, as LMICs such as Colombia, India, Malaysia, and Kenya have on average fewer health care resources and are thus known to have fewer services available for diagnosing and supporting people with dementia and less policy prioritisation [19,53,57]. Therefore, the first method of increasing access to diagnosis and care would have to be increasing service availability whilst also creating better linkage between health and social care services (where available). Thus, it is perhaps unsurprising to see fewer evidence from LMICs, despite a great need for targeted solutions to improve access to diagnosis and care in these countries, where the majority of people with dementia across the globe live [68].

Strengths and limitations

This systematic review benefitted from having searched five databases, studies eligible in English and German, and a large number of abstracts each screened by two research team members. Studies were included from 13 countries. As discussed, whilst studies in two languages were eligible, it is possible that research from non-English or non-German academic publications may have been missed. This may explain why only one study from LMICs was included [16]. However, it may also be the case that LMICs have substantially less health and social care infrastructure available [57]. There were some limitations to the included studies. There was a lack of research focused on the cost-effectiveness of interventions, compared to standard care or system approaches. This evidence however is crucial for Governments and care systems to take up specific interventions and make changes to usual care and practice.

Conclusions

A range of evidenced interventions show promising outcomes in increasing equity in access to diagnosis and care for people with dementia and their carers. Interventions are varied, focusing on different individual-, community-, and system-level inequalities, with different levels of effectiveness. However, clear solutions have emerged - such as one-stop diagnostic clinics, dementia link workers, and integrated memory clinic networks - which have the potential to address some of the barriers that people with dementia and their carers are facing. To address inequalities most effectively, an array of intersecting solutions needs to be implemented. Being mindful of differing cultural needs, future research needs to replicate promising interventions in different settings and countries, as well as evidence the cost-effectiveness of interventions, whilst greater focus also needs to be paid to getting effective interventions implemented and written into national guidance to improve dementia care and thus outcomes for those living with dementia. Future research should use clear measurements of health and social care outcomes and economic impact.

CRediT authorship contribution statement

Fiona Rushton: Data curation. **Joanne Hitchen:** Data curation. **Anna Volkmer:** Writing – review & editing, Data curation, Conceptualization. **Louise Robinson:** Writing – review & editing, Data curation, Conceptualization. **Dorota Szczesniak:** Writing – review & editing, Conceptualization. **Clarissa Giebel:** Writing – original draft, Project administration, Methodology, Formal analysis, Data curation, Conceptualization. **Bryony Waters-Harvey:** Writing – review & editing, Data curation. **Catherine V Talbot:** Writing – review & editing, Formal analysis, Conceptualization.

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Declaration of Competing Interest

No conflicts to declare

Appendix A. Overview of quality ratings for included studies

Qualitative descriptive study design

Authors (date)	S1 Are there clear research questions?	S2 Do the collected data allow to address the research questions?	1.1. Is the qualitative approach appropriate to answer the research question?	1.2. Are the qualitative data collection methods adequate to address the research question?	1.3. Are the findings adequately derived from the data?	1.4. Is the interpretation of results sufficiently substantiated by data?	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	Quality score
Giebel et al. [24]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7 100 %
Kontos [35]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7 100 %
Lee (2025)	Can't tell	Yes	Yes	Yes	Yes	Yes	Yes	6/7 85 %
McConnell et al. [42]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7 100 %
Morgan et al. [45]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7 100 %
Morgan et al. [45]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7 100 %
Scher et al. [56]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7 100 %
Kagwa et al. [34]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7 100 %
Heinrich et al. [29]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7 100 %
O'Connell et al. [48]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7 100 %
Goeman et al. [25]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7 100 %
Dassel et al. [15]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7 100 %

Quantitative Descriptive Study design

Authors (Date)	S1. Are there clear research questions?	S2. Do the collected data allow to address the research questions?	4.1. Is the sampling strategy relevant to address the research question?	4.2. Is the sample representative of the target population?	4.3. Are the measurements appropriate?	4.4. Is the risk of nonresponse bias low?	4.5. Is the statistical analysis appropriate to answer the research question?	Quality check
Alty et al. [3]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7 100 %
Turner et al. [63]	Yes	Yes	Yes	Can't tell	Yes	Can't tell	Can't tell	4/7 57 %
Satoh et al. [54]	Yes	Can't tell	Yes	Yes	Yes	No	Can't tell	4/7 57 %
Pinzon et al. [50]	Yes	Yes	Yes	Yes	Yes	no	Yes	6/7 85 %

Qualitative Randomised Study Design

Authors (Date)	S1. Are there clear research questions?	S2. Do the collected data allow to address the research questions?	2.1. Is randomization appropriately performed?	2.2. Are the groups comparable at baseline?	2.3. Are there complete outcome data?	2.4. Are outcome assessors blinded to the intervention provided?	2.5 Did the participants adhere to the assigned intervention?	
Guterman et al. [26]	Yes	Yes	Can't tell	Yes	Yes	Can't tell	Can't tell	5/7 71 %
[32])	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	6/7 85 %
Possin et al. [52]	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes	6/7 85 %
Livingston et al. [39]	Can't tell	Yes	Yes	Yes	Yes	Yes	Yes	6/7 85 %
Eichler et al. [18]	Yes	Yes	Yes	Yes	Yes	No	Yes	7/7 100 %

Qualitative Nonrandomised Study design

Authors (Date)	S1. Are there clear research questions?	S2. Do the collected data allow to address the research questions?	3.1. Are the participants representative of the target population?	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?	3.3. Are there complete outcome data?	3.4. Are the confounders accounted for in the design and analysis?	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?	
Mason et al. [41]	Yes	Yes	Yes	Can't tell	Can't tell	Yes	Can't tell	4/7 57 %
Thyrian et al. [62]	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell	6/7 85 %

Mixed Methods

Author (Date)	S1. Are there clear research questions?	S2. Do the collected data allow to address the research questions?	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?	5.2. Are the different components of the study effectively integrated to answer the research question?	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	Quality check
De Carvalho et al. [16]	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	6/7 85 %
Piercy et al. [49]	Yes	Yes	Yes	Yes	Yes	Can't Tell	Yes	6/7 85 %
Alexander et al. [1]	Yes	Yes	Yes	No	Yes	Yes	Yes	6/7 85 %
Webster et al. [67]	Yes	Yes	Yes	Yes	No	Yes	Can't Tell	5/7 71 %
Haydon et al. [27]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7 100 %
Casey et al. [12]	Yes	Yes	Yes	Yes	Yes	Can't Tell	Yes	6/7 85 %
Cha et al. [13]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7 100 %
Heinrich et al. [30]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7 100 %
Nielsen et al. [47]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7 100 %
Plunger et al. [51]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7 100 %
Spencer et al. [59]	Yes	Yes	Yes	Yes	no	Yes	Yes	6/7 85 %
Van Mierlo et al. [65]	Yes	Yes	Yes	No	no	No	Can't tell	3/7 42 %
Morgan et al. [44]	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	6/7 85 %
Medina et al. [43]	Can't tell	Yes	No	yes	Can't tell	Can't tell	No	2/7 28 %
Henrich et al. (2016)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7 100 %
Gaugler et al. [20]	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell	6/7 85 %
Berridge et al. [7]	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell	6/7 85 %

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