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Barriers and facilitators on the pathway to mental health care among 12-25 year olds

Sophie Leijdesdorff ^a, Rianne Klaassen^b, Di-Jon Wairata^a, Stefanie Rosema^b, Therese van Amelsvoort^a and Arne Popma^{b,c}

^aDepartment of Psychiatry and Neuropsychology, Mental Health and Neuroscience (MHeNS) Maastricht University, Maastricht, The Netherlands; ^bAcademic Child and Adolescent Psychiatry, Levvel, Amsterdam, The Netherlands; ^cDepartment of Child and Adolescent Psychiatry, Amsterdam University Medical Centers, Amsterdam, The Netherlands

ABSTRACT

Purpose: The mismatch between the number of young people that require mental health care and who actually receive it, questions access to care. This study aims to gain in-depth understanding of barriers and facilitators in the pathway to mental health care among 12 to 25 year olds as experienced by visitors of youth walk-in centres of the Dutch @ease Foundation.

Methods: Open interviews were conducted to explore participants' experiences and attitudes towards mental health care. Following inductive thematic analysis, barriers and facilitators in participants' pathways towards care were described.

Results: Fifteen participants were included, heterogenic with regard to age, sex and nationality. Three main themes in the process of seeking help were 'attitudes towards mental health problems and seeking help', 'entrance to care' and 'in care itself'. A fourth theme consisted of suggestions for improvement.

Conclusion: Negative attitudes towards mental health problems make young people to only seek help when problems begin to escalate. The lack of knowledge about mental health problems, treatment options and costs asks for more awareness and clear information. Updates about waiting lists and alternative options, informal settings with walk-in options and personalized care are feasible and crucial improvements to decrease the individual and societal burden.

ARTICLE HISTORY

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KEYWORDS

Youth mental health; adolescence; early detection and intervention; access to care; attitudes towards mental health

1. Introduction

The vast majority of mental health problems develops before the end of adolescence (Kessler et al., 2007, 2005); a crucial phase with physical, social, emotional and cognitive developments (Arnett, 2000; Kessler et al., 1995). However, only 20–30% of young people with a mental disorder receives appropriate care (Aalto-Setälä et al., 2002; De Graaf et al., 2010; Jörg et al., 2016; McGorry et al., 2014; Slade et al., 2009). For adolescents who do seek professional help, the treatment delay is often multiple years (De Graaf et al., 2010), which is associated with worse outcomes (De Girolamo et al., 2012; Patton et al., 2014) and potential negative consequences for future social and professional life. As a result, mental disorders play a major role in the total burden of disease globally (Eaton et al., 2008; Lokkerbol et al., 2013; Wittchen & Jacobi, 2005; Wittchen et al., 2011; World Health Organization, 2009). The mismatch between the number of young people that require mental healthcare and the ones who receive it, raises questions

regarding access to care: what are the barriers as well as facilitators?

Barriers to (youth) mental health care have been addressed before. Commonly, a distinction is made between attitudinal barriers and structural barriers (Andrade et al., 2014). Among the attitudinal barriers, negative associations (public, perceived or self-stigmatizing) surrounding mental disorders are most prevalent. Other prevailing themes include questions around confidentiality, lack of mental health literacy, reliance on self, lack of knowledge about mental health services, inadequate emotional competence and lack of (perceived) accessibility (Frank & McGuire, 1986; Gulliver et al., 2010; Jorm, 2000; Thornicroft, 2008). The following situations are often reported: young people feel embarrassed or ashamed, think they can solve their problems themselves, not recognizing the gravity of the problem or having no confidence in the types of treatments that are available. Instrumental barriers include lack of information as where to find help, care-related costs, long waiting lists, and fluctuating symptoms

that interfere with diagnostic processes that may be required to start treatment and no available time to seek treatment (Frank & McGuire, 1986; Gulliver et al., 2010; McGorry et al., 2007; Rickwood et al., 2005). Lastly, the organizational gap in mental healthcare around the age of 18 creates a situation in which only 5% of the population is satisfied with the transition from Child & Adolescent Mental Health Services to Adult Mental Health Services (Singh et al., 2010).

On the other hand, several facilitating factors have been identified in earlier research, including positive attitudes, higher levels of emotional competence, positive earlier experiences and mental health literacy are factors playing a facilitating role in the pathway to mental healthcare (Rickwood et al., 2005). Furthermore, social influences can stimulate help-seeking and access to care, with often parents, partners, teachers and GP's as important gatekeepers assisting people with mental health problems towards appropriate professional support.

Previous research has, however, focussed mainly on adult populations (Frank & McGuire, 1986; Rüscher et al., 2009; Salaheddin & Mason, 2016; Schomerus & Angermeyer, 2008; Thornicroft, 2008; Vanheusden et al., 2008), was conducted outside of Europe in the Australian or Northern American healthcare system (Frank & McGuire, 1986; Gulliver et al., 2010; Rickwood et al., 2005; Rüscher et al., 2009) or was conducted 10 to 34 years ago, in previous generations of adolescents, (thus) not accurately reflecting our current population (Frank & McGuire, 1986; Gulliver et al., 2010; Rickwood et al., 2005; Schomerus & Angermeyer, 2008; Thornicroft, 2008; Vanheusden et al., 2008).

To address these issues, various campaigns have been launched in order to initiate the reform of youth mental health services in an effort to provide more accessible care. Already, these initiatives have gained momentum worldwide, joined in an International Association of Youth Mental Health with diverse initiatives expanding across the globe (Buckley et al., 2011; Malla et al., 2016; P. McGorry et al., 2019). Headspace Australia is one of the first and leading models of this movement, followed by initiatives in Europe such as headspace Denmark, Jigsaw in Ireland and since 2017, the @ease Foundation in the Netherlands (Klaassen et al., 2019; Leijdesdorff et al., 2020; McGorry & Mei, 2018; O'Reilly et al., 2015; Rickwood et al., 2015). The @ease Foundation shares headspace's fundamental principles of easily accessible, anonymous and free psychological support to young people aged 12 to 25, and was adapted and locally designed. @ease works via youth walk-in centres, where trained young volunteers offer peer-to-peer consultation, backed up by healthcare professionals.

Easier accessible initiatives such as @ease offer a unique opportunity to study both the unexplored population with potential (unmet) needs as well as the population of young people that already seek (and receive) care. In-depth knowledge on perceived barriers and facilitators early on in the process of help seeking in this sample can inform further improvement of access to care and further development of youth mental health services. Qualitative research techniques, and in particular open interviews, are by nature appropriate to gain in-depth understanding because of their rich descriptions of experiences, attitudes and motivations during the help seeking process (Green & Thorogood, 2018).

This study aims to gain insight in the process of access to care by providing up-to-date qualitative knowledge regarding the experienced barriers and their facilitating counterparts in a heterogeneous group of young people aged 12 to 25 years old who reached out to @ease. This leads to our two main research questions. Firstly, what are the current barriers to mental healthcare for youth in the Netherlands? Secondly, what is the best way youth mental health initiatives can bridge the gap between adolescents with mental health problems and obtaining the professional help they need: which factors facilitate access to care from their own perspective?

2. Methods

2.1 Setting and procedure

The present study investigated barriers and facilitators to mental healthcare from a paradigm of social constructivism; research outcomes can be seen as a result of interaction between the study object and the observer. The chosen research approach was based on phenomenology, using open interviews with an unforced flow of questions, intended to evoke a rich description as well as an empathetic understanding of participants' experiences (Savin-Baden & Howell-Major, 2013).

This study was undertaken in two @ease centres in the Netherlands; in Maastricht and in Amsterdam. As part of the routine care, young people visiting @ease were asked to complete an optional questionnaire at the end of their visit. This routine questionnaire included an invitation to participate in the present interview study. If consent and contact information were given, in the weeks following their visit to @ease, participants were contacted with comprehensive study information and an appointment for the interview was made. Informed consent was obtained in person at the beginning of the interviews, providing the ability for participants to ask remaining questions or discuss any concerns. Participants were

offered a compensatory voucher of 20 euros. Withdrawal from participation of the study was repeatedly stated by the researchers and was possible at any stage in the process. The medical ethical committee of Maastricht University reviewed the study protocol (number: 2018–0961) and approved its procedure.

The interviews were recorded with an audio-recorder and later transcribed to text in their original language, using Transcribe software (<http://transcribe.wreally.com>). Any relevant notes made during the interview were included in the transcript as well. A summary of themes per interview was sent back to the participants (member check; Lincoln, 2007). None of the participants disagreed with the interpretation by the research team.

2.2 Study participants

To gain insight into the full scope of barriers and facilitators, a heterogeneous group of young people between the age of 12 and 25 was selected (purposive sampling; Palinkas et al., 2015) with respect to age, gender, cultural backgrounds, educational levels and reasons for visiting @ease. Inclusion and data analysis ran in parallel, providing a constant feedback-loop between both processes. To provide adequate depth on this topic, inclusion was continued until no new insights with respect to the main research questions emerged (Boeije, 2005; Braun & Clarke, 2006).

2.3 Data collection

Open interviews were conducted to optimally explore participants' experiences and attitudes. Interviews were performed at the @ease centres, since these were familiar places for the participants. An exception was being made in case this was geographically not possible; then, the interview was conducted online via Skype. Interviews were conducted in a one-on-one setting in either Dutch or English, according to the preference of the participant.

Interviews started with an open-ended question such as: *"We're investigating barriers and facilitators experienced by young people in the process of seeking help when they're not feeling well. When you hear that, is there something that comes to mind?"*, followed by a discussion about barriers and facilitators that the interviewee describes, with the interviewer using probing questions to reach more in-depth answers. Only when the interviewee struggled with giving (further) information, a topic list consisting of sensitizing concepts – based on the researchers' experience, knowledge and literature – was used to stimulate further conversation. The structure and topic list formed the interview guide (Appendix A), designed

during four pilot conversations with volunteers at @ease, including experts by experience.

2.4 Data analysis

Inductive thematic analysis was conducted in three phases, based on comparisons within and across respondents (Boeije, 2005; Braun & Clarke, 2006). The analysis started with open coding of the first three interviews by two research team members together in order to achieve full consensus in real time. In this explorative phase, basic themes were defined. In the second phase, the following five interviews were analysed by means of axial coding; merging explorative themes that emerged from the first three interviews into more conceptual categories. These interviews were coded independently by the researchers, but discussed afterwards. The last seven interviews were coded independently. Throughout this process, the coding tree grew more complete. After the major topics were identified, codes were analysed further in the third phase of selective coding, identifying the most important themes. Software used for qualitative analysis was ATLAS.ti version 8.

As researchers in qualitative research form their own means of investigation it is important to reflect on the background of the research team. Our research team consisted of two psychologists (SL, SR), three psychiatrists (RK, TvA and AP), and one trained medical master student (DW) who was also active as a young volunteer at @ease. One of the psychologists (SL), the medical student and one of the psychiatrists (RK) supervised the inclusion, conducted the interviews and performed the thematic analyses. Transcription from audio to text and coding was executed by the one of the psychologists (SL) and the medical student. Careful attention was paid to not let own ideas or perceptions about the topic influence the interview.

3. Results

A total of 15 interviews were conducted. Mean age of the participants was 21, ranging between 15 and 25 years old, of which 5 identified themselves as male, 9 as female and 1 as transgender male. Two out of 15 participants visited the @ease centre in Amsterdam and nine participants had the Dutch nationality. Other nationalities included English, German, Italian and Ecuadorian. Main reasons to seek help were "not feeling well", depressive symptoms including suicidality, attention problems and loneliness.

Thematic analysis showed four main themes. Three themes represented different phases in participants' pathways towards care, with corresponding barriers

and facilitators. The fourth consisted of suggestions to improve accessibility of mental healthcare:

- 1) Attitudes towards mental health problems and seeking help;
- 2) Entrance to care;
- 3) In care itself;
- 4) Suggestions for improvement.

3.1 Attitudes towards mental health problems and seeking help

3.1.1 Barriers

Participants mentioned clear negative attitudes towards mental health problems. They saw their mental health problems as a weakness or their own fault, and therefore, something they should fix themselves.

(R14) "It's all in my head, so it's something I'm doing myself. I should be able to solve it myself as well then."

Participants felt unentitled to have mental health problems because they were growing up in privileged circumstances, in a prosperous country, not in a war situation, or being seriously abused or neglected. Needing help produced feelings of shame and only felt acceptable if mental health problems were severe or escalating.

There was fear of stigmatization, as they felt that psychiatry is for "crazy" people, and participants were anxious about being subject of gossip, especially in subcultures, such as student communities.

(R9) "It's just a small world actually [...]. Everyone knows each other, and yeah, if there's a rumour or something, then the next day, the whole city, or at least the entire student community knows about it."

Mental health problems were seen as something that comes only with an older age.

(R10) "These are adult's problems, not something someone my age should experience. Like people my age don't have grey hair."

They desperately wanted to be normal. Our participants compared themselves extensively to peers, in which they did not see similar issues, leaving them feeling lonely.

(R5) "Everyone else seems to be doing fine. Why do I need help? Why can't I just be happy, or normal?"

Participants felt concerned to share their problems with friends or family members fearing a lack of understanding, downplaying of their problems or to be seen as a cry-baby. In addition, participants did not want to place a burden on their loved ones.

(R12) "I believe they would not understand it. And I was also afraid that they wouldn't care, or to place a burden."

Some participants tested their expectations and in some cases, their family members admitted that participant's problems were indeed burdensome. Others expressed that their parents never shared their emotions, making young people feel that they have never learned how to express themselves.

(R5) "I think some people just learn how important it is to talk to someone, so for them it's not a problem, I guess. In our family it's different."

In most cases, so called "normalizing", generally referring to cause something previously considered as atypical to be accepted as normal, was helpful, but by some participants it was experienced as downplaying as well; one participant mentioned a teacher who tried to normalize her suicidal thoughts, making her feel that she was not allowed to further discuss it.

Concerning mental healthcare professionals, participants did not feel worthy of occupying their time and described feelings of anxiety about having their mental health problems registered, which could thereby threaten their future career. This last opinion was, in particular, vivid among international students in the current study population. Lastly, negative experiences of other people, as well as own adverse experiences with seeking help, resulted in negative expectations of future help seeking.

Participants mentioned lack of time as a factor preventing them of seeking help. They prioritized educational, occupational or social activities rather than seeking help. In addition, our population of youth was characterized by frequent relocating between different cities (e.g., to start a new study), causing them to see starting a new treatment as purposeless because of the lacking certainty about being able to finish the treatment.

(R1) "It took too long because I have to be in therapy prior to the summer holidays to be able to get in class next year. Otherwise I won't make it."

3.1.2 Facilitators

In contrast to the perceived barriers, some facilitating attitudes were stated as well. Two participants who recently moved to the Netherlands experienced less taboo on mental health problems than in their home country. In addition, participants came up with helpful coping strategies, such as restricting social media use, leading to less comparison of themselves to their peers and a decrease in experienced symptoms. Luckily, participants found it acceptable to ask for help when their problems escalated, in case of suicidality or self-harm. Furthermore, in most cases, talking about their problems to family and friends appeared to be less negative than expected; their social networks reacted understanding and supportive. Moreover, hearing positive experiences of others

receiving mental healthcare turned out to be encouraging.

(R14) "Some people reacted reassuring, that they experienced something similar or that they recognized my problems, only then you learn that there are other people struggling as well. And yes, that decreases the level of shame."

There were examples of friends, parents, partners, people from a church community or deans at school recognizing mental health problems, helping participants to seek informal or professional help.

(R14) "I think it made a difference that my parents knew quite a lot about it, that they were there for me."

Participants experienced less of a barrier in sharing their problems with professionals, as they expected it to be less burdensome for them. In addition, a professional is neutral to the situation, whereas friends and family members were seen as biased or prejudiced, and sometimes they were part of the problem itself. Some participants expected seeking help would lead to being diagnosed with a mental disorder, which would justify their problems. Others expected that talking about their problems would be a relief.

(R9) "Close friends and family members are there for me but I found it nice to have this objective perspective"

3.2 Entrance to care

3.2.1 Barriers

When participants realized they needed help, it was not always clear where help could be found. Searching online or at school, participants often did not find appropriate services, and they mentioned a lack of awareness for resources.

(R7) "I guess the first problem is not knowing. A few days ago career services from University came and that's when I first knew that you could apply for psychological support or to go to a psychologist at University for free, and that was already seven months after I started University here"

Waiting lists provided a next obstacle. Knowing there is a waiting list prevented some participants from seeking help. Participants perceived waiting lists as being long and unnecessary, while they needed help at that very moment. In some cases, participants experienced a worsening of symptoms during a previous waiting period, making them anxious about another waiting period. In addition, being on a waiting list led to insecurity among participants, including questions such as "did something go wrong" and more personal: "do they not want to help me".

(R1) "It feels like no one in that building wants to help me, because I'm waiting so long already."

Diagnostic assessment procedures formed another delay in the process towards help. Participants had to tell their stories multiple times to different professionals, which they found burdensome. In addition, they had to fill in long and overlapping questionnaires and in some cases incomplete childhood information prevented getting a diagnosis and therefore help could not be offered.

(R1) "I think it took an extra month because of all those questions [...]. During the intake there was someone who I won't see again, the person with the questionnaires will I not see again, and then there was also this intern, who also wanted to know my story, and I don't see that person anymore either. It makes me feel like, I tell you my story, [...] which is hard for me [...] and then I never see them again. [...] Yes, eventually I feel like, why even bother, because there will be other people again."

Lastly, care-related costs formed an obvious barrier for young people. Participants, mostly expressed a lot of uncertainty around financing of care. Several participants stated anxiety for being surprised by an invoice, even years after their treatment ended. Compensation by health insurance companies was unclear and while they already felt ashamed about their mental health problems, they felt an extra layer of shame about not understanding financial aspects.

(R10) "I was terrified, terrified so to speak, that I would wake up one day and would find an invoice in my mail, open it and that I would have developed an enormous debt."

(R12) "Even if someone tells you: 'yes, it is included in your standard insurance and will be reimbursed', many young people still won't really understand what that means."

Participants stated that budgeting can be challenging for young people and they were nervous about whether their diagnosis would be severe enough to receive reimbursements from health insurance. Some participants could not afford treatment themselves which refrained them from getting help to avoid placing a financial burden on their parents. Other participants lowered the amount of appointments with their mental health care professional because of financial aspects. One participant avoided a diagnosis to prevent health insurance's premium from increasing.

(R2) "I tried to keep the number of sessions as low as possible but I also knew that every time I had such a session I would definitely feel better."

3.2.2 Facilitators

Some participants mentioned their general practitioner (GP) to be easily accessible to discuss their mental health problems with. Furthermore, walk-in

possibilities such as @ease were appreciated, as well as a smooth referral by GP's to their in-house psychologists. Other participants visited University psychologists, found help by searching online, asked a teacher or had enough knowledge of the healthcare system due to their own specific education.

(R13) "And this doctor was like: 'okay well we'll tell ..., we'll let you go to the psychologist that is just like upstairs'."

(R14) "Yeah I just googled therapy and nightmares and that's how I found them."

Some participants experienced situations without waiting lists and described this as very pleasant. For some participants, the GP offered weekly counselling to overcome waiting periods. Remarkable were differences in experiences with care-related costs; international students in our study mentioned that their insurance would pay for their treatment and therefore, money was not seen as a barrier. Some of the native Dutch participants did not experience any financial barriers because their parents covered the health-care costs. Free of charge services were mentioned as easily accessible.

(R3) "I think someone told me like: there is a sort of GP psychologist who you can just visit, the first couple of conversations will be free."

3.3 In care itself

3.3.1 Barriers

Not all young people who managed to get into care, immediately received the care they needed. Some participants found out that their problems were too severe or too complex for the service they visited, leading to another referral followed by a second waiting period.

(R15) "So I was referred in October and had an intake in February. The period in between was very heavy, I had another suicidal period."

Also within one facility, several participants experienced changes of therapists, or prematurely stopped treatments because of leaving therapists, leading to a decreased sense of trust. The relationship with the therapist seemed to be very important for a treatment to succeed.

(R4) "Wherever I come, I always get referred to someone else because a professional stops working there or goes traveling or something. And then I have to trust this new person enough to tell my whole story."

Sometimes, it was the participant who stopped treatment because of residential relocation, a satisfactory decline in symptoms or insufficient effect of treatment.

(R15) "It was like: 'How do you feel?' 'Well, like shit.' 'And how could you change that?' 'I don't know.' It didn't help me."

Some participants are still in need for help after a unfinished treatment trajectory and some still experienced problems for which they hold themselves accountable because they feel that they should be able to manage their mental health problems after receiving care.

3.3.2 Facilitators

On the contrary, some participants were very positive about the care received. In general, it was highly appreciated when treatments were personalized with room for spirituality and autonomy, instead of following a strict protocol. One participant mentioned relief after finding out that receiving care did not automatically mean being hospitalized. Another person mentioned that it was nice to visit the same professional for a longer period as this person was aware of all relevant details. Several participants mentioned that treatment was very helpful as they learned to talk about their problems, discovered patterns in their behaviour, received tools to manage their situations, learned to involve their social circle and to ask for help in case of future problems.

(R14) "I now know how to handle it and I'm way more open to people around me. So I won't get as deep as I did before, and I can get out of it more easily."

Previous positive experiences with a GP or a psychologist facilitated seeking help. Once young people were in the healthcare system, it was easier to find appropriate care.

(R14) "[GP] was always very helpful. I think that if you feel listened to by your GP, that that helps to visit your GP a next time when you're not well."

3.4 Suggestions for improvement

(1) Young people wished for more awareness among youth around mental health problems. They hope that by sharing information and experiences it becomes normal to talk about mental health problems and to ask for help.

(R5) "The more we try to help each other, the more it might become normal that people who realize that they have problems actually go and seek help."

(2) Combined with awareness, they asked for information about possibilities of care and what to expect when they would seek help. They request mental health education at schools, clear information online as well as leaflets and posters.

(R12) "Information about 'how do you get a psychologist?' How do you do that? [...] I, personally like it to know what to expect."

(3) Young people underline the importance of an approachable psychologist at every School/University.

(4) In an ideal world, there would be no waiting lists. Participants, however, were understanding about scarcity in time of psychologists, and suggested to give updates during the waiting period.

(R1) "Yeah, if they could just send an email or make a call, like: we're working on it, but it is busy [...] and in the meantime you could go here or there [...] then you might feel that they are trying. Now I'm just waiting ... a long time, and I didn't hear anything."

(5) Participants liked informal settings and asked for more funding for these kind of initiatives.

(R4) "Well, that it's not like formal, with a psychologist and stuff, but that there're just people who you can talk to and who will actually listen."

(6) A maximum amount of therapists per person.

(R4) "Try to really keep it to a maximum of 1 or 2 therapists and without extra referrals. Because it just doesn't work. It takes longer to trust a therapist enough to open up."

(7) Accessibility would increase if it was possible to have a phone or online chat conversation prior to visiting a service.

(R3) "Online contact is easier to initiate. You don't have to go somewhere and you don't have to look someone in the eyes [laughs], like, in case that's difficult for you ..."

4. Conclusion

This study explored barriers and facilitators in the pathways to care for youth aged 12 to 25 with mental health problems, in the Netherlands. Results were structured into three main themes in the process of seeking help, namely "Attitudes towards mental health problems and seeking help", "Entrance to care" and "In care itself", and a fourth theme consisted of suggestions for improvement.

Attitudes included clear negative cognitions about mental health problems for which participants hold themselves accountable. Although participants considered the current situation in The Netherlands to be better compared to other countries, mental disorders in general were still taboo. Participants were concerned to share their problems with friends or family members and felt unentitled to have mental health problems as they were growing up in privileged circumstances. Although the objectivity of professionals was highly valued, participants did not feel

entitled to occupy their time. In addition, they prioritized educational, work or social activities above seeking help.

The phase of entrance to care showed barriers such as not knowing where to find help, waiting lists, diagnostic processes and financial barriers.

Even after getting into care, not all young people reported to have received appropriate care and prematurely stopped treatments were experienced as problematic.

Clear suggestions for improving the pathway to care were more awareness for youth mental health problems; hearing experiences of others was supportive. There was a need for clear information about treatment options and care-related costs. Our participants asked for updates about waiting lists and alternative options, informal settings with walk-in possibilities, phone or online chat possibilities and a maximum amount of different therapists, trustable and offering personalized care.

5. Discussion

Above mentioned negative attitudes towards mental health problems led to late recognition and acceptance of mental health problems among our participants, only making them to seek help when problems began to escalate. This is in line with earlier research (Rickwood et al., 2007) stating a growing need for independence during adolescence combined with believing that they should handle problems themselves, leading to the problematic situation in which even adolescents with serious suicidal ideation believed that they should be able to manage their own problems. This shows the magnitude of this problem and its possible consequences, with suicide being the main cause of death among youth (Statistics Netherlands (Centraal Bureau voor de Statistiek), 2020).

Remarkable was the idea that mental health problems develop with an older age: a strong contrast to the abundance of evidence advocating for mental health problems as (chronic) disorders of young people (Insel, 2009). When investing in awareness around mental disorders, this finding stresses the importance to particularly accentuate their existence in youth.

While stigma has been well documented as a barrier (Gulliver et al., 2010; Jorm, 2000; Salaheddin & Mason, 2016; Schomerus & Angermeyer, 2008; Thornicroft, 2008; Vanheusden et al., 2008), our respondents deepened our understanding of this theme by explaining different types of stigma that they associated with mental health. It was not only the stigma on mental disorders that played a role, stigma was also associated with seeking help (and thereby being perceived as weak) and with asking

for assistance to seek professional help when the person is unable to find adequate information herself.

Findings in the present study, showing that participants constantly compared themselves to their peers are in line with previous studies showing young people to be extremely sensitive to peer rejection and validation (Knoll et al., 2015), further underlining the significance of awareness for youth mental health problems. Participants expressed their wish for more online awareness and information, as well as online chat possibilities. Indeed, earlier research showed that the internet can facilitate help-seeking in three ways: (1) as a gateway to further information, (2) as a way to connect with others, professional or peer and (3) as an alternative option to offline help-seeking (Pretorius et al., 2019). Thereby, online help-seeking might better meet the needs of young people with a preference for self-reliance and offers anonymity and privacy, easy access, inclusivity, and the ability to connect with other people in a similar situation to share experiences. Nonetheless, online help-seeking does not overcome all barriers. Concerns about privacy and confidentiality, and uncertainty about the trustworthiness of online resources may prevent young people from seeking help online. To conclude, and similar to offline help-seeking, mental health literacy is necessary to effectively seek help online.

In line with earlier research, experienced barriers in the phase of “Entrance to care” showed that in spite of all well-designed awareness and early detection programmes and campaigns the issue of access to care has not yet been solved (Malla et al., 2016). This advocates for, in addition to funding the actual projects, incentives for (more thorough) evaluations concerning effectivity and reach of these programmes and campaigns. Concerning the structural barrier of waiting lists, our respondents add to the existing knowledge that not only the waiting period is too long, also the expectation of a long waiting period can decrease the motivation to apply for professional help in the first place. Additionally, a waiting period often comes with insecurity about the progress (e.g., not knowing how long he/she still has to wait and not being offered in-between psychological support). Updates, guidance and support should therefore always be provided to young people on waiting lists, to maintain motivation for treatment and avoid worsening of symptoms. Regarding financial barriers, our respondents added to the existing knowledge (Gulliver et al., 2010; Salaheddin & Mason, 2016; Vanheusden et al., 2008) that the uncertainty surrounding care-related costs sometimes plays a bigger role than the actual costs itself. Therefore, a less obvious but very helpful facilitating role could be played by healthcare insurers, by making information more youth friendly and easier accessible. Lastly,

participants expressed their appreciation for walk-in options and experienced GP’s and psychologists with such options as easier accessible. In literature, this is not a frequently mentioned facilitator. An explanation for this finding may be that participants were recruited via the @ease walk-in centres, making that the studied population has at least some experience with walk-in services. However, participants mentioned other walk-in options as well. This might be explained by the structure of the Dutch healthcare system, where GP’s play an important role as gatekeepers and are experienced, at least by a part of the population, as approachable. Therefore, expanding walk-in options might benefit both young people and (mental) healthcare services as no-show rates form a significant problem in healthcare organization (Van Dieren et al., 2013). Walk-in options may be a starting point to bridge this gap between waiting lists and no-shows.

Regarding the experienced barriers after entering the healthcare system itself, earlier research showed continuity of care to be challenging as well as essential for youth, especially around the age of 18 (Leijdesdorff et al., 2020; Singh et al., 2010). Indeed, participants mentioned several changes of therapists or prematurely stopped treatments damaging the therapeutic relationship or leading to another waiting period and worsening of problems.

5.1 Strengths, limitations and future directions

Our study showed that shame and stigma still play a huge role in mental health problems in youth. It can therefore be considered a strength of the present study that 15 young people opened up about their experiences during a vulnerable period in their lives. We are thankful that these young people stepped out of their comfort zones to contribute to scientific research.

The current study showed a broad spectrum of experienced barriers and facilitators in youth with mental health problems. Their experiences, knowledge and attitudes, however, are not generalizable to the whole population of youth in need of care, and are only valid in their specific context.

Although the sample of participants was already quite heterogeneous, future research could aim for more diversity by including people with a background of immigration, LGBTQ+, intellectual disabilities or parental mental illness. In addition, perspectives of people in the direct environment of young people, such as parents/carers, teachers, close friends and siblings could add further information, as these gatekeepers can play a crucial role in the process of help-seeking (Rickwood et al., 2005).

To conclude, our results were in line with earlier research and showed similarity in barriers and facilitating factors between the Netherlands and other countries. These shared factors can be seen as a validation of the shared approach in improving youth mental health services worldwide (WHO, 2017; Buckley et al., 2011; Malla et al., 2016). In addition, this study showed that further innovation in youth mental healthcare is still very topical to realize easy accessible care and early detection and intervention.

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Disclosure statement

All authors are involved in the @ease Foundation, either as staff, volunteer, management and/or advisory board member.

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Notes on contributors

Sophie Leijdesdorff currently works as a postdoctoral research fellow at Maastricht University and is involved as psychologist and trainer at @ease. Her work focuses on youth mental health, and in particular ways to improve access to care for young people with mental health problems.

Rianne Klaassen is a Child and Adolescent psychiatrist and clinical teacher at Levvel. She is one of the founders of the @ease Foundation and involved in research concerning youth mental health and High Risk populations.

Di-Jon Wairata is a passionate, hard-working doctor-to-be at Maastricht University with a special interest in psychiatry and research on outpatient treatment of adolescents and adults with mental health problems.

Stefanie Rosema works as a psychologist at Levvel, while being in training to become a specialized mental health care psychologist. She combines this with being a staff member and trainer at @ease and is involved in research into youth mental health.

Therese van Amelsvoort is professor in Transitional Psychiatry and psychiatrist at Mondriaan and Koraal. She is one of the founders of the @ease Foundation.

Arne Popma is professor and head of the department Child and Adolescent psychiatry at Amsterdam UMC. He is a member of the advisory board of the @ease Foundation.

Data availability statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ORCID

Sophie Leijdesdorff  <http://orcid.org/0000-0001-9930-3391>

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Appendix A Topic Guide: qualitative study @ease

English version Requirements

- Audio-recorder
- Notes printed or digitally
- Topic Guide

- Socio-demographic questionnaire
- Informed consent form

Introduction

- **Introduce yourself + thank you for participation in this research**
- **Explanation of the purpose of this study:** We would like to know what the barriers are among youngsters to seek professional help when they feel down. We're also interested in the factors that make it easier to get help, these are called facilitators. Your opinion can help us to make mental healthcare more accessible when you need it.
- **Explanation use of data:** We will analyse the most common themes in the interviews and write an article about it. With this information, we can better adapt the health care system to the needs of the young.
- **Length of the interview:** The interview takes half an hour to an hour.
- **Explanation of recording:** The audio is recorded anonymously and then transcribed to text. After transcription, the audio file is destroyed. All names and institute names are left out in the transcription.
- **Anonymity:** Everything you tell us will be processed anonymously. Nothing you say or give us can be traced back to you.
- **Informed consent:** Do you have any questions? Would you be willing to sign this consent form to give your approval?
- **Time management and note keeping:** Please feel free to elaborate as much as you want on any topic. The interviewer (me) will keep track of time. Additionally, I will be keeping notes as a reminder for myself during our conversation, so I don't have to interrupt you while talking.

Opening question (open):

We often hear from youngsters that it is sometimes hard to seek professional (psychological) help when you're feeling down. Do you recognize this? Are there things that made it hard for you to seek help? Or that made it easier? This can be anything, so thoughts or feelings, too.

Opening question (suggestions):

We often hear that someone is afraid to seek help because of **stigma**, not **trusting professionals**, concerns about your **future** job or **insurance**, not wanting to be a **burden**, those kinds of stuff. We also hear that some things make it extra hard to receive help, such as **health insurance** and long **waiting lists**. If you're hearing these things, is there something that comes to mind?

Topics and questions

Stigma
 Confidentiality
 Not wanting to be a burden
 Self-reliance
 Concerns on future or job
 Negative or positive attitude towards mental health care
 Past experiences with mental health care
 Accessibility
 Financial aspects
 Waiting lists and intake
 Fluctuating symptoms
 Mental health literacy, recognition of the problem.
 Fear of seeking help
 Rather seek help from informal sources (friends or family)
 Social support and stimulation
 Already existing relationships with health care professionals.
 Knowledge about where to seek help
 Being to ill to seek help

Probing questions:

- How does that work? Could you elaborate on that?
- Why is this a barrier, what makes it a barrier to you?

Miracle question

What would the ideal scenario be if it was up to you? If you could give a tip to the policymakers and health-care

professionals, what would it be? How would you do it if you were in charge of the mental healthcare?

@ease

- What do you like about @ease?
- What does @ease do to decrease barriers and make seeking help easier?
- What can @ease further improve to make seeking help even easier?

Closing

- **Check if every topic has been reviewed** (interviewer and participant):
- **Announce closing**
- **Check info; ask for missing information.**
- **Thank the participant and ask for questions**
- **Snowball sampling:** Do you know anybody in your environment (friends, family) that is struggling with mental health issues and might be interested in participating in this study? We are mainly looking for participants who haven't taken the first step yet towards professional help, but even if they have done, they are welcome to participate.