

Who is @ease? Visitors' characteristics and working method of professionally supported peer-to-peer youth walk-in centres, anonymous and free of charge

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Abstract

Aim: Although mental disorders often emerge early in life, only a minority of young people receive timely and appropriate mental health care. A worldwide youth mental health movement aims to prevent development and persistence of psychiatric disorders. As part of this movement, the first four @ease centres were opened in the Netherlands. @ease is a youth driven, professionally supported initiative, providing peer-to-peer counselling, anonymous and free of charge, for people aged 12–25.

Methods: Data consist of a detailed description of the working method of @ease, combined with characteristics of all young people accessing the services between its inception (January 2018) and July 2020.

Results: Young-adult peers, including experts by experience, served as counsellors after training in listening, motivational interviewing and solution-focused strategies. They were supervised by a diverse group of healthcare professionals. A total of 291 visitors, aged 21 on average, were satisfied to very satisfied with @ease's services. Psychosocial distress, social functioning and quality of life measures at first visit showed moderate to severe levels of impairment, and almost half of all visitors reported skipping classes. One third reported parental mental illness, 28% suicidal ideations, and 11% had made specific plans. Less than a third of visitors had received mental health care in the 3 months prior to their visit.

Conclusion: This study showed the need for and feasibility of a youth driven, professionally supported organization offering peer-to-peer counselling in the Netherlands. Its flexible and individualized working method enables @ease to normalize problems when possible and intervene when necessary.

KEYWORDS

adolescence, innovation, peer-to-peer, service reform, youth mental health

1 | INTRODUCTION

The majority of mental disorders emerge before the age of 25 (Kessler et al., 2005). To reduce individual and societal burden and to limit further negative consequences of mental disorders, early detection and accessible intervention strategies are of utmost importance in youth (McGorry & Mei, 2018; McGorry & Van Os, 2013).

In the Netherlands, the healthcare system includes compulsory insurance for all citizens, free of charge for people under the age of 18. General practitioners (GP) services are fully covered, it is standard procedure for all secondary school students to be checked at least once by a youth paediatrician, and there are few areas without healthcare facilities in this small, densely populated country. Despite these services there is still a gap between the number of young people with mental health problems and those who receive appropriate care. As in other countries, less than a third of all young people (aged 12–25 years) experiencing mental health problems receives any professional help (De Graaf et al., 2010; Slade et al., 2009). Barriers such as stigma, a lack of mental health literacy, and a strict separation between child and adolescent versus adult mental healthcare lead to a misfit between service structures and young people's needs (Hetrick et al., 2017; Rickwood et al., 2007; Vyas et al., 2015).

Over the last two decades, worldwide, several innovative programs have been developed to bridge this gap and improve access to care. Most well-known is the Australian, youth-friendly service headspace (www.headspace.au.org; McGorry et al., 2007), accompanied by amongst others, headspace Denmark and Israel, Jigsaw in Ireland, Maison des Adolescents in France, and Foundry and ACCESS Open Minds in Canada (Hetrick et al., 2017; McGorry & Mei, 2018; Vyas et al., 2015). Within this global youth mental health movement, @ease was founded in the Netherlands in 2018 (www.ease.nl).

Similar to the youth mental health initiatives mentioned above, @ease centres are easily accessible, inviting youth aged 12–25 to discuss their mental health as well as physical, sexual, financial, vocational and social problems. @ease differs from some other initiatives by offering peer-to-peer counselling by trained and professionally supervised young-adult peers. Forms of peer-support vary, ranging from reciprocal self-help groups to unidirectional guidance by peer employees within traditional mental health services (Ansell & Insley, 2013). The definition cited by Castelein et al. (2008) best illustrates the philosophy of @ease: 'Peer support is based on the assumption that people who share similar experiences can offer each other emotional, appraisal, and informational support and hope'. Peer support has been shown to improve both quantitative and qualitative measures of recovery (Mahlke et al., 2014), and a recent review concluded that peers are an essential source of support for young people with mental health problems (Shalaby & Agyapong, 2020). Furthermore, peer support by trained young adults, whether or not experts by experience, improved well-being and educational performance. Therefore, incorporating peer support appears to be a high priority in developing innovative mental health services for youth.

@ease has a clear mission to reach young people in order to increase resilience and thereby the chance of positive development.

The overall goal is to prevent aggravation of emerging or existing mental health and developmental problems in people aged 12–25. This aim of the Dutch @ease Foundation translates into the working methods of its four currently operating walk-in centres for young people. This article describes the @ease working method and presents a comprehensive profile of its visitors during the organization's first 2.5 years.

2 | METHOD

2.1 | Design and setting

To describe @ease's current working method, information was extracted from the foundation's 'primary process' description. In addition, two young-adult peers were asked to comment on the described working method. Their feedback was incorporated in the article.

To construct a profile of @ease's visitors, all visitors were invited to complete an anonymous, 5-min @ease questionnaire on an iPad at the end of their conversations. Information about the goal of the questionnaire, its non-obligatory character and contact details of one of the researchers was included at the beginning of the questionnaire and in printed handouts available at all centres. To complete the questionnaire, visitors needed sufficient knowledge of the Dutch or English language. There were no further in- or exclusion criteria. If a visitor was not willing or able to complete the questionnaire, the young-adult peer part of the questionnaire was still filled in. Data presented in the current study are from first visits. The Medical Ethical Committee of Maastricht University approved the study (METC number 2017-0046). Data were anonymized and stored on a secured server at Maastricht University.

2.2 | Measurements

The @ease questionnaire consisted of two parts. The first and major part of the questionnaire was completed by the visitor. It included questions assessing demographic characteristics, access to @ease and two validated measures evaluating psychosocial distress and quality of life.

Psychosocial distress was measured with the Clinical Outcomes and Routine Evaluation (CORE-10). The CORE-10 is a short, acceptable and feasible 10-item questionnaire designed for 17–25-year-olds (Barkham et al., 2013), assessing presence and severity of common mental health problems in the context of primary healthcare. The total score on this measure of psychological distress can range from 0 to 40; scores of 11 or higher denote a clinically significant level of psychological distress (Barkham et al., 2013).

Quality of life was measured using the EuroQoL (EQ-5D-5L), comprising five dimensions: mobility, self-care, usual activities, pain/discomfort, and anxiety/depression. Each dimension has five levels, ranging from 'no problems' to 'not able to perform a certain activity'. The EQ-5D reflects the impact of common mild to moderate mental

health conditions on quality of life and discriminates between subgroups in terms of severity (Brazier, 2010; Lamers et al., 2006).

The second part of the questionnaire was completed by the @ease peer-workers with whom the visitor spoke. Two items assessed *suicidal ideation*, including whether the visitor had made specific plans to end his/her own life. The possible *need for referral* to extra care, such as consulting a GP, psychologist or other (mental) healthcare professional, was also recorded. Finally, *social functioning* was evaluated with the Social and Occupational Functioning Assessment Scale (SOFAS; American Psychiatric Association, 2013). Scores could range from 0 to 100, with higher scores representing higher levels of functioning.

2.3 | Analysis

Characteristics of the current sample of @ease visitors were summarized using descriptive statistic functions in IBM SPSS statistics software version 25.

3 | RESULTS

3.1 | Working method

3.1.1 | Staff

At all @ease centres, visiting young people were welcomed by two young-adult peers trained to conduct the @ease conversations. The majority of these volunteer peer-workers were between 18 and 30 years old; experts by experience were well represented. Potential young-adult peers were screened by @ease and took part in a special 2-day training where they learned how to actively listen to a variety of topics and to use their own experiences in an appropriate and helpful way. In addition, the training covered @ease's working method, some solution-focused and motivational conversation techniques, and dealing with crisis situations. Special attention was focused on the role and responsibility of the young-adult peers. Experienced peer-workers were involved in training the new young-adult peers. The training was followed by a trial period to ensure a good fit between prospective young-adult peers and the @ease organization and objectives.

Young-adult peers were supervised by healthcare professionals, including psychologists, psychiatry residents, behavioural scientists, social workers and specialized nurses. This supervision comprised preliminary discussions of potentially complex situations during conversations and mandatory discussions following each individual conversation. During opening hours, a psychiatrist was on call, easily accessible for phone consultation and referrals to the crisis intervention team if needed (Figure 1). The diversity in professional backgrounds of the staff members, combined with ongoing efforts to build bridges within the @ease regional contexts, enabled @ease to offer the needed support.

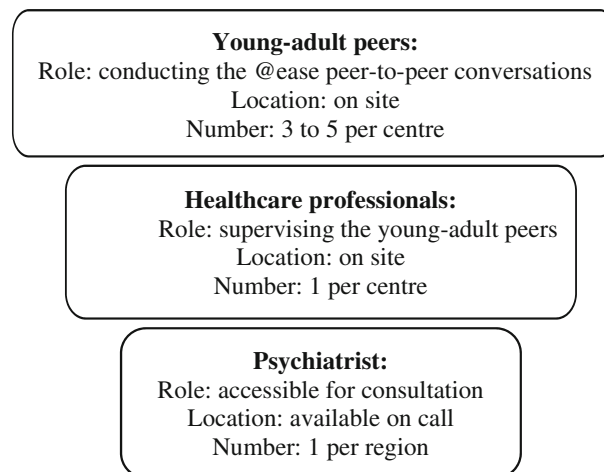


FIGURE 1 Organizational chart @ease

3.1.2 | Setting

As clearly communicated on the @ease website, young people could either walk in unannounced during opening hours or make an appointment, online or by phone. @ease services were free of charge, anonymous and visitors could return as many times as they wanted. Visiting @ease could be a first step towards seeking help, but could also be an adjunct to current care elsewhere or follow-up.

As part of the ongoing process of adapting the working method to match visitor's needs, regional youth advisory councils were set up to provide solicited and unsolicited feedback to make sure all @ease centres are located, organised and furnished to be youth-friendly and welcoming. This allowed subtle regional differences in the centres, fine-tuned to the local landscape. This flexibility also enabled @ease to respond quickly to changing conditions, illustrated by the quick initiation of online chat and phone services when in-person visits were limited during the COVID-19 lockdown.

3.2 | @ease questionnaire data

3.2.1 | Demographic characteristics

Of all 291 young people who visited @ease between its inception and July 2020, the majority were female; mean age was 21 years (range 10–55) (Table 1). Given @ease's anonymous working method, it could not always be ascertained whether a visitor was older than 25 years of age. When visitors clearly did not fall within the target population, staff members guided them towards suitable alternative options. Of those who were engaged in any form of education, 51.9% was studying at an university, 20.3% at an university of applied sciences and 19.2% in secondary education. 44.6% of visitors mentioned that they had skipped classes in the last 3 months, with a mean of 7.6 days (SD = 11.3). One third reported parental mental illness. Although only one young person stated being homeless, three other visitors

TABLE 1 Demographic characteristics

	N	Mean (SD)
Age	229	21.03 (4.2)
Core-10 total	214	20.43 (7.0)
Satisfaction with waiting time	178	4.72 (0.8)
Satisfaction with conversation	179	4.40 (0.8)
SOFAS	213	63.97 (18.0)
	n (%)	
Sex	Female	158 (65.0)
	Male	83 (34.2)
	Otherwise	2 (0.8)
Occupation	Education	175 (74.2)
	Work	25 (10.6)
	Both	21 (8.9)
	None of both	15 (6.4)
Living situation	Parents	73 (29.9)
	Caregiver	2 (0.8)
	Peers	71 (29.1)
	Alone	61 (25.0)
	Partner	19 (7.8)
	Homeless	1 (0.4)
	Other	17 (7.0)
Country of birth	NL	124 (54.6)
	Other	103 (45.4)
In mental health care		54 (28.7)
Parental mental health problems		72 (33.8)
	Mother	48 (22.5)
	Father	15 (7.0)
	Both	9 (4.2)

Note: The item about being 'In mental health care' was assessed for the 3 months prior to their visit. Satisfaction with waiting time and Satisfaction with conversation: on a scale from 1 to 5, with 1 being 'very unsatisfied' and 5 'very satisfied'.

mentioned living in a homeless shelter or with friends as a temporary solution. The visitors' countries of birth represented all continents.

3.2.2 | Access to @ease

Most visitors learned about @ease online (20.4%), via friends (20.8%) or otherwise (39.4%), namely, via family members, people or presentations at school or healthcare professionals. 68.1% visited @ease on his/her own initiative, whereas 20.4% was urged to visit by a friend or family member. Wanting to discuss feelings was the main reason for the visit (Table 2). 67.0% walked in without an appointment. Visitors were on average satisfied to very satisfied with both the waiting time and their conversations.

TABLE 2 Reasons for visiting @ease

Reasons for visit	N	%
To discuss concerns about		
Feelings	173	75
Social relationships	51	22
Education	50	22
Drugs/alcohol	11	5
Physical health	6	3
Sexuality	5	2
For advice	63	27
For practical help	43	19
Other	20	9

Note: Multiple answers were possible.

3.2.3 | Psychosocial distress, social functioning and quality of life

Only 7.9% of visitors scored below the Core-10 clinical cut-off of 11 points. On average, visitors showed moderate impairments in social functioning. Regarding quality of life, 75.1% perceived at least moderate problems related to anxiety and depression, 43.9% was hindered doing usual activities and 22.9% experienced at least moderate levels of pain/discomfort (Table 3). 28.4% expressed suicidal thoughts and 11.7% had made specific plans to end their lives (Table 4).

Following their @ease visit, 13.9% made an appointment with their GP, 16.7% planned to visit a psychologist and 32.8% chose to make other arrangements, such as consulting a student psychologist/mentor or returning to @ease. The remaining 36.6% experienced their visit to @ease as sufficient for the time being.

3.2.4 | Differences and similarities between centres

The first two @ease centres opened in 2018 (one in Maastricht and one in Amsterdam); the Heerlen and a second Amsterdam centres opened in 2020. Here, we only compare the first two individual centres.

The Maastricht centre welcomed 228 visitors, with an average age of 21.6, of whom 53.0% born outside the Netherlands. 84.8% was engaged in education. Mean Core-10 and SOFAS scores were 20.3 and 63.6, respectively. Satisfaction with the visit averaged 4.3 on a scale from 1 to 5. The main reason for the visit was to talk about their feelings.

Sixty-three young persons, aged 19.0 years on average, visited the Amsterdam centre. 75.5% was involved in education and 84.8% was born in the Netherlands. The average Core-10 score was 20.9; the mean SOFAS score 65.4. Satisfaction was 4.8 on a scale from 1 to 5, and the main reasons of visit were similar to those at the Maastricht centre.

TABLE 3 Severity of problems reported on the five-dimensional, five-level EuroQol questionnaire

	No problems N (%)	Minor problems N (%)	Moderate problems N (%)	Severe problems N (%)	Extreme problems N (%)
Mobility	175 (92.6)	11 (5.8)	3 (1.6)	0 (0.0)	0 (0.0)
Self-care	160 (84.7)	23 (12.2)	4 (2.1)	1 (0.5)	1 (0.5)
Usual activities	64 (33.9)	42 (22.2)	56 (29.6)	23 (12.2)	4 (2.1)
Pain/discomfort	91 (48.4)	54 (28.7)	30 (16.0)	10 (5.3)	3 (1.6)
Anxiety/depression	12 (6.5)	34 (18.4)	72 (38.9)	52 (28.1)	15 (8.1)

Note: The boldface values are indicating the sub scales on which a considerable number of participants reported problems.

TABLE 4 Suicidality

Expressed thoughts and/or plans	N	%
No suicidal thoughts	154	71.6
Suicidal thoughts	61	28.4
Specific suicide plans	25	11.7

Note: All visitors with suicide plans also had suicidal thoughts.

3.2.5 | COVID-19 adjustments

In response to the COVID-19 regulations, which forced @ease to close its face-to-face services for 3 months, online chat and phone services were initiated in March 2020. During the lockdown period, 127 @ease conversations took place through the online chat service and 41 by phone. Fifty-four young persons filled in the @ease questionnaire at the end of their online or phone conversation and were thereby included in this study.

4 | DISCUSSION

The current article described the @ease working method and summarised characteristics of its visitors during the first 2.5 years of operation. In line with its mission, young people indeed visited @ease's walk-in centres to discuss their mental health, social, vocational, sexual, physical or other problems. They did so mostly without an appointment and to their satisfaction. Apart from affirming the necessity (Mahlke et al., 2014), this study thereby showed the feasibility of the development of innovative mental health services incorporating peer-support. Lived experience and a diversity in backgrounds of the young-adult peers and supervising professional staff members made it possible to offer the support needed for visitors in their daily activities and to intervene when necessary.

Crucial conditions for implementation of peer-support include a clear description of the roles of young-adult peers and non-peer staff, as well as training and supervision (Mahlke et al., 2014). The @ease training and supervision policy met these conditions, resulting in fully operational centres and satisfied visitors.

Because a level of reciprocity is an important component, peer-support has great potential to prevent a helper-helpee relationship

from perpetuating the patient's role (Miyamoto & Sono, 2012). Therefore, further research should study long-term effects of @ease's working method. Providing peer-support can also be beneficial for the young-adult peers (Mahlke et al., 2014; Shalaby & Agyapong, 2020), including increased self-knowledge, confidence, and improved communication skills (Mahlke et al., 2014). Further research will address motivation, well-being and retention/attrition rates of the young-adult peer workforce of @ease, as well as lessons learnt during the shift to online delivery during the pandemic.

Our questionnaire results mirrored headspace's clinical, functional and demographic data (Filia et al., 2021), showing that most visitors suffered from both psychological distress and impairments in social functioning, with one third expressing suicidal ideation. Strikingly, less than 30% reported receiving mental health care during the 3 months prior to their visit. This underscores the scale of this problem and its possible consequences, with suicide being the main cause of death among youth (Statistics Netherlands, 2020). Although the results are worrisome, the fact that young people felt free to talk about their mental health problems and indicated satisfaction (directly and by repeated visits to @ease) suggests that the @ease method can help bridge the gap between the needs of young people and the mental healthcare arsenal.

Stated reasons for visiting @ease were similar to those of headspace visitors (Rickwood et al., 2014). Only problems regarding education seemed to be more prominent as reason for presenting among @ease's visitors, which may reflect the slightly higher percentage of students in the @ease population (Filia et al., 2021; Rickwood et al., 2014).

A specific group of young people that needs attention are adolescents with parental mental or addiction disorders (COPMI). One third of all visitors reported falling in this group, which is known to be at high risk for the development of mental disorders (Leijdesdorff et al., 2017). If they feel welcomed and listened to, even in the absence of current symptoms, this high risk group might return to a walk-in centre if mental health problems do emerge. Our results might therefore contribute to timely treatment of (emerging) mental disorders.

Consistent with its mission, @ease was accessible enough to reach at least part of the population of young people in need of help. For one third of visitors, having a conversation was enough for the time being. Perhaps the positive experience of being listened to might lead to higher resilience and a lowered threshold to seek help in the future. For visitors in need of more or other forms of support, @ease

bridged the gap and guided them towards appropriate care, thereby facilitating early intervention.

The two @ease centres were broadly similar in terms of visitor characteristics. However, almost all visitors of the Amsterdam @ease centre were native Dutch, whereas more than half of the Maastricht visitors were born abroad. Most of these foreign visitors were international students, a relatively large population in Maastricht. Possible explanations for this high number of foreign visitors could include larger barriers to care for people who are unfamiliar with the Dutch healthcare system, or an attenuated social support system compared with what they might have had in their home countries.

4.1 | Limitations

The majority of visitors were involved in higher education, making it unclear whether @ease is equally effective in reaching the most vulnerable young people. Future research should investigate the needs of vulnerable subpopulations, such as those with intellectual disabilities, COPMI or a refugee background, to better address their specific needs.

The sample of the current study consisted of visitors of the first two @ease centres as the third and fourth centre were only recently opened. Future research should include higher numbers of visitors from a larger number of centres to allow for a more thorough between-centre comparison.

A final challenge is to maintain model fidelity (Bridgman et al., 2019), given the growing number of @ease centres. In addition, continuous engagement of and input by young people as (potential) users is essential for ensuring youth-friendly and high quality service. In this regard, the youth advisory council 'Be @ease' will play a prominent role.

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[Correction added on 31 March 2022, after first online publication: Special thanks to Hana Ibrahim, Jorn Hartgens, and Nancy Nicolson have been added to the Acknowledgements.]

CONFLICT OF INTEREST

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

DATA AVAILABILITY STATEMENT

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

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