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RESEARCH

Everybody @ease - reaching Out To Vulnerable Subgroups of Young People with Mental Health Problems in the Netherlands: an Adaptation of the Standard @ease Working Method

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Abstract

Young people with mental health problems do not always receive appropriate care. This study aims to increase understanding of the barriers and facilitators that young people face in their pathways towards care, by making use of targeted outreach activities by @ease, a youth-friendly walk -in center in the Netherlands. A questionnaire enquiring demographic characteristics, symptom levels and levels of functioning was administered to young people as part of a pilot-outreach program at @ease. Semi-structured interviews were conducted with participants to explore their attitudes towards and experiences with mental health care and how these influenced their help-seeking. Sixty-six participants were included in the pilot-outreach @ease program. Main themes concerning participant help-seeking were 'beliefs about self and others', 'accessibility of care', 'social network' and 'previous experiences with mental health care'. Participants also gave suggestions for care improvement. The outreach pilot successfully reached young people previously underrepresented through the regular @ease program. A key finding is that participants' previous experiences with mental health care played an important role in shaping their attitudes towards future help-seeking for mental health problems, influencing them both positively and negatively.

Keywords Youth mental health · Access to care · Outreach · Attitudes towards mental health

Introduction

Mental health problems are the leading cause of disability among European young people [13], with at least 45% of the overall burden of disease in those aged 10–24 years being accounted for by mental ill-health [43] and up to 75% of all mental illnesses emerging before the age of 25 [12, 52]. The transition from childhood into adolescence and young adulthood is a crucial period of one's life with regard to social, emotional and cognitive development [50]. The presence of mental health problems during adolescence has been linked with poorer educational, occupational and life outcomes in adulthood [17, 26]. Therefore, the prevention and treatment of mental health problems in youth is critically important for their wellbeing [38] However, a significant amount of young people does not receive sufficient and timely professional care [25, 36, 48].

A multitude of known barriers impede young people's access to mental health support, including long waiting lists [1], limited mental health literacy [18], stigma and shame [16, 45], self-reliance [45], lack of youth friendly information [28] and complications in the transition from child to adult mental health services at the age of 18 [3, 9, 56]. Protective factors include social and school support [28, 42],

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positive experiences with care [1, 45], and accessible and flexible mental health services [21].

In an attempt to improve access to mental health care for young people, several initiatives have been launched globally [37], including headspace Australia, ACCESS and Foundry in Canada, headspace Israel, CHAT Singapore, Soulspace Germany, Maisons des Adolescents in France, Jigsaw in Ireland and @ease in the Netherlands [5, 6, 20, 24, 30, 34, 35, 37, 40]. These initiatives have made an important contribution to the improvement of youth mental health, with several of them reporting high visitor satisfaction, reductions in psychological distress and improvements in social functioning [8, 40, 47]. Despite these positive signs, young men and young people from at-risk minority groups, underrepresented in traditional mental health services, continue to be less likely to engage with these mental health initiatives.

One solution to this problem might be found in community youth mental health outreach programs, which have been suggested to increase accessibility and therefore be more effective in reaching a more diverse group of young people, than more traditional mental healthcare settings [2, 27, 49]. Some of the above-mentioned initiatives already incorporate outreaching activities in their standard working method, such as CHAT Singapore, Maisons des Adolescents, and Bergid Headspace in Iceland [20, 37].

In line with this, in the Netherlands @ease (youth mental health walk-in centers, Leijdesdorff et al., [30] implemented a pilot outreach program aimed at increasing awareness of their walk-in services, providing a unique opportunity to broaden its engagement with young people.

This study aims to investigate the barriers and facilitators in the help-seeking behavior of young people with mental health problems who either do not seek care for their mental health problems or who have previously sought help but have stopped doing so. Additionally, this study will explore the characteristics of the young people reached by the pilot outreach program.

Materials and Methods

Setting & Recruitment

Participants were recruited through a pilot outreach initiative conducted in three Dutch cities where @ease centers were already operational. In pairs, social workers and young adult peers approached young people at community centers and known neighborhood hangouts and invited them for a conversation at one of three @ease locations; in Maastricht, Heerlen and in Amsterdam http://www.@ease.nl. Social workers received training in the @ease working method and principles, and were paired with @ease young adult peers who had undergone the same training focusing on the @ ease approach and instructing them on key conversational techniques, including active listening, solution-focused communication and motivational interviewing.

At the end of each conversation, young people were asked to fill in a questionnaire. A heterogeneous group of young people (gender, age, education, nationality, living situation and specialist mental health care use), was selected from the filled in questionnaires. They were asked for an additional interview. All but one of the interviews were performed at one of the aforementioned @ease locations in the Netherlands. This was done to enforce a secure environment in which all participants had been before. One interview was conducted online via Zoom.

Inclusion ran in parallel with interviewing and analysis, allowing initial findings to inform ongoing data collection. This iterative approach provided early insights into emerging themes, allowing these to be further explored in subsequent interviews. Inclusion continued until no new findings with regard to the research questions were obtained, to make sure that no important insights were overlooked [7, 10].

Potential participants were asked to read and sign an informed consent form with information regarding the study and data storage and contact points at which they were able to ask questions. The Medical Ethical Committee of Maastricht University has assessed and approved the protocol (METC-number 2018 −0961). The interview audios were recorded and later transcribed ad verbum. After transcribing, all audio recordings were deleted. Participants were able to withdraw from the study at any given time.

Data Collection

Quantitative Data Collection

The @ease questionnaire is designed to collect demographic data, as well as visitor’s symptom levels and level of functioning. All respondents were asked about their gender, age, current level of education or highest education attained, current employment status and whether they were born in the Netherlands or elsewhere. Additionally, the questionnaire enquires about respondents’ living situation, the mental health of their parents, their own mental health help seeking and school absenteeism.

In a second part of the questionnaire, @ease peer workers assessed suicidal ideation, answering two questions about the presence of suicidal thoughts and the presence of a specific plan to end their life based on the conversation they had with the participant [30].

To assess psychological distress, the 10-item Clinical Items and Routine Evaluation (CORE-10) was used. The CORE-10 is a short questionnaire, extracted from the longer CORE-OM. The CORE-10 can be a useful tool for screening because of its relatively short administration time and its satisfactory psychometric properties (an internal reliability of 0.9 and converging validity with the CORE-OM of 0.94 and 0.92 in clinical and non-clinical samples, respectively [4]. O'Reilly et al. [41] also found the CORE-10 to be a suitable measure for psychological distress specifically for the target population of this study, being young people between the ages of 12–25.

Qualitative Data Collection

In this study, qualitative data were collected through custom, semi-structured interviews, using an interview guide that focused on examining the participants' experiences, beliefs and attitudes towards the subject of help-seeking. All participants were given the choice to have the interview in either Dutch or English. Each participant was interviewed once by one or two researchers between October 2021 and May 2022. Interviews lasted for 20 to 60 min, depending on how much the participant wished to share. The interview consisted of 8 open-ended questions (*Appendices 1 and 2*). Depending on the answers given by the participants, the question was either further elaborated on, or the answer was summarized to confirm interpretation made by the interviewer(s). In case a participant struggled for more than 20 s to answer the question or found it hard to interpret the question, the interviewer would give provide encouragement to the participant, for example by repeating the question in an easier fashion.

Data Analysis

Quantitative Data Analysis

SPSS 29 was used to collect descriptive statistics on the questionnaire data provided by participants, including mean scores, standard deviations and frequency percentages.

Qualitative Data Analysis

After extensive reading and rereading, reflexive thematic analysis of the transcripts was conducted. Three research members began with open coding the first five transcripts, followed by a consensus meeting to align coding approaches. Two researchers then independently coded the remaining seven transcripts. Narrative summaries were then created for each participant, which allowed for the identification of thematic patterns across cases. After this narrative analysis, the same researchers distilled the initial codes into conceptual categories, by means of axial coding. While coding took place independently, results were discussed collaboratively afterwards. Lastly, selective coding was used to merge the conceptual categories into the most important themes. Atlas.ti (versions 22–24), supported all stages of analysis.

Results

Sixty-six participants filled in the questionnaire as part of the @ease outreach program. The discrepancy between the number of included participants and the maximum number of responses per demographic variable (*n*= 64) is attributable to missing data. The majority of these participants had sought out professional care for mental health problems in the 3 months that preceded the administration of the questionnaire. An overview of the demographic variables can be found in Table 1.

Psychosocial Distress and Social Functioning

Out of 61 participants that completed the CORE-10, the vast majority (*n*= 55, 90.2%) scored above the clinically significant cut-off of 11. See Fig. 1 for the distribution of CORE-10 scores.

13.8% of participants indicated that they had suicidal thoughts, with 5.2% having made concrete plans to do so. 36.1% of participants had been absent from school in the last three months (see Table 2).

Qualitative Results

Interviews were conducted with 12 participants out of the 66 that filled in the questionnaire. Interviewees' ages ranged between 14 and 29. 4 participants were interviewed at the @ease center in Maastricht, 4 at the @ease center in Amsterdam and 4 at the @ease center in Heerlen. All but one interviewee had the Dutch nationality. All participants chose to have the interview conducted in Dutch. In the interviews, 7 out of 12 participants mentioned that they had experienced some mental health problems but never received specialist mental health care. The remaining 5 participants reported that they had received specialized mental health care for their mental health issues.

Thematic analysis revealed five main themes. Four of these themes included both barriers and facilitators to participant help-seeking behaviors, the fifth comprised participant recommendations to increase the accessibility and improve the functioning of mental health care services.

Table 1 Demographic characteristics of study sample (n = 66)

Characteristics	n (%)	Mean (SD)
Age (n = 58)		
≤ 18	34 (58.6)	18.4
> 18	24 (41.4)	(3.6)
		n (%)
Gender (n = 59)	Female	27 (45.8)
	Male	27 (45.8)
	Non-binary	5 (8.5)
Living situation (n = 64)	Parents	30 (46.9)
	Caregivers	2 (3.1)
	Peers	9 (14.1)
	Staying over	1 (1.6)
	Alone	15 (23.4)
	Assisted	4 (6.3)
	Other	3 (4.7)
Current education (n = 60)	Primary education	1 (1.7)
	Pre-vocational education	14 (23.3)
	Higher vocational education	10 (16.7)
	Preparatory scientific education	8 (13.3)
	Vocational education	13 (21.7)
	Applied Sciences	4 (6.7)
	University	10 (16.7)
Country of birth (n = 61)	The Netherlands	42 (67.7)
	Abroad	20 (32.3)
Parental mental illness (n = 57)	None	32 (56.1)
	Mother	9 (15.8)
	Father	5 (8.8)
	Both	11 (19.3)
Visited healthcare professional in last three months (n = 62)	Yes	39 (63.9)
	No	22 (36.1)

I. Beliefs about self and others.
II. Accessibility of care.
III. Previous experiences with mental health care.
IV. Social network.
V. Recommendations.

I. Beliefs about Self and Others

Expected Reactions of Others

A majority of participants (7 out of 12) expressed low levels of trust in others. They feared they would not be taken seriously and would not be understood.

[R6] I found it really difficult to receive help because I had to open up and be vulnerable and I did not know how people would react or if they would understand.

Another participant expressed the belief that their problems were so big that sharing them would put an unreasonably high burden on their caregivers.

[R9] What I also struggled with, is that I felt like I was pushing my caregivers to the limit. So, I didn't dare to tell them about the full degree of the problems that I was struggling with, because I was thinking: "They cannot handle this".

Attitudes Towards Treatment

Three participants mentioned that they did not seek out help because they believed that their mental health problems would pass on their own.

[R4] I would often think: 'Oh, this will pass in a while', but actually, recently, I have not been able to cope with it at all.

Two of them shared the belief that seeking help and receiving treatment would cost a lot of time, preventing them from partaking in recreational activities such as spending time with their friends.

Stigma

Seeking help for mental health problems was looked upon negatively by a majority of participants (9 out of 12). They felt like their problems were something to be dealt with on their own. Not being able to take care of their own problems was seen as something shameful, gave rise to feelings of inadequacy and was seen as a sign of weakness.

[R11] I think it's more of the shame […] you want to be able solve more of it yourself.

To some participants having to be strong was linked to their sense of masculinity.

[R9] I think it really plays a big part that you have to be sort of strong as a man, or something. That played a big part for me.

Other People Have It Worse

In contrast to participant attitudes that made it more difficult to seek help, some attitudes made seeking out help easier. One participant found it easier to talk about their problems, by comparing them to the problems of others.

[R10] I find it pretty easy to talk about my problems. I don't think that it is a very big problem that I've got either. There are people facing much bigger problems.

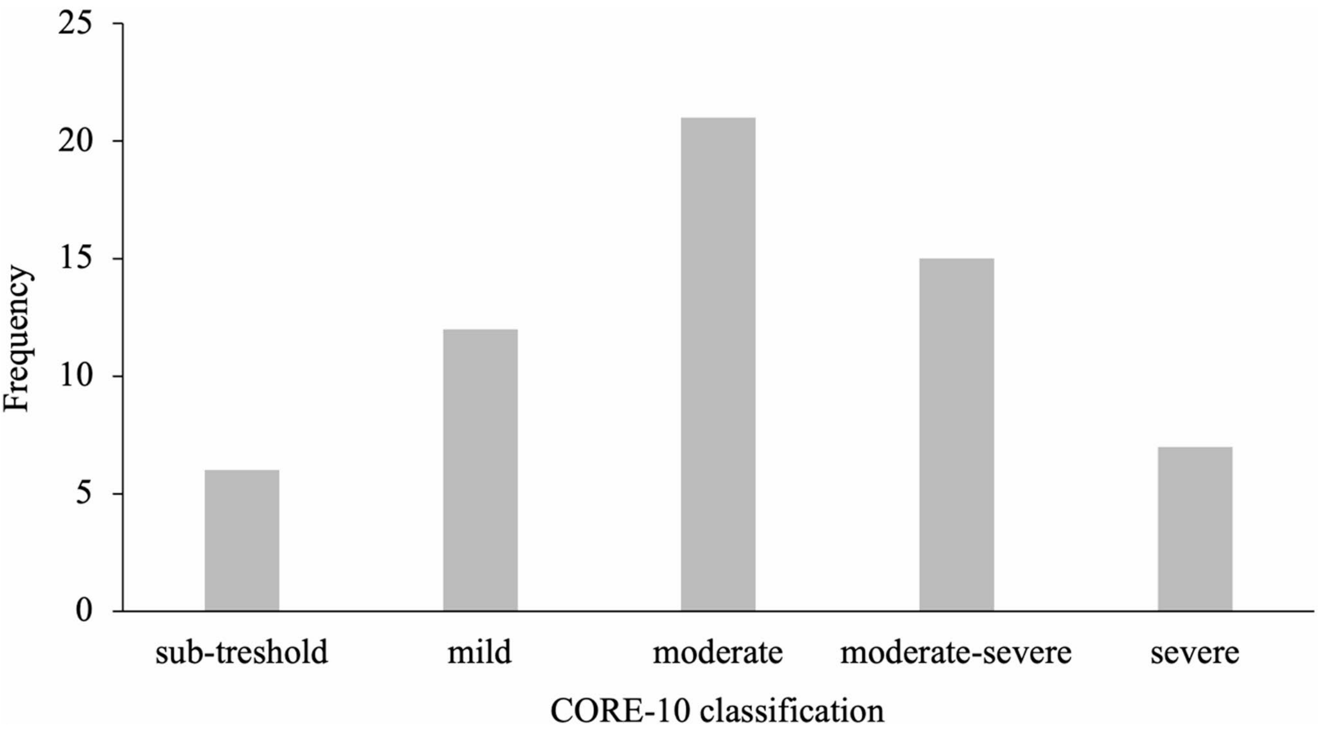

Fig. 1 Distribution of core-10 scores

Table 2 Suicidality, school absenteeism and psychological distress

Expressed thoughts and/or plans		n (%)
No suicidal thoughts		50 (86.2)
Suicidal thoughts		8 (13.8)
Specific suicide plans		3 (5.2)
School absenteeism		n (%)
≥ 1 day in past 3 months		22 (36.1)
None		39 (63.9)
CORE-10	n	Mean (SD)
Computed score	61	17.7 (6.2)

II. Accessibility of Care

Knowledge of Treatment Options

Participants felt like they lacked information about where they could go to find appropriate care, which was a barrier to seeking out help.

[R7] I think that there are enough places to go to, but I think young people don't know about them.

Waiting Lists

Long waiting lists were a frequently mentioned problem by the majority of participants (8 out of 12). When they would seek help, their problems had often been building up for so long that they needed urgent care. When participants got turned down and placed on a waiting list at that stage, they would often drop-out and stop seeking help altogether. One participant said that their symptoms increased significantly during their time on the waiting list.

[R9] I had to wait for 8 months. And in those 8 months (…) I hit my rock bottom. I did not want to go on anymore, I was ready to die.

Another three participants expressed frustration at being placed on waiting lists after being referred to a new type of treatment.

In contrast, three participants expressed that waiting lists had never been a problem for them at all. One out of these three believed that the expectation of long waiting lists could in itself be a barrier to young people seeking help.

[R4] you hear people say: 'Oh you need to go see a therapist but (…) you will be on a waiting list for three months.' I think that stops people from going to a psychologist.

Knowledge of Financial Aspects

Participants expressed their uncertainties about the costs of seeking out care within the Dutch healthcare system. Several participants mentioned that they had refrained from seeking out care because they feared unforeseen treatment costs.

[R9] I was very afraid that I would sign up for the wrong health insurance plan and have to pay tens of thousands of euros for therapy.

Furthermore, one participant mentioned that they were very aware that there were societal costs to them seeking out help.

[R9] I think about how much money I'm costing society pretty regularly.

III. Previous Experiences with Mental Health Care and Mental Health Literacy

Prior negative experiences with healthcare providers were mentioned by five participants as a cause for not seeking out care in the future (5 out of 12). One participant recalled his disillusionment after an error by his caregivers led him to be re-institutionalized.

[R3] I Know They Are Going To Fail Me, so why even Seek Out Help??

Another participant, whose father had recently passed, stated that a lack of improvement of their symptoms after visits to a psychologist led them to seek out alternative care from an energetic healer. While the participant declared that they did not really believe in the power of chakra's or flows of energy throughout the body, they did feel comfortable with the healers more holistic approach, rather than the more symptom and life-event focused method of the psychologist.

While previous negative experiences with mental health care were mentioned as a barrier by participants, prior positive experiences made it easier for participants to seek out help. Mental health care professionals who made clear commitments and lived up to their promises were greatly appreciated. One participant gave the following view on the difference between 'good' and 'bad' caregivers:

[R2] For example: the good ones would see if they could organize something for the (care)group. They would look carefully at the budget and if it was possible. The others would say they wanted to organize something and three weeks later we'd hear that it wasn't going to happen, while they had known from the start that it wasn't possible. They didn't honor their commitments.

Another participant mentioned that seeking peer-support made it easier for them to seek out professional care afterwards.

[R9] Meeting peers who I could recognize myself in and who were a little bit further on in their journey, who were able to be more open about it and help others. For me that was an important example, because it made me think: 'I want that, and I can have that too. If they can do it, so can I. I can get to that point.'

IV. Social Network

Half of all participants (6 out of 12) mentioned the important role their parents had played in them first seeking out and continuing to seek out care for their problems. Mothers were mentioned more often as active facilitators of help-seeking behavior than fathers.

[R1] I did not always enjoy going to a psychologist, but she [mother] would be the one to say: 'come on, let's just go'.

In contrast, strong parental opinions about mental health problems could form a barrier for help-seeking behavior. One participant mentioned that his fathers' beliefs on the importance of being strong as a man, made it more difficult for him to seek help. When asked if any factors had made it more difficult to seek out care, another participant answered:

[R6] I think my parents mostly, because my parents have very strong opinions and I'm not always able to form my own. Often, I'll abide by my parents' opinions, even if I don't support them myself.

Outside of parental support, several participants (6 out of 12) expressed the importance of support from their peers in helping them talk about their mental health struggles and encouraging them to find care. The difference in relationship between participants and their families, compared to their peers played a part in this. Participants mentioned that some topics, such as dealing with (soft)drug use, were easier to bring up to their peers, than to their parents.

V. Recommendations

Half of all participants (6 out of 12) wished that professionals reached out to them proactively in locations they felt comfortable at, such as **at school or in their neighborhood** hangouts. They suggested that being approached and asked about their mental health directly could reduce stigma surrounding talking about their feelings. Introducing an element of (role)play or sport might also help young people speak up about their feelings, they said.

[R7] It is very important to let them know "you don't have to be afraid; it is not taboo."

Over half of participants (7 out of 12) mentioned **walk-in facilities and peer-support**, advertised via social media as another way to increase the accessibility of mental health care.

[R1] Just always leave the front door open between certain times. Make sure people can always come in and tell their story.

[R9] I think that care should be based much more on contact with peers, so for me I really dig talking to people who have been through the same thing.

Nine out of twelve participants preferred **personalized** care and wished that care providers would let go of protocols. Three of those nine mentioned solution-focused approaches as their preferred way to receive care.

[R1] I think they shoud employ people who have got the right feeling and the right eye for it and not just people who are well educated. More off the cuff and less by the book.

Two participants found it very important that mental health care providers communicated and respected the **confidentiality** of the problems shared with them.

[R11] Mention that, no matter the size of the problem, it is okay that it is being shared with you and that you are to be trusted (...) that the story won't be passed on.

Additionally, six participants wanted mental health care providers to take their time in building up rapport with them. Caregivers needed to **invest time in their relationship** so that they could form a bond of trust. The best way to achieve this, was to be reliable and available.

[R8] Let me put it this way, he is available 24/7 and he always picks up (the phone). That's how I recognize my caregiver and that's how I came to trust him.

Reducing **waiting lists** was recommended by the majority of participants (8 out of 12). However, they varied strongly in their beliefs about how this problem could be solved. One participant suggested that mental health care providers could perform a better triage of patients. Several other participants recommended hiring more mental health care staff and yet another suggested that politicians should speak with help-seeking young people to get a better understanding of the problems they face.

Discussion

Participant demographic characteristics in the pilot outreach program differed noticeably from those found in previous studies that focused on the @ease walk-in centers. The mean age of participants was lower than what has previously been found in studies on the characteristics of young people visiting @ease [9, 30]. Unlike previous studies, female young people did not make up the majority of the participants in our sample. Participants in the present study were also enrolled in lower levels of education compared to the @ ease population. Additionally, a larger share of the participants in this study was born in the Netherlands. Lower level of education and larger amount of Dutch born participants might be related, as a large share of the @ease visitors born abroad tend to be international students enrolled in university programs. Suicidal ideations, including concrete plans to commit suicide were less prevalent. Considering all of the above, the @ease outreaching method is a hopeful strategy to reach young people that have thus far been underrepresented among @ease visitors.

As expected, no single factor promotes or dissuades help-seeking behavior in youth with mental health problems by itself, but we were able to identify four main themes. **Participant beliefs about themselves and others** played an important role in their help-seeking. Feelings of inadequacy and anticipation of other people's negative judgement hampered participants in the acknowledgement of their symptoms and their search for care. Additionally, participants' estimations of the magnitude of their problems were found to be barriers when the problems felt large and facilitators when the problems felt small. Considering the **accessibility of care**, lacking knowledge of treatment options and treatment-associated cost were barriers to help-seeking, as well as (the expectation of) long waiting lists. Furthermore, **previous negative experiences with mental health care** prevented many participants from seeking care. In contrast, previous positive experiences facilitated further help-seeking, with the therapist-client relationship being considered especially important. Participant **social networks**, especially their direct peers and their parents, played an important role in facilitating their help-seeking through their validation of participants' problems. However, strong parental opinions on mental health problems could prevent young people from seeking out help as well. Moreover, the interviews provided **recommendations**, with participants expressing their support for community and school outreach programs, care provided in walk-in centers with peer support, personalized care, investment in client-caregiver trust and a reduction of waiting lists.

Long waiting lists have previously been found to be an important barrier to help-seeking behavior for young people with mental health issues [1, 15, 19]. Previous research has also found young people's expectations of mental health treatment to be unclear and highly dependent on their initial experiences with care [57]. Our findings support this, as several participants cite previous negative experiences as a reason not to seek (further) help. The present study also adds to previous research by showing a common pattern in the discontinuation of help-seeking. The threshold for help-seeking behavior was high for many of the participants in the sample. When they finally did search for treatment, the level of their distress had often risen to a high level. When they were not able to receive immediate care, or when the initial care received was not satisfactory, many participants were so disillusioned that they stopped seeking help altogether.

The present study findings reconfirm that stigma and health illiteracy are important barriers for help-seeking youth, as described previously [1, 2, 16, 22]. Additionally, participants expressed their preference for outreach programs that proactively approach young people in educational or neighborhood settings. The combination of these two factors suggests that the organization of educational or community-driven awareness campaigns could be an effective way to reduce stigma and increase help-seeking behavior in young people.

Furthermore, the present study found that many participants chose to express their feelings in the third person or in general terms, especially when confronted with difficult or taboo subjects. This matches recent findings by Madaran et al. [33], in which young people in Suriname were asked about their help-seeking behavior. This method of answering questions may be a way for young people distance themselves from the taboo subject, thereby avoiding negative judgement by their peers.

Another interesting finding was that young people may be inspired by their peers to seek out help for their mental health problems. During adolescence, young people are uniquely sensitive to peer rejection and validation [54]. While previous research has suggested that these dynamics make young people especially vulnerable to mental health stigma, there might also be a positive pathway, in which young people are inspired by peer role models to improve their own mental health.

Moreover, the present study found that the mere expectation of long waiting lists or high treatment costs could serve as a barrier for help-seeking. This is supported by previous findings, which suggest that the anticipation of either long waiting lists or high treatment costs can be a large demotivator in itself [18, 28, 48, 55]. A lack of knowledge about treatment costs and waiting list triage may lead to uncertainty about the value of help-seeking for young people, which in turn could lead to avoidant behavior. The provision of easily accessible information to young people about treatment access and costs continuous to be an important avenue for intervention, as recommended in earlier research [16, 28]. Although research on the clinical outcomes of waiting list interventions for children and young people is limited, several interventions, mostly offering psychoeducation, have shown some evidence of their effectiveness [53].

Lastly, the present study found that young people express a preference for personalized, or client-centered approaches, in line with previous research [51]. Such methods could also aid in the transition from child and adolescent to adult mental health services, a process that often leads to a lack of continuity in care [29]; Swaran P. Singh et al., 2010). It also highlights the critical role of young people's initial contact with mental healthcare in shaping their attitudes towards care, and thereby their future help-seeking behaviors and engagement with treatment.

Strengths and Limitations

An important strength of this study was the inclusion of young people typically underrepresented among visitors of youth walk-in centers in the Netherlands. This provided the opportunity to investigate barriers and facilitators that affect them specifically, possibly helping to explain their underrepresentation in the population of young help-seekers [22].

Furthermore, several participants had sought specialized care for their mental health problems, and this had a significant impact on their lives. The fact that they were willing to share their experiences to support the present study can certainly be called a strength, and we thank them for doing so.

It may be considered a limitation that participant recruitment was limited to urban centers, which may have excluded rural perspectives known to face unique barriers to care [32, 39].

Lastly, @ease wants to avoid the possibility that the questionnaire forms a barrier to potential visitors. Young people were actively consulted during the design of the @ease centers, and they indicated a preference for short questionnaires. Therefore, the @ease questionnaire is as brief as possible, and allows for questions to be skipped by participants. This does result in substantial missing, as few participants completed the full questionnaire.

Future Directions and Implications for Practice

Although the sample of participants was diverse, future research should aim to include at-risk youth in minority groups, including those from rural areas, LGBTQ +communities, individuals with a mild-intellectual disabilities, or culturally and linguistically diverse backgrounds [11, 23], as their pathways to care remain understudied and they appear hesitant to seek out mental health support [14, 32, 44]. However, these groups do face unique barriers to care such as geographic isolation, fear of discrimination, cultural mismatches with service providers and homophobia [23, 31, 32, 39]. More knowledge on the pathway to mental health care for these young people is required, to address their needs [38].

Additionally, the present study focused solely on the experiences of young people. Involving the perspectives of parents/caretakers, teachers and other caregivers, might offer additional insights into the barriers and facilitators to care that participants come across [28, 46].

Conclusion

The results of the present study showed similarities with earlier research into the barriers and facilitators of help-seeking behavior in young people. What stood out, and requires more attention was the impact of previous negative experiences with mental healthcare on later help-seeking in the participants in our sample. The barriers and facilitators found in our study support the value of walk-in centers where young people can receive accessible information about their pathway to professional mental healthcare. Services aiming to provide care to the understudied subgroups of young people included in our sample, may be improved by emphasizing trust between care providers and young people, providing mental health education and informing young people about treatment costs. Additionally, services may also consider incorporating outreaching programs in their standard working method, as a way to reach out to subgroups that are difficult to reach.

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Data Availability 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.

Declarations

Competing Interests All authors except for M Daemen are or were involved in the @ease Foundation, either as staff, volunteer, management and/or advisory board member.

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