BARRIERS AND FACILITATORS TO YOUNG PEOPLE'S ACCESS TO AND ENGAGEMENT WITH MENTAL HEALTH SERVICES

By

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Master’s research project submitted to

The School of Social Work

To obtain a Master of Social Work Degree

Under the supervision of

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University of Ottawa

July 2020

ACKNOWLEDGEMENTS

I’d first like to thank my family. To my parents, Duane and Valerie; thank you for pushing me (bordering on forcing me, in mom’s case) to pursue my education. I credit you both for my strong work ethic and my drive to always give 110%. As for my little sisters, Emily, Erika, and Jenna; thank you for helping shape me into the person that I am today, and for making me want to be a good example for you to look up to.

I owe a major shutout to my long-time best friends Brigitte, Tori, Kyla, Emma, and Meagan. You all have been my personal cheer squad throughout this process; thank you for your ongoing encouragement and for celebrating with me every step of the way. To my Masterettes, Cassidy, Kaily, Emilie, Naomi, Sarah, and Genève; I would not have made it through those first few weeks, let alone this whole program, without your support. Thank you for making me feel like I was not alone in my struggles and for sharing in my frustrations over the last year. Our late nights in the study room and the time we spent procrastinating there are some of my favourite grad school memories. My partner also deserves an honourable mention; Liam, I am forever thankful for your constant reassurance, your unwavering patience and understanding, and your unconditional love.

Additionally, I’d like to express my thanks to my supervisor Marc Molgat. As a student who struggles with a severe case of ‘imposter syndrome’ and a deep seeded fear of failure, I am so grateful for all of the guidance and feedback you have provided me.

Last, but most definitely not least, I’d like to address my participants. Vito, Ani, Donatella, Marley, and Brittany; I cannot thank you all enough for opening up and sharing with me about your experiences. Your insights were absolutely invaluable, and this would not have been possible without each of you. Thank you for letting yourselves be vulnerable and for being so honest with me. You have all overcome so much, and you should be so proud of yourselves!

ABSTRACT

This research project was conducted with the intention of gaining a better understanding of the barriers and facilitators that youth, aged 16 to 24 years, encountered while accessing and engaging in professional mental health care. Furthermore, it investigated the perceived impact of these barriers and facilitators on the young people's satisfaction with the service and on the progress that they accomplished during treatment. The study also sought the participants' input on how to improve this populations access to services and how their ongoing involvement in treatment could be encouraged.

The data was collected through individual semi-structured interviews with five young people who had experienced a mental health concern and engaged in services for at least two months. The project's findings demonstrate that while some barriers and facilitators occur as a result of the youth' own thoughts and behaviors, others are imposed on them by the members of their entourage, by the service / treatment itself, by the provider, as well as by society. The results also suggest that barriers harm young people's level of satisfaction and progress, while facilitators increase their satisfaction and enhance their progress. Finally, several recommendations, as proposed by the participants themselves, that could facilitate young peoples' access to and engagement with services are presented.

Keywords: Young people, youth, mental health, treatment, mental health services, barriers, facilitators, access, engagement.

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LIST OF ABBREVIATIONS

ADHD:	Attention Deficit Hyperactivity Disorder
BPD:	Borderline Personality Disorder
CCHS:	Canadian Community Health Survey
DBT:	Dialectal Behaviour Therapy
DID:	Dissociative Identity Disorder
MHCC:	Mental Health Commission of Canada
OPH:	Ottawa Public Health
OSFED:	Other Specified Feeding or Eating Disorder
PTSD:	Post-Traumatic Stress Disorder

INTRODUCTION

According to the Mental Health Commission of Canada (MHCC) (2015), “[at] least 75 per cent of mental health problems and illnesses have an onset in childhood, adolescence, or young adulthood” (p.5). Such conditions are also often exacerbated during certain developmental periods and in times of transition and change, both of which young people experience as they approach adulthood (Children’s Mental Health Ontario, 2013). When mental health problems are not properly addressed, they are likely to persist and have negative consequences on the individual’s quality of life, as well as their educational, occupational, and social functioning (Anderson, Howarth, Vainre, Jones, & Humphrey, 2017; Canadian Institute for Health Information, n.d.; Kutcher, Hampton, & Wilson, 2010). This is of great concern when it comes to youth because, in addition to being disproportionately affected by mental health challenges, they are also very reluctant to seek professional help and most likely to disengage from services (Edlund et al., 2002; Gulliver, Griffiths, & Christensen, 2010; Rickwood, Deane, & Wilson, 2007).

This research project focused primarily on identifying the barriers and facilitators that young people faced in their access to and engagement with mental health services. It investigated the factors that hindered or enabled their efforts to reach out for support, as well as those that encouraged and discouraged them from continuing their involvement in treatment. Subsequently, it explored how the youth believed that these barriers and facilitators influenced their level of satisfaction with the services rendered, as well as their progress in treatment. Finally, the study solicited the participants input on what should be done in order to make services more easily accessible, and what changes could be implemented that would make young people more likely to pursue treatment to completion.

CHAPTER 1: RESEARCH ISSUE

Youth are confronted with a number of barriers in their efforts to access and engage in mental health services. They are therefore very unlikely to receive treatment, and when they do, they are likely to disengage before the services have run their course. It is known that unaddressed or inadequately addressed mental health issues tend to have serious consequences later in life; hence the importance of finding ways to encourage this population to both reach out for professional support when needed and stay involved with the services until their end.

1.1 Mental health problems, mental disorders, and mental health services

Mental health problems are defined as emotional, cognitive, and / or behavioral difficulties that compromise an individual's ability to function and that typically arise as a result of significant environmental stressors (Mulvale, Kutcher, & Winkup, 2014). Mental disorders, on the other hand, are the result of a complex interaction between an individual's genetics and their environment. They are diagnosed by a qualified health care professional according to internationally established and recognized criteria (Mulvale et al., 2014). For the purpose of this research project, the terms mental health 'concern(s)', 'problem(s)', and 'challenge(s)'will be used interchangeably to refer to both of these conditions.

Mental health services "address a range of social, emotional, behavioural, psychological and/or psychiatric problems" for youth who have developed, or are at risk of developing, a mental health problem, illness or disorder (Ministry of Children and Youth Services, 2013, p.5). This includes but is not limited to, brief services, case management, psychiatry, counselling and therapy, psychotherapy, specialized consultation, crisis support services, and intensive treatment services.

1.2 Extent of the issue

In 2002, Statistics Canada conducted the Canadian Community Health Survey (CCHS) – Mental Health and Well-being which sought to collect data regarding psychological well-being, mental disorders, and mental health problems among Canadians over the age of 15. Its results revealed that one in five Canadians experienced high psychological distress and that the "overall prevalence of high psychological distress in the 12 months prior to the survey [was of] 21%" (Caron & Liu, 2010, p. 86). Furthermore, the prevalence of this high psychological distress was highest among Canadians between the ages of 15 and 24 years. In addition, according to Ottawa Public Health (OPH) (2018), 35% of students in grades seven to 12 in Ottawa "scored as having moderate to serious levels of psychological distress over the past four weeks, including symptoms of anxiety and depression such as nervousness, restlessness, worthlessness and sadness" in 2017 (p. 47). This was more likely to be found in those in grades nine to 12 than those in grades seven to eight. These findings are consistent with those from the Centre for Addiction and Mental Health's 2012 Ontario Student Drug Use and Health Survey, which looked into the risk behaviors and physical and mental health of students between 12 and 19 years of age (Audet, 2013). It showed that 34% of students reported high psychological distress, such as symptoms of depression, anxiety, and social dysfunction.

In addition, the CCHS revealed that one in 10 Canadians reported that they were suffering from or had suffered from at least one of the five mental disorders surveyed (i.e. major depression, mania, panic disorder, agoraphobia, and social phobia) or a substance use disorder (i.e. alcohol dependence and illicit drug dependence) in the 12 months leading up to the survey (Caron & Liu, 2010). Of these disorders, major depression proved to be the most prevalent, affecting nearly 5% of those surveyed. Substance abuse was the second most prevalent, followed by social phobia, then panic disorder. Similar to the trend found in psychological distress, “[the] overall prevalence of [these disorders] decreases significantly with age” and Canadians aged 15 to 24 are five times more likely than those over the age of 65 to present with one of them (Caron & Liu, 2010, p. 87). In 2013-2014 in Ottawa specifically, over 71,000 residents over the age of 19 reported being diagnosed with a mood disorder and roughly 59,700 reported having an anxiety disorder diagnosis (OPH, 2018). Although there is a lack of Canadian research on the prevalence of mental health problems and mental disorders among children and adolescents, studies suggest that between 15 and 21% of this population is affected by a mental health challenge (Audet, 2013).

Unsurprisingly, there has also been an increase in the demand for mental health and addictions services across the province of Ontario. According to OPH (2018), “there was a 25% increase in physician visits […] for mental health concerns among children and youth” between 2006 and 2014 (p.26). This was also accompanied by a 56% rise in their rate of emergency department visits for mental health and substance use disorders. In regard to Ottawa’s population aged 15 to 24 years, there has been a drastic increase in their use of health care services for reasons related to mental health and addiction. In 2015, their number of physician visits for such a concern was 689 visits per 1,000 people, as compared to 544 visits in 2006. Between 2006 and 2016, Ottawa’s rate of emergency department visits in relation to mental health and substance use conditions increased by 46% and the population in question accounts for the majority of this rise (OPH, 2018). In fact, the number of emergency department visits for such concerns among those aged 15 to 24 more than doubled between 2007 and 2016. Following suit, Ottawa’s hospitalization rate for mental health and addiction conditions also increased by 45%, primarily due to an increase among individuals between the ages of 15 and 24 (OPH, 2018).

Despite the high prevalence of mental health problems and the evident need for services to address them, there is a major discrepancy between the number of people who would benefit from treatment and those who actually receive it. Based on the results from the 2002 CCHS, “less than 40% of Canadians with a self-identified mental disorder, including substance dependence, consulted at least one type of public, private or voluntary provider in the past year” (Lesage, 2006, p. 15). This rate is likely lower for youth and young people, as being over the age of 24 is positively associated with involvement in treatment (Kessler, 2005). In fact, Canadian reports indicate that only between 25 and 40% of youth in need of mental health services receive them, and that nearly half of Canadians between 18 and 24 with depression are not being treated (Kutcher, et al., 2010).

Furthermore, young people who are involved in services are at a significant risk of disengagement. Several studies have demonstrated that they are more likely to drop-out of services than any other age group (Edlund et al., 2002; Mental Health Commission of Canada, 2015). In fact, roughly 40% of those who are in treatment will terminate their services prematurely (Sylwestrzak, Overholt, Ristau, & Coker, 2015). Studies examining the average length of youths’ involvement in services have estimated that they attend as little as four appointments, and as few as 9% of them are still involved in treatment three months after intake (Kim, Munson, & McKay, 2012).

1.3 Barriers to access

The existing body of literature on the factors that influence young people’s help seeking for mental health problems has revealed that this population encounters several barriers throughout their efforts to access services.

One of the challenges that youth have reported facing is poor mental health literacy (Gulliver et al., 2010; Rickwood et al., 2005). They have disclosed lacking the self-awareness and / or knowledge to identify, acknowledge, and understand their feelings, emotions, and experiences. This prevented them from recognizing these as potential symptoms of a mental health problem.

In addition, this population commonly fails to perceive a need to reach out for professional mental health care; they have reported that they often did not consider their situation as severe enough to require treatment (Sylwestrzak et al., 2015; Wilson, Rickwood, Bushnell, Caputi, & Thomas, 2011). This belief seems to be particularly strong amongst young people (Wilson et al., 2011). They have also stated that they believed that the issue they were struggling with would resolve itself over time and that they were often "not bothered or affected by their problem or symptoms at first" (Sylwestrzak et al., 2015, p.779).

Youth also tend to have negative attitudes about the act of both seeking help and of receiving treatment (Rickwood et al., 2005). This includes negative beliefs such as the thought that reaching out for support is a sign of weakness or personal failure. It can also consist of the presumption that services will not prove to be useful or yield any benefits, or that treatment will not contribute to the alleviation of symptoms (Rickwood et al., 2005; Sylwestrzak et al., 2015).

Stigma is arguably the most prominent barrier associated with young peoples' tendency to avoid seeking support in addressing their mental health struggles. Youth have reported feeling embarrassed about seeking help and uncomfortable discussing their thoughts, feelings, and emotions with others, including professionals (Coyne, McNamara, Gower, & McNicholas, 2015; Gulliver et al., 2010). They have disclosed being preoccupied with what those around them would think if they were to discover that they were suffering from a mental health problem or seeking support in regard to their mental health (Gulliver et al., 2010).

Another group of barriers that have emerged from the literature are those pertaining to the potential source of help itself. This includes certain characteristics of the provider such as their race, the youth's perception of their ability to help, the youth's perception of their credibility, as well as the youth's level of familiarity with them (Gulliver et al., 2010). Many young people have disclosed being fearful of the source of help and worrying that the provider would be disrespectful towards them (Anderson et al., 2017; Gulliver et al., 2010). They have also reported being concerned about the attitudes of the person they would approach for help, and about what that person would say or do in response. In addition, this population is often preoccupied by the possibility that the provider may breach their privacy and break confidentiality by revealing the content of their sessions or the fact that they are seeking services to others (Anderson et al., 2017; Gulliver et al., 2010). Youth have also reported "not being satisfied with the available service providers" (Sylwestrzak et al., 2015, p.778).

Furthermore, young people would often rather rely on themselves than reach out for support, which makes them less likely to attempt to access services (Gulliver et al., 2010). In fact, they commonly do not want to be in treatment because they prefer to address the problem on their own (Sylwestrzak et al., 2015). Many youths believe that they should be independent and autonomous, and that they can or should solve their own problems, which evidently dissuades them from seeking help from a professional (Wilson & Deane, 2012; Wilson et al., 2011).

In addition, this population frequently reports that there is a lack of services available to them, that they lack knowledge about those that are available, and that the available services are often inaccessible. There is a dire lack of services targeting young people with mental health problems (Audet, 2013) and young people are often unaware of the resources that do exist, which leaves them unsure of where to turn for help (Anderson et al., 2017; Gulliver et al., 2010). Even if they do know of establishments that offer services, many do not know where these are located, how to get there, or how to make an appointment (Anderson et al., 2017). Furthermore, the times at which services are offered is also a challenge for youth as these often conflict with their own schedules (Anderson et al., 2017).

A final significant obstacle to access that is highlighted within the literature is that of the infamous waiting list. This population has "expressed their frustration with the fact that their problems were not considered serious enough to get them seen soon", which resulted in a proportion of them not attending their scheduled appointment (Anderson et al., 2017, p. 167). Others have also reported that they've lost interest in receiving services due to the length of time that had, or would have, elapsed between their initial contact with the agency and their appointment (Anderson et al., 2017; Gilmer et al., 2012; Rice et al., 2018).

1.4 Barriers to engagement

If a young person does manage to overcome these challenges and begins to receive services, the majority of these barriers persist and continue to impede on their willingness or ability to stay engaged in treatment.

As previously mentioned, this population's strong desire for self-reliance is a significant barrier to their access to mental health services (Wilson & Deane, 2012; Wilson et al., 2011). This has proved to continue to hinder them in terms of their involvement in treatment; in fact, the most frequently reported reason cited by youth for having dropped-out of services is that they wanted to resolve the issue themselves (Sylwestrzak et al., 2015).

Young peoples' negative attitudes and beliefs also follow them into treatment, and a significant amount of them have disclosed that they disengaged from services because they did not think that they were getting better, and / or because they thought that treatment would not be effective (Sylwestrzak et al., 2015).

Inconvenient scheduling is yet another reoccurring barrier. Youth report that they still struggle with the timing of appointments, which are often only available during school and / or work hours (Anderson et al., 2017; Gilmer et al., 2012). Booking and attending sessions can prove to be a challenge when providers fail to accommodate their client's availability, which arguably increases the likelihood of treatment disengagement.

Young peoples' concerns regarding privacy and confidentiality also persist over the course of the treatment process. They continue to fear that others will discover that they are receiving services or that the provider will inform their parents of the information they disclose during appointments (Anderson et al., 2017). This barrier is more prevalent within the younger proportion of this population and is especially evident when parents attend the sessions as well. In these instances, youth have disclosed that they find it particularly difficult to fully and honestly express themselves (Coyne et al., 2015).

Unsurprisingly, the influence of stigma is still prevalent and impedes on this population's involvement in services. Mental health problems and getting help are both perceived negatively in society which often makes these individuals resistant to continue attending their appointments (Coyne et al., 2015, Gulliver et al., 2010). Many young people have revealed that they were hesitant to disclose their involvement in treatment to others and that the fear of being judged by their peers caused them to feel reluctant to continue receiving services (Coyne et al., 2015). Furthermore, a significant proportion of them have also reported their fears about what others would think of them as their reason for prematurely ending treatment (Sylwestrzak et al., 2015).

In addition to these persisting barriers, several other obstacles also arise over the course of youth’s engagement with mental health services that discourage them from continuing their involvement.

One such obstacle is a lack of information; young people have stated that they felt unprepared for their appointments and as though they were not sufficiently informed about the services they were receiving (Coyne et al., 2015). They often lacked information on crucial aspects of these services, such as the treatment process and the provider’s role.

Furthermore, limited involvement in decisions was also identified as a barrier to engagement among those who make up the younger portion of this age group. They disclosed being unsatisfied with their level of implication and feeling as though their input was disregarded in both the initial decision to receive services as well as those regarding the treatment plan (Coyne et al., 2015).

Another factor that dissuades youth from maintaining their involvement with mental health services is a poor therapeutic alliance between themselves and the professional. Many of these individuals struggle to openly share their thoughts and feelings with the provider, and those engaged in ongoing services have reported that the duration and frequency of sessions did not allow enough time for a bond to be established (Coyne et al., 2015; Gilmer et al., 2012). Many young people have also disclosed that frequent changes in staff subjected them to having to repeatedly recount their experiences and made it difficult for them to develop a strong relationship and build trust with their service provider (Coyne et al., 2015; Gilmer et al., 2012).

1.5 Facilitators to access and engagement

The factors that facilitate youth’s access and engagement have not received nearly as much attention in research. A few studies suggest that positive past experiences, social support and encouragement, mental health literacy, positive attitudes towards help-seeking and treatment, as well as established and trusted relationships positively contribute to this population’s access to services (Gulliver et al., 2010; Rickwood et al., 2005; Wilson & Deane, 2012).

CHAPTER 2: HELP-SEEKING THEORY AND ECOLOGICAL SYSTEMS THEORY

2.1 Help-seeking theory

A long and interdisciplinary history underlies help-seeking research; consequently, there is a lack of consensus in the literature as to the definition of help seeking (Rickwood et al., 2005). The most comprehensive explanation was put forth by Barker, Olukoya, & Aggleton (2005), who define it as "[any] action or activity carried out by a person who perceives [themselves] as needing personal, psychological, affective assistance or health or social services, with the purpose of meeting this need in a positive way" (p.316). Rickwood, Deane, Wilson, and Ciarrochi (2005) expanded on this by stating that help-seeking "is about communicating with other people to obtain help in terms of understanding, advice, information, treatment, and general support in response to a problem or distressing experience" (p.4). As such, it is an adaptive way of coping with adversity that is "often based on social relationships and interpersonal skills" (p.4). They also put forth that help-seeking is an effective strategy that takes on an 'approach' style of coping in which "a problem is acknowledged and actively addressed in some way" (p.5).

According to these authors, help can be sought from both formal and informal sources. The former source consists of what could be considered 'professional' forms of support (i.e. counsellors, psychologists, medical staff, teachers, youth workers, etc.), while the latter is representative of the people with whom the individual has a more 'personal' connection (i.e. family members, friends, members of the community, etc.) (Barker et al., 2005; Rickwood et al., 2005).

One aspect of help-seeking that is generally accepted is the notion that this behaviour is not a singular action, but rather a process. However, several models and theories that underlie this process have been proposed, and one has yet to be agreed upon (Gulliver, Griffiths, Christensen, & Brewer, 2012). Rickwood and her colleagues (2005) conceptualize help-seeking as "the process of actively seeking out and utilising social relationships, either formal or informal, to help with personal problems” (p. 8). According to their model, this process occurs in four steps. The trajectory begins when an individual becomes aware of their symptoms and acknowledges the presence of a problem, then assesses their ability to solve it themselves. If they determine that another person’s assistance is needed, the individual must then be able to articulate and feel comfortable expressing the problem and their need for help to another person in such a way that this person will understand. Following this, the individual must search for and identify potential sources of help, and these sources need to be available and accessible. Finally, they must be willing and able to disclose their problem and their need for assistance to these resources (Gulliver et al., 2010; Rickwood et al., 2005).

Within the field of help-seeking research, barriers consist of factors that inhibit an individual from seeking help, that impede their access to or use of services, or that hinder the success of services (Wilson & Deane, 2012). Facilitators, on the other hand, are the factors that encourage an individual to reach out for support, that enable their access to or use of services, or that enhance the success of mental health services (Wilson & Deane, 2012; Rice et al., 2018).

Barriers and facilitators can be categorized according to whether they occur on the personal or structural level; personal barriers are typically belief-based and intrinsic to the individual, while structural barriers are the result of the system and are usually out of the individual’s control (Barker et al., 2005; Rice et al., 2018).

This research project adopts Rickwood and colleagues’ (2005) help seeking model because it was developed by researchers who have conducted many of the studies on this subject. It is also based on a body of research that specifically addresses young people’s help-seeking for mental health problems. In addition, other help-seeking theories tend to emphasize the “social and economic factors that affect access to services”; however, this model also accounts for the “individual and psychological factors that facilitate or inhibit” help-seeking (Rickwood et al., 2005, p. 8).

2.2 Ecological systems theory

Bronfenbrenner first proposed the Ecological Systems model in 1973 and it has since undergone several modifications, with its most recent version having been published in 2006 (Rosa & Tudge, 2013). The approach posits that human development is influenced by six interdependent and interactive systems; it can best be illustrated through a comparison to a ‘Russian doll’ in which each system is contained within another. The first and smallest system, the Ontosystem, refers to the individual themselves. This includes their strengths, weaknesses, personality traits, abilities, as well as their physical and biological characteristics (Rosa & Tudge, 2013). This is enveloped in the Microsystem, which is composed of the person’s immediate family (i.e. their parents and siblings) and the individual’s relationships with these people. The third system, the Mesosystem, contains the various environments that the individual frequents on a regular basis such as their home, school, work, and / or community (Rosa & Tudge, 2013). These environments often interact with each other and the relationships between them also play a part in development. These systems are imbedded within the Exosystem, which comprises the many systems in which the individual does not directly participate, but that still exert an influence on them, their lives, and their development. The fifth, named the Macrosystem, consists of the socio-political context in which the person lives; found within it are the governmental policies and current issues that influence society at large (Rosa & Tudge, 2013). Finally, the last and largest system, the Chronosystem, refers to the socio-historical context of the individual’s life; the stage of life that they are in, their past experiences, as well as broader temporal implications all affect development (Rosa & Tudge, 2013).

This approach allowed the study to explore and investigate all of the different aspects of the young person's life, as it takes into account the different environments and contexts that individuals live in. It also led to a better understanding of the social reality of the research participants (Lacharité, 2013). During the analysis of the data, the use of this model informed the interpretation of the participants' responses, while in the presentation of the results, this perspective demonstrated that the barriers to access and engagement stem from a variety of 'systems' and that young people are not solely to blame for their limited involvement in services (Kim et al., 2012).

CHAPTER 3: METHODOLOGY

This research was conducted with the intention of gaining a better understanding of the experiences of young people in relation to their access to and engagement with mental health services. The project was guided by the following 3 questions; What barriers and facilitators did young people encounter over the course of their help-seeking process and in their ongoing involvement in treatment? How did these barriers and facilitators impact the youth's level of satisfaction with services and the progress they made while in treatment? How can young people's access to and engagement in mental health care be facilitated?

3.1 Methodological approach

This study was heavily rooted in a qualitative approach, which seeks to understand a given phenomenon rather than to quantify it, and aims to create exploratory, descriptive, or comprehensive knowledge about a behaviour, a situation, or a social problem (Anadón & Guillemette, 2007; René & Dubé, 2015). The use of this method allowed the project to explore the interactions that occur between the various barriers and facilitators within the youth's trajectory, and investigate the effects that these have on the individual's level of satisfaction with the service as well as the progression of their treatment (Mucchielli, 2007). It also allowed for a better understanding of the issue, as it is designed to describe the experiences and perceptions of the participants, all the while taking into account each of their complex and subjective realities (Padgett, 2016).

3.2 Data collection

The data was collected through an individual semi-structured interview conducted with each of the study's participants; the exchange took place virtually via video-chat. Savoie-Zajc

(2016) describes this method as a verbal interaction subtly guided by the researcher, who follows the rhythm and content of the exchange, for the purpose of addressing the general themes that they want to explore with the participant. Through this interaction, the two collaboratively build a rich comprehension of the phenomenon in question. In semi-structured interviews, the participant is able to describe their experience in detail, and these allow the researcher to clarify what the participant thinks but can't be observed, such as their thoughts, feelings, intentions, etc. (Savoie-Zajc, 2016). This method was particularly well suited for the research project as it allows for the understanding of the complex behaviors of others (Savoie-Zajc, 2016). In addition, it serves to highlight the individual's perspective on a given subject, which contributes to its understanding. During semi-structured interviews, there is a real exchange between two people; one who wants to express their thoughts and another who wants to better understand the thoughts of the other (Savoie-Zajc, 2016).

Although the form that this method takes does quite resemble a conversation, the themes that were discussed were predetermined and there was a certain structure to the interaction. This method entailed the use of an interview guide (Savoie-Zajc, 2016) (see Annex A – Interview guide). The guide ensured that the research questions were addressed and helped the participant organise their responses. While this guide was important, it was also subtle and flexible; it was not relied on too heavily, as the success of the interview also depended on the relationship established between the interviewer and the participant (René & Dubé, 2015; Savoie-Zajc, 2016).

The content of the interview was audio- and screen-recorded. Precautionary measures were taken to avoid any technical difficulties; this included as doing test calls and recordings as well as ensuring that the interviewer's laptop was fully charged. In addition to the recordings, handwritten notes were also taken over the course of the interviews. These allowed the interviewer to write down things that needed to be clarified or followed-up on, as well as new ideas or understandings that emerged. This was also helpful in keeping the researcher attentive and could have served as a backup had any technical difficulties arisen (Savoie-Zajc, 2016).

The recordings were then transcribed into verbatims, which contained all of the interview's verbal content. This allowed for the data to then be analyzed more finely because the transcriptions closely resembled the interview (Savoie-Zajc, 2016). However, this process was very tedious and also didn't include any non-verbal content such as the participant's attitude, the tone and pace of their voice, their movements, or their posture.

3.3 Sampling method and selection criteria

A study's chosen sampling technique depends on its research questions and target population, as well as the constraints that are imposed on the researcher conducting it (Beaud, 2016). This project used a non-probabilistic sample as the participants were chosen based on the specific characteristics of the target population in question (Ouellet & St-Jacques, 2000). This technique is often favoured by qualitative studies in the field in social sciences and is particularly useful when the objective of the research is not necessarily to measure a phenomenon, but rather to discover the logic behind it (Beaud, 2016; Ouellet & St-Jacques, 2000). Non-probabilistic samples are said to be more economical and convenient, as well as easier to understand and apply. However, they are not as representative as probabilistic samples, and thus, the results that emerge from studies that make use of them are not as generalizable (Beaud, 2016). The study's sample also consisted of a voluntary sample as it called upon volunteers to constitute it (Beaud, 2016). This sampling technique was particularly appropriate as the research topic is considered quite taboo or intimate. One criticism of this type of sample is that the participants that it generates all tend to have certain psychological characteristics, such as the desire to please or the need to solve problems, which can limit the generalizability of the study's results (Beaud, 2016).

The sample for this research project consisted of individuals between the ages of 16 and 24 years who were experiencing or had experienced a mental health concern and had consulted or were consulting professional services to address it.

The age range was selected based on the fact that studies have shown that youth and young people are least likely to seek professional help (Rickwood et al., 2007) and most likely to disengage from services (Edlund et al., 2002; Mental Health Commission of Canada, 2015).

Participants were either living with or had experienced a mental health problem or a mental disorder. A mental health problem is defined as an emotional, cognitive, and / or behavioral difficulty that compromises an individual's ability to function and that typically arises as a result of significant environmental stressors (Mulvale et al., 2014). A mental disorder, on the other hand, is a condition that is diagnosed by a qualified health care professional according to internationally established and recognized criteria, and results from a complex interaction between an individual's genetics and their environment (Mulvale et al., 2014). Both of these conditions were included as it is possible to receive mental health services without a disorder or diagnosis.

All of the participants had been involved in some form of mental health treatment for at least 2 months. These "address a range of social, emotional, behavioural, psychological and/or psychiatric problems" for youth who have developed, or are at risk of developing, a mental health problem, illness or disorder (Ministry of Children and Youth Services, 2013, p.5). This included, but was not limited to, brief services, case management, psychiatry, counselling and therapy, psychotherapy, specialized consultation, crisis support services, as well as intensive support services. Due to the fact that the research project sought to identify the factors that facilitate or hinder access to and engagement with services, it was essential that participants had received said services. In addition, they had to have been consulting professional help for at least two months because otherwise, they wouldn’t have been involved for long enough to be able to determine whether their level of satisfaction or perceived progress was affected.

The number of participants was restrained to five individuals due to limits in terms of time, finances, and resources; they were selected on a first-come, first-served basis.

3.4 Recruitment

The members of the sample were recruited through various social media platforms (i.e. Facebook, Instagram, Snapchat, and Reddit). A ‘poster’ was created to facilitate recruitment (see Annex B – Recruitment poster); it included the relevant information pertaining to the research as well as the inclusion criteria. It also provided the primary researcher’s contact information and encouraged those who were interested in participating to get in touch. The poster was shared on the primary researcher’s personal social media profiles and posted in the ‘uOCollective 4 Mental Health’ Facebook page. A text post with this information was also made within two local Reddit communities (r/Ottawa and r/geegees). This recruitment method was chosen because it is aimed towards the target population (Turcotte, 1997). It can also be done relatively quickly and easily and is inexpensive. In addition, this method reinforced the fact that participation was voluntary; it was important to avoid having potential participants feel as though they needed to participate. This recruitment method ensured that individuals didn't fear that their access to services would be negatively impacted by their participation, or lack thereof, in the research project.

3.5 Data analysis

The collected data was analysed through a qualitative analysis, which is used to extract information from a set of documents for the purpose of discerning the themes and ideas that are present within them (Leray & Bourgeois, 2016). This involved classifying the elements of a document into categories so that different characteristics emerge, which allowed for a better understanding of their meaning (L'Écuyer, 1987). More specifically, the general inductive approach was adopted. It's purposes are to "condense raw textual data into a brief, summary format", "establish clear links between the […] research objectives and the summary findings" and "develop a framework of the underlying structure of experiences or processes that are evident in the raw data" (Thomas, 2006, p. 237). In this approach, although the analysis is guided by the research objectives, the categories within which the data is organised are not pre-determined; rather, they emerge from the analysis itself (Thomas, 2006). This method follows a process which includes five steps; in the first, all the data is made to match a consistent format (Thomas, 2006). The second involves detailed readings of the data and in the third, the researcher identifies the themes or categories that they discovered in their readings. The fourth step involves eliminating certain categories in order to reduce overlap and redundancy between them. Finally, the researcher revises and refines the categories by combining those that have a similar meaning and identifying extracts that "convey the core theme or essence of a category" (Thomas, 2006, p. 242). In the end, the researcher is left with a few categories that they believe reflect the central elements of the data and are most important, given the research objectives (Thomas, 2006).

The general inductive approach was selected because it was the primary researcher's first time conducting a qualitative analysis, and this is a simple and nontechnical means to do so (Thomas, 2006). It is easy to use, has a systematic set of procedures, and "does not require indepth understanding of a specialist approach" (Thomas, 2006, p.245). As such, it was a "straightforward option for analyzing qualitative data" that still produced reliable and valid findings (Thomas, 2006, p.245).

In order to facilitate the interpretation and the presentation of the study's results, an analysis guide was constructed (see Annex C – Analysis guide). It contained four tables, each relating to one of the study's research questions. The first table was used to organise the information pertaining to the barriers and facilitators identified by the participants. It was made up of five categories based on the themes that emerged from the data; individual, network, service / treatment, provider, and society. Each of these categories was divided to include a 'barrier' and 'facilitator' section. The data related to the effects of these barriers and facilitators on satisfaction and progress were imputed into the second and third tables respectively. The fourth and final table included all of the participant's recommendations as to how young people's access to and engagement in mental health services could be facilitated.

3.6 Ethical considerations

The participants' clear and informed consent was obtained verbally. Prior to the interview, they were sent the Consent Information Form via email and asked to read it through (see Annex D – Consent information form). This form included information pertaining to the purpose of the study and the details regarding the individual's participation in it. The form addressed the potential risks that participation entailed, and the measures that would be taken to minimize these risks. It also informed the individual of the potential benefits that may come of the study. In addition, the form assured participants that the primary researcher would respect their confidentiality and anonymity by describing the measures used to do so. It also detailed how the data collected would be conserved and subsequently disposed of. Furthermore, it mentioned the compensation that participants would receive in exchange for their time. The individuals were also reminded that their participation in the study was voluntary and assured them that they would not suffer any negative consequences should they decide to withdraw. At the beginning of each interview, the primary researcher asked if the participant had read the consent information form and encouraged them to ask for further details or for clarification.

Due to the sensitive nature of the research topic, the participants ran the risk of feeling uncomfortable and / or experiencing unpleasant emotions during and / or following the interview. In order to minimize these risks, each participant was allowed to take as much time as needed to answer the questions, take breaks if needed, and could chose not to answer any of the questions. In addition, following the interview, participants were provided with a list of resources that they could contact if they felt they needed support.

3.7 Limitations

A few limits to this study need to be considered. Most notably, due to the timing constraints imposed by the fact that this is a master's level research project, the number of participants was restrained to five individuals. As such, its results are not very generalizable. In addition, all of the research participants were English-speaking and identified as women; as such, this study's results may not adequately represent the challenges faced by linguistic minority communities or be representative in terms of gender. It is likely that these groups and people of other gender identities face different barriers and facilitators that affect their access to and engagement with mental health services. Furthermore, every member of the project's sample had received some form of treatment for a period of at least two months. Therefore, the results may not reflect the experiences of individuals who encountered barriers so significant that they either dropped out of services before having been involved for this amount of time or were unable to access services at all.

3.8 Potential contributions

This study contributes to the limited body of research that has been conducted on this topic as little is known about the facilitators to access and engagement amongst this population. To the primary researcher's knowledge, there have been no studies that have investigated the potential effects of barriers and facilitators on perceived satisfaction with services or treatment progress. The results may also contribute to the advancement of practices, because service providers may use this information to adapt their interventions to the needs of young people. In fact, when providers "are aware of the barriers that youth face and the reasons that youth are reluctant to engage in treatment [, they] are better able to address these issues and prevent early dropout and premature termination" (Sylwestrzak et al., 2015, p.776). In addition, while previous studies have provided suggestions for measures that could be taken in order to facilitate young people's access to and engagement with mental health services, these were provided by the researchers. In the context of this research, the participants were the ones to provide such recommendations.

CHAPTER 4: ANALYSIS

This chapter analyses the project's results related to the participants' experiences accessing and engaging in mental health services. In order to contextualize the research, the first section presents the characteristics of the sample and the individuals it was composed of. The 10 subsequent sections address the barriers and facilitators that were identified in relation to the five categories listed the analysis guide (i.e. individual, network, service / treatment, provider, and society). The first category of factors is those related to the youth's own cognition, while the second includes those related to the young person's entourage. The third refers to elements associated with the service or treatment itself, and the fourth revolves around those that concern the professional providing them. The last category pertains to the factors having to do with society's norms, values, and beliefs. The two final sections discuss the youths' perceptions of how the barriers and facilitators affected their satisfaction with the services as well as the progression of their treatment.

4.1 Profile of participants

The study's sample was composed of five young women aged 19 (2), 20 (1), 23 (1), and 24 (1). All of the participants self-identified as experiencing a mental health concern and had been involved in treatment for at least two months.

Although a formal diagnosis was not required to participate, the following were among the mental health challenges disclosed by the participants; Anxiety, Depression, Attention Deficit Hyperactivity Disorder (ADHD), Dissociative Identity Disorder (DID), Other Specified Feeding or Eating Disorder (OSFED), Borderline Personality Disorder (BPD), and Post-Traumatic Stress Disorder (PTSD). It's important to note that each participant reported being formally diagnosed by a professional with at least two of these conditions.

All but one of the participants was involved in treatment at the time of their interview, and all but another had received some form of mental health services prior to the age of 16. The participants had all consulted several of professionals including psychologists, psychiatrists, psychotherapists, counsellors, medical doctors, and nurses, among others. In addition, some youth were involved with more than one service at a time.

Vito has been diagnosed with severe Generalized Anxiety, major Social Anxiety, and major Depression; she also presented with binge-eating and restricting or purging behaviors, as well as somatization. Vito had received both inpatient and outpatient services with a children's hospital, as well as outpatient services from a mental health hospital. In the past, she had also consulted a psychologist and multiple counsellors through her university's student services, as well as a psychiatrist at a private health clinic. At the time of her interview, she had been seeing a psychologist in private practice for about a year and was being followed by her family physician for medication management.

Ani was diagnosed with Depression in her early teens, with Anxiety in her late teens, and with ADHD as a young adult. In addition, some therapists have suggested that she also exhibited tendencies that would be consistent with the symptoms of PTSD. Since the age of seven, Ani has been involved with various counsellors, therapists, social workers, as well as other mental health professionals and social service providers. She had accessed and attempted to access multiple public services at the community level and has received treatment in the private sector. Ani was also involved in virtual counselling through an online platform for one year. Although she was not in treatment at the time of the interview, she was actively seeking help.

Donatella has been diagnosed with Depression, DID and an OSFED. She was previously diagnosed with Schizophrenia and BPD, although both of these diagnoses have been overturned.

In the past, Donatella was seen by several psychologists and psychiatrists from different hospitals and received treatment from her family physician. She has had multiple hospitalizations, spent 6 months in a residential treatment facility, and has attended group therapy programs. At the time of her interview, she was seeing a psychologist privately, receiving outpatient psychiatry services, and was involved with a mental health case manager.

Marley has been diagnosed with Anxiety and Depression since early 2019 and received a BPD diagnosis roughly 6 months after her 18th birthday. She has had several visits to the hospital emergency department as well as short-term admission to an inpatient hospital mental health program due to suicidality. Marley also saw a mental health counsellor and a psychotherapist in the past. At the time of her interview, she was receiving outpatient psychiatry services and attending a weekly Dialectal Behaviour Therapy (DBT) program offered by a private clinic; this involved group meetings as well as individual sessions with a psychologist.

Brittany was diagnosed with Generalized Anxiety and Depression in her mid-teens and with PTSD at the age of 18. She was involved with a few therapists and counsellors in the private sector on-and-off throughout middle- and high-school and once accessed the counseling services offered by her university's student service. Brittany consulted her family doctor for diagnoses and her medication regimen was being managed by them as well. At the time of her interview, she was undergoing treatment with a psychotherapist in private practice and had been doing so since January of 2020.

4.2 Individual - Barriers

4.2.1 Poor mental health literacy

All of the study's participants spoke of lacks in their knowledge about mental health problems and their associated symptoms. They did not know much about their conditions prior to being diagnosed, which prevented most from recognising their symptoms as such.

> So yeah, I was not recognizing my inability to get out of bed for 4 months as a symptom. I was like "Nah. Sometimes people are just tired for 4 months. It's okay". […] To me, it was like Autism is a real thing because it's super obvious. PTSD is a real thing because you could see it, the symptoms are super clear. But Depression and Anxiety aren't because they're sneaky. – Ani

Furthermore, Vito and Brittany both disclosed that even when they knew that they were struggling, they found themselves minimizing their symptoms or the severity of their situation.

> Like "Oh, it's not that bad, I just get a little anxious". – Vito

> "Maybe I'm just being overdramatic right now and it's actually not that serious". – Brittany

Vito explained that a lack of self-awareness also played a part in this. She stated that she had difficulty acknowledging that she was experiencing a mental health concern because she had always felt this way and simply assumed that everyone felt as she did.

Most participants also mentioned not knowing how to express their thoughts and feeling uneasy about discussing their mental health. Additionally, three of them stated that they wanted to avoid confronting the issues that they were facing.

> Opening up about something like that is kind of uncomfortable. No one is always – I don't think – fully comfortable talking about their mental health. – Marley

> It was really different, and I was scared of change and scared of changing my old habits and old ways. […] At that point, I guess I got a bit scared to deal with my emotions and the real stuff. […] You get there and you’re like “Okay, this is fine. I can do this”. And you start working and you're like “Okay, I want to work. I want to get better”. And then shit gets hard and you're like “Fuck this; I'm out”. – Donatella

4.2.2 Negative attitudes and beliefs

Four participants disclosed that they had negative attitudes and beliefs about asking for help and about treatment, which was detrimental to their access and engagement. They spoke about having trouble admitting that they needed help, preferring to ‘deal with it’ themselves, and / or not wanting to burden others.

> I think it’s part of my ego - it’s hard to accept the fact that I can't do it on my own. […] Like, “I should be able to do this on my own”. It’s hard to accept that you need all this support around you. You see some people and they don't need medication to function and they don't need to have weekly appointments with all these professionals. And you're like “Why am I like this? Why do I need this help? I feel really dumb, I feel really stupid, I feel really incompetent”. It’s hard on the ego and on your self-esteem sometimes. – Donatella

The youth also reported thinking that the service either wouldn’t work out or wouldn’t actually be helpful.

> I'm always scared that I'm not going to get what I hoped I was going to get or that I'm going to get disappointed or that it won’t fulfil what I was hoping for. – Donatella

Such negative beliefs persisted throughout their involvement, which made them reluctant to keep engaging in treatment.

> And I think that was the other frustrating thing too - when I felt like it wasn't working. […] Sometimes I just felt like "Oh, why bother? It's not worth it. It's lot of time and a lot of effort on both our parts. There's no point, it's not doing anything". So, I was like "You go about your business, I'll go about mine; we'll just part our ways". – Vito

An interesting point raised by Marley was that she feels as though one of the reasons that people hesitate to reach out for help is due to the accounts that they hear from others who attempted to access services but were denied or who were subjected to poor quality treatment. This discourages them from reaching out for help as they believe the same will happen to them as well.

> And that's just very frustrating because I feel like – and this might answer your question from a bit earlier about why people are kinda afraid to go and do therapy – it's because they hear so many stories of people being failed so, personally, they just feel like they're going to get failed. – Marley

4.2.3 Symptoms

Each of the youth described how the various symptoms associated to their mental health concern(s) played a role in the difficulty they experienced in reaching out for support and maintaining their involvement in services. Although this was true of ADHD and BPD as well, it was most evident in Anxiety and Depression.

The participants spoke of feeling anxious about doing things like making phone calls and scheduling sessions; they also worried about how the meetings themselves would unfold.

> I was very anxious – I still get anxious sometimes before appointments. Just worrying, like, "What am I going to talk about? Am I going to cry for the whole appointment? What if it doesn't work out?". – Vito

Ani recounted a time when her anxiety prevented her from attending one of her sessions;

> I had an appointment with a mental health person, and I had the means to get there and I knew where the place was - but when I left the house, I looked at the clock and realised that I was going to be late. And I was like “Well, I don't want to go if I'm going to be late”. So, I called, I cancelled, and I sat in a parking lot for like 6 hours, just being like “You're so stupid. How could you leave the house 5 minutes late?”. And so yeah, that’s totally on me; that’s my own symptoms of being really anxious and trying to do it perfectly. – Ani

The feelings of hopelessness, the lack of motivation, and the low self-esteem that are commonly experienced by those with Depression also significantly impacted these young people.

> And you feel like a burden and like you're a waste of time. Sometimes I feel like that’s just the depression talking. You just don't feel like you're worth it or worth anybody’s time or anything else. So, you just want to save everybody the trouble, right? […] When you're dealing with depression and they're trying to adjust your meds, you don't really want to do it if you're not even motivated to get out of your bed, you know? […] And that’s why it took me so long to get engaged in treatment; it’s because when you're not on the right medication and you're always depressed, it’s hard to have goals which means it’s hard to find the motivation to go to appointments. – Donatella

4.3 Individual – Facilitators

4.3.1 Mental health literacy

Self-awareness was identified as a facilitator that lead to the youth recognizing that they were struggling. This ability allowed them to identify behaviors and / or feelings as symptoms and therefore acknowledge that they were in need of some support.

> I really just had to sit myself down and be like “Okay, you're not yourself. What's going on?” and feel what my body was saying to me. Because your body is your biggest indicator to tell you when something's wrong. […] But just acknowledging it and being like “Okay, I'm not feeling my best right now”. And then that’s when I brought it up to my parents’ attention. – Marley

For Vito and Donatella, this skill was developed thanks to the services they had received in the past.

> Throughout the counselling and stuff, I learned a lot more to be very self-aware and be more introspective. […] I start to recognise certain situations and triggers. And I started noticing that I was coping in certain ways and I was like “Ouh, I haven’t done this in a while, and I shouldn’t be doing this”. – Vito

4.3.2 Knowledge of services

Two participants reported that the knowledge they had acquired through their past experience in services helped them in their later access and engagement. Vito, who had extensive prior involvement in the health care system, attributed the greater ease with which she could navigate and engage with services to this. For Ani, the first few sessions with a new provider were facilitated by the fact that she had previously consulted many mental health professionals and was therefore familiar with the process.

> I knew how the game went. Like, you sit down and in the first session your therapist wants to spend like a half hour going over consent. And it’s like “No, I get it; you only have to call the police if I say that I'm going to kill myself at 3 o’clock or I’ll kill him at 4 o’clock. We can skip half of that”. […] Yeah, in 2017, that was a huge learning curve. Like, “Woah!

> This is how therapists work?”. And then once I knew, it made it a lot easier to connect with a new therapist because I get the routine, we can dive right in. We can spend the first 10 minutes of our first session being like “I'm depressed, I have anxiety, my dad is an asshole, I consent. Okay, so today’s issue is that my boyfriend is mean to me”. I didn't have to spend so much time getting adjusted to my therapist. – Ani

4.3.3 Positive attitudes and beliefs

Having positive attitudes and beliefs about treatment also emerged as a facilitator to engagement. Ani, Donatella, and Marley all spoke of how seeing their treatment as valuable and helpful made it easier for them to continue in their efforts. This was evident in their comments about noticing that they were applying the skills they had learned and recognizing their accomplishments.

> I would catch myself doing the therapy to myself, you know? I’d mess up on something and I’d be like “Urg, you're so stupid! You're the stupidest. You're the total and absolute worst”. But then I’d be like “Well, I'm not the total worst. Let’s list 5 people who could be worse”. And I was like “That’s exactly what [therapist] says to me all the time!”. So, I could hear their voice in my head, and I was like “Woah, I integrated the thing!”. – Ani

> My [case manager] - she reminds me every so often about the progress that I've made, and it’s very, very, very, very, very, encouraging to see how far I have come. So, that makes me want to work at it more and be like “Okay, next goal! Next thing on my list!”, you know? When I see how far I've come and I compare myself to how I was before, it’s easier to want to do it more. – Donatella

4.4 Network – Barriers

4.4.1 Unsupportive family members, friends, or peers

All five participants disclosed that the strained relationships they had with family members hindered them in terms of their help-seeking process and their ongoing participation in services.

> My family was not a mental health - anything. […] So, I grew up with a narrative of "That's bullshit". […] From [my dad] - my mom was a different story. But then it was patronizing to hear it from my mom. My mom would be like "You know, some people have depression" and I was like "Shut the fuck up. Don't talk down to me, that's not a thing". – Ani

> I've never really been close with my dad, but I've tried to open up to him about it and he's told me I was crazy before. He's not supportive of it; he thinks I shouldn't be on medication, yet the guy doesn't even really know how I am without it. – Brittany

They also reported being fearful of how their parents would react if they were to tell them they were struggling and feeling that their parents would be disappointed.

In addition, it was difficult for some when their friends and peers didn't understand mental health or what it is like to struggle with it.

> But my friends, some of them didn't really understand. […] Yeah, when you're young and you get hospitalised and people don't really understand why you're not at school and stuff. And then they start asking questions and you don't really want to tell the truth because it's easier to say that you have a physical illness than a mental illness because people understand better. They're like "Ah, okay, she can't come to school", but if you say "Oh, I'm depressed, I can't come to school", they're like "Why?", you know? – Donatella

4.5 Network – Facilitators

4.5.1 Existing connections to professionals

Each of the youth stated that already having an established relationship with some kind of health care or mental health professional was also helpful in getting access to new or additional services. When youth were already receiving one kind of service but needed another form of support, they appreciated getting suggestions or referrals.

> And my inpatient psychiatrist from the hospital that was dealing with me, she referred me to a bunch of groups. – Marley

In cases where the youth was facing involuntary termination, it was helpful when the practitioner connected them to another professional prior to ending the service.

> But they were trying to help me transition, they had set me up with a counsellor in [city] so I just sort of had to make it a few months. And they stretched the limits a little bit; they were like "We can see you a little bit as part of the discharge process, and then when you get to [city], there will be someone waiting". – Ani

4.5.2 Supportive friends and peers

The youth also benefited from having people with whom they felt comfortable talking about their mental health. For Vito, Donatella, and Brittany, their friends and peers encouraged them to seek treatment and even made recommendations about potential sources of help.

> She would talk to me about like "You don't want to end up like that. You hurt a lot of people in your family. A lot of people love you and care for you. You probably don't realise that right now, but it would hurt a lot of people, including me". So that made me want to get help even more. – Donatella

> She knew more about campus because she worked for the school and stuff. I definitely trusted her opinion, and I literally asked her "Should I?". So, she definitely convinced me more. […] She recommended me places and she sent me a link - I think it was her - a link to mental health services or something. – Brittany

All but one of the participants also stated that having positive relationships with their entourage encouraged them to stay active in their treatment process.

> I just feel like I have a good support group everywhere with my therapist, my family, my friends, my DBT group. […] And for the DBT group, we have a very close and intimate group, and we're very nice with each other, so that's always helpful. – Marley

4.5.3 Supportive parents

Despite the aforementioned troubled relationships that participants had with their families, each of them also gave examples of how their parents positively impacted their access to and engagement in services. They shared stories of how their parents encouraged them to seek professional help and, on several occasions, parents were the ones to search for, identify, and reach out to services for the youth.

> Yeah, well, having a family that's really supportive and that was super involved was really helpful because they want to help you, they push you to get help. If I didn't have that, I probably wouldn't have [sought] help [as early], per say. – Donatella
>
> My mom and I are really into more natural stuff, so my mom found [psychotherapy service] and she's like "Oh my God, you're going there!". […] So, my mom found it, probably from her friends or on Facebook or something, honestly. – Brittany

Understanding parents were also helpful when the young person would have had difficulty getting treatment due to a lack of transportation or the financial means to pay for it.

> I don't drive but my parents do. So, they take me to and from appointments. But we live in [outskirt area], and there's no busses, so I'm lucky because otherwise - like if I lived alone - there is no way I could go to appointments. […] But I am able to pay for it and I do have parents who are like "If you need me to help you pay, I will". – Vito

Furthermore, each of the participants described how their parents' support significantly contributed to their ongoing participation in services. This was especially true for Marley, whose parents took a very active role in her treatment.

> They have done a bunch of research on it to get to know it. […] So yeah, every day after my individual therapy I just explain to them what I went through. So, kind of keeping them in the loop because they're interested in it. And then I always show them what I do in my group. […] Yeah, so for me, I guess what has helped and what has made it easier is being transparent with them. […] But honestly, when you have parents who are willing to learn about it, and actually try and make a difference. – Marley

Vito, Ani, and Brittany's parents helped them by ensuring that they were following their treatment plan and attending their sessions.

> Also, my mom would be like "When are you next seeing your therapist?" and I'm like "Wednesday". And then Wednesday would come around and she'd be like "What time are you seeing your therapist?" and I'd be like "Oh, at 1". And she'd be like "Okay, well, its 12:30", you know? Cause then it's okay to talk about it, and we've talked about it, and now I'm accountable. People know that I have therapy at 1 so I have to go, or else people will think that I'm a slacker. – Ani

Donatella expressed just how thankful she is for her parents in the following statement;

> If I didn’t have my parents to advocate for me and stuff like that – like let’s say I was living on my own or I had no support - I don't know what I would do. I would probably be dead right now. I'm not going to lie – I'm sorry to be super upfront – but I'd probably not be alive or just be in a basement all the time and just not seeing daylight. – Donatella

4.6 Service / treatment – Barriers

4.6.1 Service inaccessibility

Although some faced more challenges in respect to this than others, all of the youth stated that they had trouble accessing and engaging in treatment due to difficulties in terms of identifying potential sources of help, strict access requirements, strenuous request processes, as well as inconvenient appointment times.

> So, I found my own therapist, but it was a whole process! You have to apply on the portal online. […] I think I applied to 2 or 3 different people, and 2 or 3 different people gave me phone calls and we chatted, and I was like “Okay, I like you”. And that’s how I picked my therapist for the summer. […] But you just get exhausted of checking “Are you depressed?”, “Yes”. “Are you anxious?”, “Yes”. “Describe your situation briefly.”, “Have you had thoughts of suicide in the last 2 weeks?” and I'm just like “Oh my God, I just did this for the last 3 guys!”.

Another barrier faced by Marley and Donatella was restrictive eligibility criteria. The two spoke at length about how discouraging it was to not be seen as ‘bad enough’ to get help and how frustrating it was to not be taken seriously when they attempted to access services.

> And as an adult or an older teen, it’s so freaking hard. You go and you have to be hospitalized multiple, multiple times for them to be like “Oh, she's really having a hard time” or “Oh, she really needs help”. […] When you're not really struggling, they don't really care, I guess. – Donatella

In addition, many community-based agencies targeted towards children and youth only accept clients under the age of 18, and many ‘adult’ providers cannot accept clients bellow the age of 18. This put Ani in a precarious situation;

> Being right on the edge of the “Am I a youth or am I an adult?” thing was actually really troubling. Because at 17, when I was trying to find a new counsellor, they were like “Well, we can't talk to you yet, not until you're 18” but I was like “Well, these people can't talk to me after I'm 18” so I would have loved for it to overlap a little bit. – Ani

Furthermore, these age-based restrictions forced Vito, Ani, and Donatella out of the services they were receiving.

> But like, look at the people who turn 18 and they're kicked out and they completely go off the map. […] It sucked! I went from having a bunch of supports to nothing. And I was like “What am I going to do with myself? I don't have the help that I need”. I just felt very abandoned and given up on. And just like “I don't know how to get the help that I need now” and “I'm an adult now and I have to find my own help”. – Donatella

4.6.2 Service inadequacy

Insufficient or inappropriate services were also an issue for both access and engagement. Ani explained how she found it challenging to find agencies or organizations that offered the type of treatment that she needed. The services that were available to her were often limited or short-term; this was especially evident in the case of the free or subsidised services offered in the community or through student services.

> I couldn’t afford the higher end stuff and the lower end people didn't really want me; they were like “Look, it sounds like you’ve had a lot of counselling. You need long-term stuff and we can't offer you that; that’s not what we do”. […] So, I did go back to the [university] campus a few times to try to find something and they can only offer you 2 sessions of crisis counselling. But my life is a crisis, so I'm gonna need more than that. – Ani

Such service provision limits also made it difficult for youth to stay involved in services because, despite wanting to continue, they were unable to as they had reached the maximum allowance.

In addition, all but one of the young people also reported being unsatisfied with the length and frequency of appointments.

> The appointment was very very quick, even with all the intake stuff. And even my dad - he had stuff at [Hospital] too - and he was kind of like “You're done already?”. […] I was also frustrated because I only saw him every few months and I finally had an appointment scheduled. And even though I didn’t like him, I was actually really looking forward to it because it was my first appointment in 4 months, and I wanted to talk to him about [something]. But then it was just the same 5 minutes and I remember that my dad was with me and I went into the lobby and just started crying. – Vito

4.6.3 Physical environment

For both Donatella and Brittany, the esthetic of the place where their treatments took place also hindered their engagement. The atmospheres of these spaces were not welcoming or enticing, which made them not want to be there.

> I think that the hospital setting is very displeasing. […] Because it's so miserable and it's not really fun to be in. It's very depressing; the walls are all white and there's no activities or anything when you're an adult. […] There's a couple of art pieces that are in the halls that are very ugly, first of all. Some of them are nice, but some of them are – there's a knitted thing in a frame and it looks very old. I don't know how long it's been there but its super dusty. – Donatella
>
> The old place, it was dingy and dark, not comfortable, old. […] The old place was grungy and dark looking. […] The environment around it was so dark and you could feel it; it was just so negative. – Brittany

4.6.4 Location / transportation

Although their situations varied, four youth reported facing challenges related to the location of services and their means of getting there. They had trouble finding somewhere that was conveniently located and easy to travel to, and they often had to rely on inconvenient transportation methods or public transit systems.

> She had an office way out in [suburb] and I am a student on a bicycle - so I was like, "Can't do that one". […] And even then, I was like "Well, I can pay for [transportation service]". But I had never had to pay for therapy before, so now I'm paying like \$200-\$300 a month to this lady and on top of that like \$50 per session for [transportation service]. So, nah, I can't do that. […] She had another office downtown but then it was a whole thing to get downtown too. I was working 2 jobs in the summer, and I gotta get downtown, and I gotta lock up my bike and there were one-way streets, and it was kind of an intimidating and scary thing. – Ani

4.6.5 Cost

Another barrier that impeded on the participants' access to and ability to engage with services was the cost. This barrier affected some more significantly than others; nonetheless, each of them spoke about the financial burden of treatment.

> So, in my family - my parents are separated - and money is hard to come by sometimes. It's just not always there. [...] So initially, they wanted to get free help, but that is so hard to come by. – Donatella

> The problem is that you either pay $250 a session, or you pay $40 a session and it's subsidized and it's crisis counselling; there was no in between. I couldn't find someone who just wanted $80 a session and that I could hang out with forever. – Ani

Vito even disclosed that she would sometimes schedule her sessions further apart than what was ideal in order to save money.

> And obviously, another thing that I forgot to mention too is the prices; it is pricey. Sometimes I'm like "Okay, I need to see you next week" but other times – like when I'm doing okay - I'll push it a few weeks because I'll be fine. – Vito

4.6.6 Wait time

Every participant emphasized how much of a barrier the wait time for an initial appointment was; they were all dissatisfied with how much time had to pass between their request for services and their scheduled meeting.

> So, at 13 my mom put me on the waiting list, and I got an appointment when I was 17. Because that's how long the waiting list is; it's insane. – Ani

> And also losing hope after you hear about the waitlists. Because it's like "Well, how am I supposed to get better in the meantime?". […] Especially if you're in a state like I [was], where I really didn't have control of any of my emotions or anything, you need the help right away. – Marley
>
> You're put onto these long waitlists for years on end, and you just don't need the help by then. […] You're on a waitlist forever and ever and you get discouraged. You're like "Forget it. I'm not doing it anymore". – Donatella

This barrier even persisted past some of the youth's intake appointments; Vito, Donatella and Brittany all talked about it being difficult to schedule subsequent sessions with some practitioners.

> And the guy was really nice too, but it was just so hard to get in to see him again. […] I remember getting an email cause I wanted to make another appointment with him, and it was like 2 to 3 weeks or something. And I was so devastated; so let down. – Brittany
>
> At the end of grade 12, I stopped seeing my psychiatrist for a while because he was booked up for months and months. […] I remember, we were at the end of the school year and they were like "He can see you in December". – Vito

This barrier was especially troubling in Vito's case. She was originally being treated at a children's hospital and as she approached her 18th birthday, she was offered a transition service where a worker essentially assessed her needs and referred her to the appropriate 'adult' services. It then took three years for her to actually be contacted by the hospital she was referred to. No follow up or support was provided in the interim.

> The first meeting was just getting to know me a little bit. The second meeting was us trying to figure out "Okay, this is what you need" and getting set up at [Hospital] and all that

> stuff. And that was it. […] And then I heard nothing for years. And then all the sudden, 3 years later, someone from [Hospital] calls me. And I had forgot; so, I was like “Oh yeah!”. And they were like “Do you want to get started?” and I was like “Well, it's been 3 years, but I guess so”. – Vito

4.6.7 Lack of information and / or involvement

Three participants spoke about feeling unsatisfied with the amount of information they received about both their diagnoses and treatment, as well as with their level of involvement in decisions about the treatment process, including the one to start treatment in the first place.

> I felt a little bit betrayed that they wouldn’t talk to me about it first. I mean, I wanted the help, I wanted to go but it would have been nice to know, you know? I was an adult at that point, and I don't know why things were done behind my back, so it made me feel a little bit betrayed. – Donatella

Vito, Ani, and Donatella all spoke about not having much of a choice but go to their appointments, which for Donatella, made her want to attend even less.

> So, when I was first put on the [Community Treatment Order], I was really refusing to see these people. […] Because - it’s weird to say – but it’s like when you were going to do something, and then somebody tells you to do it, and then you're like “No, fuck you. I'm not going to do it now”. […] It’s like that thing where you're like “You're not going to tell me what to do, I'm going to do it on my own terms.”. – Donatella

An interesting finding about this is that Ani and Donatella identified it as both a barrier and a facilitator. It was a facilitator to access in the sense that they didn't necessarily have to decide to get help, find it, and reach out for it because someone did so for them. It was a facilitator to attendance due to the fact that they were showing up, although not of their own volition. On the other hand, it was a barrier to engagement because they felt as though the treatment was being imposed on them. Both explained that while they were unhappy about this at the time, it is something that they have come to be thankful for.

> It’s been helpful - I hate to admit it. But I don't like it; I like to be able to do things on my own terms. […] I'm glad I got put on it though, I really am glad. I'm at a point in my life where I know that I needed it. […] There's a reason why they put me on it, and I can see it now and how helpful it has been. – Donatella

4.6.8 Negative past experiences

For all but one of the youths, the negative experiences they had with services in the past significantly harmed their subsequent help-seeking and later engagement in treatment. For Donatella and Marley, being repeatedly denied access to services made them hesitant to reach out again due to their fear of being turned away once more.

> It’s hard to ask for help sometimes. Because sometimes – like in the system - you ask for help and you don't really get it. So, when you get rejected a lot it’s like, “Okay, if I ask for help, will I actually get it? Or am I just going to embarrass myself?”. – Donatella

In addition, being mistreated by a provider in the past also made most of them distrustful of other agencies or professionals. Ani, Donatella, and Marley all shared extensively about how much harder it was for them to reach out for help again.

> I was resenting everybody around me; I was very on guard and my wall was up. I didn't really want to interact with anybody or get the help that I needed because I just didn't know if I was going to get the help that I needed or just be screwed over again. – Donatella

> Especially since my first experience with that psychiatrist wasn’t good, my biggest fear going into the next person was that they're going to tell me that I was dumb and stupid and that I didn’t think before acting. […] I think for a long time I tended to just not want to go see one; it took me quite some time to go back to one after. After April, I didn't see anyone until July because I was just too scared, and I just didn't want to go through that again. – Marley

Even when they got past this and did access services again, the effects of the maltreatment continued to have negative consequences on their engagement with the new provider.

> Well, it was hard for me to trust anybody afterwards. It was just like “Are you going to screw me over or are you actually going to help me? Are you actually going to listen to me?”. – Donatella

4.7 Service / treatment – Facilitators

4.7.1 Service accessibility

Three participants reported that they appreciated having more than one option for how they could attend their sessions or ‘meet’ with their provider (ex: in person, over the phone, via video-chat, etc.). This was especially the case when youth were involved in treatment but could no longer attend appointments in person as they were moving away to pursue their education.

> When I moved for school out West, I really didn't want to lose that. And she was like – she changed the network that she's using now but at the beginning she was using [video-chat platform] – so, it was nice that even when I was in [another city], I could still see her. […] She was like “We can do phone calls, or we can do this”. So, I still got to see her a couple of times while I was there. – Vito

They also appreciated flexibility in terms of availability, scheduling, and appointment times.

> And she would even call me sometimes and be like “Okay, Saturday morning?” and in my head I'm like, “You work on weekends? What an angel! You're going to talk to me on a Saturday morning?”. So, I was very very happy about that. […] I don't feel stressed about when I'm going to see her again because I know that if I send her an email, she’ll find a way to book me in somewhere. – Vito
>
> I kinda liked that about [virtual counselling service]; because it’s all online, it’s easy to be like “Oh, let’s move it by a half hour” or “Let’s make it video instead of phone”. I really liked that. – Ani

4.7.2 Cost

As mentioned above, all of the youth identified the cost of treatment as a barrier. Conversely, three of them stated that services were easier to access and engage with when they were free or had flexible pricing options such as sliding scale fees.

> She was very understanding of our financial issues. We connected a lot, so she just charges me less than what she usually charges now. – Donatella

4.7.3 Location

In addition, Vito, Ani, and Brittany mentioned that it was easier to access services and / or attend their appointments when these were offered in places that they were already frequenting on a regular basis, such as their school or university campus.

> When I had a therapist on campus and it was between 2 of my classes, it was so easy! I don't have to go anywhere. I don't have to figure out where to park. […] I'm just gonna

> finish my class and walk over. Even if we just chat about nachos for half an hour, whatever, because I would just have to sit on campus between my classes anyways, right? – Ani

For Vito, who was simultaneously accessing multiple forms of treatment at a time, it was convenient that these all took place at the same hospital.

4.7.4 Treatment approach

Four of the young people spoke of how much they appreciated the ‘practical’ aspects of their services, including when their providers suggested tools, resources, and skills.

> And then she’ll recommend apps and stuff. […] I find that she's very good at making things practical and hands-on. And at one point she was even sending me websites or articles and stuff. – Vito

> Everything I do is DBT based but its practical things that can be used in my everyday life, rather than just talking it out. […] So, if it happens again, I actually do have skills to cope with it. – Marley

4.8 Provider – Barriers

4.8.1 Concerns about the professional

Four participants disclosed that their concerns about the provider and their response made them hesitate to reach out. They reported not knowing how to approach and interact with a mental health professional and fearing that they would be judged or treated poorly.

> At first, I was kinda like “No, I don't really want to go talk to someone” because it's kind of intimidating to go to a stranger and open up about your whole life. […] It’s like “Oh, a therapist. They're just going to tell me I'm sad and that I need to quit being sad”. – Marley

4.8.2 Poor therapeutic alliance

All of the youth also faced challenges in terms of their relationships with practitioners; they spoke about struggling to share about their experiences and feelings as well as having difficulty building trust.

> But it’s hard to find somebody you can connect with, and as a younger person, and being through a lot, you don't want to open up to everybody and anybody or tell your story to everybody and anybody. – Donatella

In some cases, this lack of ‘connection’ was simply due to differences in terms of personality or worldview, but participants also identified certain characteristics or behaviors on the part of professionals that contributed to the issue. They reported encountering practitioners who were unhelpful, judgemental, and uncaring, or who lacked empathy and understanding. They also talked about situations where they were ignored or dismissed.

> I had self-harmed and when I told her, she was like “Well that's not smart. Why would you do that?”. So, that was the end of my road with her. – Marley

> And I would go to him, and he would just kind of - it seemed like in his head, he was just going through his checklist without realizing what I was saying to him. He’d ask, “How is your sleep?”, and I’d tell him “I haven’t slept in 2 weeks”. And then he’d be like “How’s your eating?”, and I was like “Oh, I haven’t eaten solid food in a month”. “How’s school?”. Like, he just went on. And I was like “Are you not going to address the fact that I'm malnourished and don't sleep?”. – Vito

Another contributing factor was high ‘turnover’ or frequent changes in terms of providers. When practitioners terminated services, the youth then had to find another provider and would have to ‘start over’ with someone new.

> Then I found a really good one and then she sadly had to move like 3 hours away. […] So, after that I kind of felt like “Okay, what's the point of me re-explaining everything?”. It was just annoying, so I didn't. – Brittany

> And because they were interns, they would change every year. So that was another barrier, in my opinion; because the rapport would have to be built up every time. – Vito

4.9 Provider – Facilitators

4.9.1 Strong therapeutic alliance

All of the youth talked about the importance of their relationship with the practitioner to the maintenance of their engagement in treatment. A “good bond” (Marley) between the youth and their provider was essential in keeping them involved in services.

> And she shows that she really cares, you know? When I'm hospitalised, she comes and visits me herself. […] And she showed me that she wouldn’t give up and she hasn’t so far, and I don't think she will. So, it makes me want to continue and show her that I can do better and be the person that she thinks I can be. – Donatella

While the therapeutic alliance is often based on individual preferences in terms of characteristics like age, gender, or race, it is also influenced by certain behaviors. Ani stated that she typically gravitates towards providers who resemble her and mentioned that she enjoyed when her therapists would bring up things she had previously mentioned.

> A similar age range, and like socioeconomic, and race thing. That’s all a little bit touchy stuff but I always loved a therapist that was like a 20- to 30-something white woman because I am one, so. […] I'd be like “Oh, you know, it’s just stuff my dad does” and they’d be like “Oh yeah, like when [dad’s name] did this”. And I'd be like, “Woah, you took notes!”. So that was cool, for them to have engaged and remembered. – Ani

The age factor was also brought up by Vito, who stated that she felt providers who were similar in age to her “understood some things more”. She spoke very highly of her psychologist, using words like “understanding”, “kind”, and “lovely”. Vito also appreciated that her psychologist was “always really good at checking in to make sure that [they] were on the same page”.

Donatella stated that she finds it much easier to engage with providers who take a more informal approach;

> It’s easy when they're not too professional, if you know what I mean? […] It makes it seem like I'm not the patient and they're not the doctor, it’s just a normal conversation that we’re having. […] And when it comes down to it, she's the doctor and I'm the client or whatever, but when it seems like it’s not like that, it’s easier to talk and open up. – Donatella

For Brittany, the fact that her psychotherapist has a lived experience with the same mental illness as she was very important.

> And she actually had PTSD. […] So, she gets it, I know she gets it. […] I think there's a big difference with therapists that haven't been through things and people that have. Because people that have been through things can relate more to people. And I get that therapists are there for you and supportive or whatever, but they haven't been through that. So, I don't think - in my head I see it as like - I don't think people get the full full full gist of how shitty it can be. – Brittany

4.10 Society – Barriers

4.10.1 Stigma

All five-youth identified that the stigma that surrounds mental health and treatment was detrimental to their help-seeking and engagement in services. They spoke of the negative perceptions about these topics within themselves, their families, their peer groups, their cultures, and in society in general.

> I really fought the diagnoses for a long time. I was like “Depression is not a thing. Anxiety is not a thing. These are just whiney bitches on the internet who can't deal with their own issues. I am not a whiney bitch”. – Ani

> There is obviously a lot of stigma around taking medication and I think especially being younger, you're like “Why do I have to take this? None of my friends are taking it”. […] And it was the stigma; I was like “I don't want to be crazy. Do I have to take these? Am I crazy? Am I not normal?”. – Vito

The participants did not want others to know they were experiencing a mental health concern and / or getting treatment; they were often afraid of being judged for this.

> A lot of people are either in denial, or their peers and their family are in denial. It’s not something they want to accept or that they want to be labeled by. Or they don't want to be treated differently by others. So, yeah, I think that's why it is. – Marley

> I wouldn't want people thinking that of me - even though it's not bad thing. […] I think I was scared that it would show up on my transcript or my profs would just know, and I just didn't want anyone to know, I think. – Brittany

Donatella and Ani both highlighted that in some cases, the providers themselves even contributed to the stigma.

> Some things that are stigmatised, like Borderline Personality Disorder or even DID, a lot of people just don't understand it. Especially a lot of doctors do not understand it; they're not even aware that it’s a thing. Some of them are just completely in denial; they're like “It’s not a thing. It’s not possible”. – Donatella
>
> It feels like sometimes - with them trying to make it so easy to access the service - it’s almost stigmatizing. It’s like they’re trying so hard to be welcoming that I almost feel like they're being patronizing. – Ani

4.11 Society - Facilitators

4.11.1 Destigmatization

Vito, Ani, and Donatella spoke about how accessing and engaging in services was facilitated when mental health and treatment was spoken about more freely and not considered as ‘taboo’ within their families or social circles.

> Having professionals or teachers who are super supportive as well. And who talk about their mental health too. If they're very open about it, it makes you want to be open about yours as well. – Donatella

Vito explained that her participation in youth advocacy groups and the fact that she often talks about her experiences in regard to her mental health and treatment have attenuated much of the discomfort or embarrassment she used to feel when discussing these topics. Ani shared that she felt much better about being involved in services when she discovered that other people she knew were receiving treatment as well.

> And it was becoming more and more common. I felt like more and more people were talking about it. […] Also, when it becomes kinda cool to be in therapy - everyone is in therapy now. – Ani

4.12 Effects of barriers on satisfaction and progress

The participants' responses regarding the influence of the barriers to access and engagement varied. However, there seemed to be a general consensus that these decreased the youths' levels of satisfaction with services.

> So, let's just say, if I was on campus in [city] and I was really going through it and I really wanted to talk to someone but I had to call, I had to email, I had to wait like 24 hours or 46 - I don't know - however long for an appointment and whatever – I would go insane. I don't even know what I would do. I just would like - I don't even know. Once I got to the appointment, though I guess it would depend on who I had, how they were treating it, and what was the outcome after that. So, I mean, I guess, it just depends on how I felt after, but I think either way I would still be less satisfied because of what I had to do to get there. – Brittany

Vito explained that the things that make it more difficult for her to access a service or attend / engage in treatment make it "really hard to see any positives in the experience". She also explained that the negative effects that the barriers to her access had were exacerbated if the appointment did not go well.

> It probably would have been less insult to injury or less salt in the wound, or just a little bit less of a sting. Cause I remember the one appointment I left bawling - like having a breakdown in the lobby - I hadn't seen him in 4 or 5 months, and it was so hard to get a

> hold of him. So, it was so frustrating to have all this work put in and then it was like "That's it?". Whereas if I saw him once a month, it'd be like "Ugh, another shitty appointment" but it was kinda consistent or it's more expected. Like, if it wasn't as much work, then it's like "Okay whatever, it was one afternoon on a Thursday". So, I think it still would have been negative, but it [wouldn't have been as bad]. – Vito

For Ani, the more effort she had to put into actually getting an appointment and showing up, and the less she wanted to continue with treatment.

> Yeah, definitely. My therapist that I saw in the summer, that's why I stopped seeing her. She was a great therapist, I connected with her really well, I loved her insights, she was recommending these books and I would read the books and I was like "Yes! I get why you recommended this, it's really helpful". But the fact that it had been hard to reach out to her, I had to be paying her every week, I had to find where I needed to park and how to get there and "Am I downtown or am I in [suburb]?", and an appointment got cancelled or moved – I was like "You're an excellent therapist, but it's just too hard to get into a session with you" and so I quit. So yeah, for sure. – Ani

Donatella described how the barriers she encountered did initially decrease her level of satisfaction with the services. However, now that those barriers have subsided, she invests more into her treatment.

> But now that I've got a taste of it and I see the progress and I see everything else, I'm like "Okay, I'm going to take full advantage of this while I have it because it was so hard to get it". […] So, I have to take full advantage of it while I have it because I won't have it forever. – Donatella

A noteworthy finding in regard to the effect of barriers on satisfaction is that both Vito and Brittany reported that their past experiences with services where they encountered more significant barriers made them more satisfied with the services which were easier to access and engage with.

> But I think it just makes me appreciate it so much more because it's like “Oh my God, you have no idea who I’ve met to get to you!”. It's like you're kissing the frog and then “Ah, the prince is finally here”. So, I think it does add a little more to it. It's not just like “Oh, you're a good service provider” but it's also like “Oh, you're so much better than X, Y, and Z that I had to deal with”. – Vito

Each of the youth described how certain barriers harmed the progress they were making in treatment as well.

> When I'd have a session after we’d had to cancel one, then I'd have resentment. I’d be like “Well, if I cancel last minute, you’d charge me. You have a 24-hour policy. Are you going to give me money because you didn't respect the 24-hour policy?”. So, then I'm not always as ready to listen to or learn from her or share with her because I'm frustrated. Or I'd need 10 minutes to adjust because I had to drive all the way to [suburb] or I had to park my bike and get here and then I can't just dive into opening up about my feelings. – Ani

For Vito, she felt that the longer she had to wait between appointments, the slower she progressed.

> There's times where I’m like “I really need to see you literally once a week” and they can't, which didn’t stop my progress, but it did slow down a bit. If it’s a very long period, it might stop. – Vito

In addition, she recounted a time when she was discharged from inpatient treatment, despite telling the hospital that she did not feel ready to return home. This made her feel as though she had lost all the progress she had made and like she had to ‘start from scratch’ when she was re-admitted.

> Then when I got back a month later, it was like “I told you I wasn’t ready”. Kind of like “I told you so. I'm back again”. So, it was like I had made all this progress, and then there was that and I felt like I was cut off, and I felt like I was starting from square one. – Vito

According to Donatella, the barriers hindered her progress by preventing her from investing herself into the treatment process.

> Yeah, if you don't want to be there, it’s kinda hard to progress. It’s going to be hard to have some sort of progress if you're just not engaged, you know? If you don't want to be there, you don't want to be there so you're just a little bit reluctant to get the help or to work on getting better. – Donatella

She also stated that her involuntary involvement in treatment and the poor relationship with her provider was detrimental to her progress.

> I feel like I resented my psychiatrist for a long time for putting me on the CTO, which made me open up a little bit slower to her, which kinda slowed the progress. – Donatella

Marley explained how being denied access to services and having to wait a long time for treatment exacerbated her mental health concern.

> And if I would have been admitted to the psych ward after my first overdose and had received DBT training, I can guarantee you that I would have not had two more overdoses and another admission to the psych ward, you know? […] I honestly would have to say the waitlists, personally. […] And it’s something that is going to get worse and worse with time because it’s just going to become a habit or a routine. […] So, if you wait longer,

> you'll obviously lose more hope, but things can also get progressively worse and you'll be in an even deeper hole. Like, I was in a deep hole, but not as deep as if I wouldn't have gotten therapy [when] I did. – Marley

4.13 Effects of facilitators on satisfaction and progress

Only three participants provided clear answers to the questions pertaining to the influence of facilitators on satisfaction. Two of them reported that the factors that positively contributed to their access to and engagement in services increased their level of satisfaction, and the other stated that they did not have an effect.

Vito highlighted that, for her, the positive effect of a strong therapeutic alliance on satisfaction outweighs the negative effect of barriers.

> Like, my psychologist right now is the same distance away so it's hard to say - but if she were to be 45 minutes away, it would suck cause I'm like "Urg, I don't want to like go all the way there 45 mins, plus 45 minutes back" but I'd be like "She's 100% worth it because I'm getting a service I need, and we have a good rapport". Even now, if I look at her price - hers is $160, and I know some other people are cheaper. And as much as I would love to pay less - and even if my friend has amazing reviews of somebody who charges only $50 an hour – it's very hard because I already built this rapport. I have that connection, and it's very worth it. Even though sometimes I'm paying $160 every week or every other week. My friends are like "Oh, I can't afford that", and I'm like "I can't always afford it, but it's worth it for me to save extra for that". – Vito

On the other hand, all the participants spoke about how facilitators expedited their progress. Vito, Ani, and Donatella reported that having a strong connection with their provider was a crucial component in the growth and healing they experienced through treatment. Donatella and Marley felt they benefited more from their services because the facilitators made them take on treatment more actively and invest more deeply and consistently into their well-being.

> Yeah, most definitely, because I think that progress is going to be made easier if you approach it right and put more time and effort into it. Like, in my first module, I put time and effort into it, but not as much as I am now, and I feel like that has made the biggest difference. You can hear one thing, but hearing one thing and practicing it, you improve so much better, you know? – Marley

Marley also emphasised that the support of her parents significantly contributed to the progress she had made thus far.

> That's why I think everyone has been like "You've made so much progress since July!". Like, it's almost going to have been 10 months and I have done a 270° so far, out of a full 360°. But honestly, when you have parents who are willing to learn about it, and actually try and make a difference. And I'm way much more sensitive and don't perceive things the same way they do. So, they've had to adapt and be more self-conscious and self-aware of how they approach me, which made a huge impact. And actually, for them to understand that - what I'm learning in class - is pure. This is because I didn't necessarily know how to apply these things. So, they actually have a better understanding of the whole thing itself. And now, I use the skills I learned every day, right? So, now they kind of know that this is my way of thinking, or the way I'll go. So, they are much more understanding. – Marley

CHAPTER 5: DISCUSSION

This project’s findings on the barriers and facilitators that young people face in their help-seeking process and in their involvement with services are quite consistent with those identified in prior research on the issue.

Similar to the studies by Gulliver and colleagues (2010) and Rickwood and colleagues (2005), this project’s results demonstrate that youth aren’t sufficiently taught about mental health. They aren’t adequately educated on the signs and symptoms of common mental health concerns and are therefore not equipped to recognise these within themselves.

A factor that was surprisingly not as prominent in this study’s results was a ‘lack of perceived need’; the data from Sylwestrzak and colleagues (2015) and Wilson and colleagues (2011) suggested that one of the reasons that young people didn't reach out for help was because they didn't feel that they needed it. Although two participants did report that they minimised the severity of their symptoms or questioned whether they were ‘overreacting’, it was expected that more of them would disclose that they simply didn't feel the need to get help, especially since this belief appears to be more common in youth (Wilson et al., 2011).

The barrier of negative beliefs and attitudes presented in Rickwood and colleagues (2005) and Sylwestrzak and colleagues’ (2015) articles also emerged in this project’s results. Four participants discussed this in relation to access (i.e. they didn't reach out for support because they thought it wouldn’t help) and three of them talked about it in terms of engagement (i.e. they considered dropping-out because they thought it wasn’t helping or making them any better).

Unsurprisingly, mentions of stigma were very prevalent in the young people’s interviews. Similar to Coyne and colleagues (2015) and Gulliver and colleagues (2010), this study’s participants also shared that they were uncomfortable talking about their mental health with others, providers included. Additionally, just as evidenced by Sylwestrzak and colleagues’ (2015) data, this sample of young people were all afraid of other people finding out that they were experiencing a mental health concern and receiving treatment. This made it difficult for them to access support in the first place and to maintain their involvement in services.

Consistent with the reviews conducted by both Anderson and colleagues (2017) and Gulliver and colleagues (2010), this project's results demonstrate that all of the youth hesitated to ask for help due to concerns about the service provider and their response. Another similarity noted between the current research and that of Rickwood and colleagues (2005) is that these fears often stemmed from and / or were exacerbated by the maltreatment that youth had been subjected to in the past. Their article stated that four of the studies they reviewed demonstrated that negative past experiences "were substantial barriers to future help-seeking intentions", "particularly when the young person felt they were not helped or that their problems weren't taken seriously" (p.16). This statement resembles what both Donatella and Marley recounted experiencing.

On the other hand, the Anderson and colleagues (2017) review presented that youth often worried that their provider would share what they disclosed in session with their parents, yet such a concern was not brought forth by any of this project's participants. The articles cited for that statement included Boyd and colleagues (2007); Hernan, Philpot, Edmonds, and Reddy (2010); and Samargia, Saewyc, and Elliott (2006). The participants in the Boyd and colleagues (2007) study were between the ages of 17 and 21, the Hernan and colleagues (2010) sample was composed of 14- to 16-year-olds, and Samargia and colleagues (2006) only used survey data collected from 16-year-olds. It's plausible that this did not emerge in this research's results due to the fact that all of the participants were above the age of 18 and therefore more assured in respect to confidentiality.

The preference to rely on oneself wasn't as present as expected either. Wilson & Deane (2012), Wilson and colleagues (2011), and Gulliver and colleagues (2010) stated that youth often didn't reach out for help as they would rather address the issue they were experiencing by themselves. Sylwestrzak and colleagues' (2015) results reflected something similar by demonstrating that young people most often terminated services because they wanted to solve the problem on their own. In this study, Brittany said that she'd always had a tendency to 'deal with stuff' on her own, and Vito reported that she struggled to ask for help because she didn't want to burden her parents; however, Donatella was the only one to outright state feeling like she "should be able to do [it] on [her] own".

Both the Anderson and colleagues (2017) and Gulliver and colleagues (2010) reviews identified service inaccessibility as a barrier; youth disclosed not knowing what resources existed and not understanding how to "access appropriate care" (Anderson et al., 2017, p.170). While such experiences were also present in this sample's responses, the participants further expanded on this by highlighting additional obstacles such as strict eligibility criteria and challenging access processes.

Another shared barrier in these findings and those of Anderson and colleagues (2017), Gilmer and colleagues (2012), and Rice and colleagues (2018) is the length of the waiting period between when youth reached out for help and when they were offered an appointment. This study's participants disclosed 'losing hope' and 'getting worse' during this time, as well as not needing the help by the time it came around. Additionally, the Anderson and colleagues (2017) review stated that young people were often upset that their "problems were not considered serious enough to get them seen soon" (p.4). Similarly, both Donatella and Marley spoke of being denied treatment or ‘sent home’ without the support they needed because they were not taken seriously or because their conditions were not considered severe enough to warrant services.

The study conducted by Coyne and colleagues in 2015 revealed that adolescents (aged 11 to 17, in this case) were dissatisfied with the amount of information they were given about the service and with the level of input they were allowed to have in treatment. This lack of information was reflected by Vito in her statements about not knowing “what was going on”, what the purpose of the appointments were, or what the providers role was in the earlier stages of her treatment. As for the limited involvement in decisions, the aforementioned authors explained that many young people were not consulted in the decision to start treatment in the first place. Four of this study’s participants reported similar experiences, explaining that they didn't feel as though they had much of a choice but to attend their appointments. Many spoke of feeling pressured by their parents and some were even forced or required to participate by their providers.

Just as demonstrated by Coyne and colleagues (2015) and Gilmer and colleagues (2012), young people report that it is challenging to stay engaged in treatment when they don't feel a strong connection to the professional providing the service. A theme that was identified by these authors and in this study’s results is that ‘staff turnover’ was detrimental to young people’s continued involvement in services. An interesting nuance, however, is that Gilmer and colleagues (2012) stated that their youth attributed the poor quality of the therapeutic alliance to the insufficient duration and the infrequency of appointments. While many of this project’s participants did say that they were unsatisfied with the length and frequency of appointments, they did not mention any connection between this and their relationship with the provider.

When it comes to facilitators, Rickwood and colleagues (2005) spoke of ‘emotional competence’ as “being aware of one’s internal, personal world and having the language with which to express it to other people and feeling comfortable doing so" (p.17) and suggested that this is positively associated with help-seeking in youth. This resembles the notion of self-awareness that emerged as a facilitator in this project's results. In addition, these authors also talked about mental health literacy as a facilitator and stated that being educated on symptoms of mental health concerns increased the likelihood of young people reaching out or help. This is similar to how Vito and Donatella explained that they learned to recognise certain signs and symptoms, which made it easier to know when they needed support later on.

Rickwood and colleagues (2005) also included knowledge about available resources and what to expect from them under the term 'mental health literacy'. Though this was categorized separately in this study's results, both Vito and Ani stated that the fact that they had been involved with services throughout their childhoods was helpful. This knowledge and experience made it easier for them to navigate the system and more comfortable accessing and engaging in treatment as young people.

The Gulliver and colleagues (2010) and Rickwood and colleagues (2005) studies both revealed that social relationships with supportive people encouraged youth to access and engage with professional mental health services. This factor also emerged in this research, with participants stating that their family members, friends, and peers often contributed to their willingness and ability to ask for help, obtain services, as well as continue their involvement in treatment.

CHAPTER 6: PARTICIPANTS' SUGGESTIONS

The purpose of this chapter is to present the participants' suggestions on how young people's access to and ongoing involvement in mental health services could be facilitated.

Vito stated that her "biggest recommendation would be focusing on the transition" between services for children / youth and those for adults. She explained that it would be helpful for practitioners to take into account the fact that young people are often exploring and forming their identity, and confronting major life decisions in terms of education, employment, relationships, independent living, etc. She advocated for a program of some kind where youth could be supported in their transition to adulthood. The MHCC (2015) has already identified 'youth transitions' as "a significant area of mental health policy concern" and acknowledged that this population is "not adequately supported" during this critical time (p.5). In their report titled *Taking the Next Step Forward: Building a Responsive Mental Health and Addictions System for Emerging Adults*, they propose a comprehensive framework for improving Canadian practice in this respect.

In terms of access, both Vito and Ani suggested making it "easier to find someone" (Vito). Ani recommended simplifying the search process and access procedures for services.

> It would be great if there was only one organization that I'd have to reach out to. Because I had to make a profile at [social service agency] and a profile at [social service agency] and I had to make a profile at [university]. So, if I could just post on the 'Ontario Mental Health Plan' and then all those organizations could come to me, instead of me having to go to them, that would be a lot easier. – Ani

Vito, Donatella, and Marley also advocated for an increase in the amount of services and providers, as well as decreased wait times.

> When I think about agencies, there needs to be more people that work and there needs to be not as long waitlists for people. – Donatella

Additionally, Ani, Donatella, and Brittany all stated that it would be helpful if professionals routinely 'checked-in' with youth about their mental health, rather than relying on the youth to reach out for support when they are struggling. One interesting idea, provided by Ani, was to have students attend some sort of 'mental health check-up' with a counsellor at their high school every once in a while. This would also destigmatize and 'normalize' mental health and treatment.

> Maybe if it would be treated more like a normal thing - like going to a dentist or a physiotherapist - then it feels like it's a more normal thing. […] I think that everybody should just have to see a counsellor a little bit. […] So, if that was a thing – like if in high school they were like "Okay, everybody. Welcome to sex ed; do your sex ed. Now everybody, go see your counsellor. Cool. Get your HPV shot. Now get back to math class". That would be a de-stigmatizing thing. […] Don't treat it like it's a big deal that you need to be coddled into. Just be like a dentist, but for heads not for teeth. – Ani

Similarly, Brittany advocated for more support for university students living in residence; she recommended that there be more of a focus on mental health during the monthly 'check-in' meetings with the residence staff. These ideas are similar to one of the recommendations put forth by Rickwood and colleagues (2005), in which they suggested that "efforts to increase young people's use of mental health services may benefit [from] strategies aimed at developing trusting and supportive relationships with professionals before the need arises" (p.20).

Donatella and Brittany both advocated for more mental health awareness and education initiatives, as well as more promotion and advertisement by the agencies that offer services. They explained that such efforts would increase this population's knowledge about mental health and about what resources are available to them.

> I think the best thing for mental health in general is that it's more talked about. […] I would say [to have] way more posters, or more handouts in classes. Because it's different than seeing a poster because you're just gonna walk by it. But when you're given it in class, you can't just throw it out, profs would get mad. […] For example; I'd probably put it in a binder or notebook or something, and bring it home then look at it. And then I'd probably be like “Oh, maybe this is actually good”. – Brittany

> I mean, there should be more advertisement and a little more talk about it. Like, let’s say if agencies - like [Mental Health Agency] or [Crisis Centre] or [Youth Agency] or whatever – they would go into schools or whatever, and they would talk about mental health and stuff. I know that some of it is done, but just a little more education on getting the help that you want and that you need and that there's no shame. Just educating kids on different – not all the mental health diagnoses or whatever – but the basic ones like Depression and Bipolar and Anxiety. Just so that people and kids and adults are not ashamed to get the help because they know that people understand out there and that there's a lot of resources out there. – Donatella

When asked about what service providers could do to improve their client retention, Vito, Donatella, and Marley spoke of the importance of the therapeutic alliance in keeping young people involved and engaged in treatment. They recommended that practitioners focus on building a strong relationship with their clients and take a genuine and authentic interest in them.

> I would say that your approach and your engagement with clients. Don't just get to know them because you have to and their problems, get to know them and their personality too. Know who they really are and what they like and what they don't like and stuff. […] But

> really engage and make them feel special. And not like you're just another person who's going to try to help them and try to fix them. – Marley

Providers who are struggling to keep their young clients engaged may need to re-evaluate their approach and the ways that they interact with these people. It may be useful to address such concerns in a session and encourage an open dialogue about how to establish and maintain a good rapport.

Additionally, Vito highlighted that mental health professionals need to be "cognisant of race, religion, and cultural practices" and Marley encouraged providers to adopt an anti-oppressive approach within their interventions. Anti-oppressive practices in social work aim to increase commitments to social justice among those who work in the field and to improve the outcomes of the people they serve (Curry-Stevens, 2016). This approach posits that power is rooted in group identities (i.e. race, class, gender, sexual identity, etc.) and insists that professionals adopt practices that "minimize power hierarchies, by assisting to build the power of those who hold a marginalized identity" (Curry-Stevens, 2016, n.p.).

Donatella and Brittany suggested that making the treatment environments more welcoming, enticing, and age appropriate would also facilitate ongoing involvement.

> A little more decoration! It's so depressing! […] Paint the walls, or something, or have a little bit of art. – Donatella

> [Have] more things that people my age would like or be attracted to. Even colour wise; I've read things about – I don't even know if it's true - but colours can have an effect on you, and where you're sitting too, or how a room looks. I think if a place was made to make someone feel comfortable and relaxed, then they'd be fine. – Brittany

While this recommendation might require some time, effort, and resources, it would be relatively simple for public agencies and private businesses to improve their client retention by ensuring that their buildings, waiting rooms, and office spaces foster a sense of security and make clients feel at ease.

Vito, Ani, and Marley also suggested making treatment more affordable; they explained that it would be much easier to access and engage in services if these were offered free of charge or covered by insurance.

> I would maybe just extend the free mental health care and incorporate more things, you know? Like if [private clinic] was more accessible or if more private clinics were more affordable, you know? – Marley
>
> Like, my anti-depressants are covered; it's free! Therapy is not. And you know what helped me a lot more than pills? Therapy! So, why don't you just pay for that? – Ani

Ani recommended that practitioners and agencies be more flexible with their availability and appointment times. She also recommended that they provide treatment through multiple means (ex: in-person, or via phone, text, video-chat) and explained that virtual treatment may be a more enticing option for this population. This may also eliminate some of the barriers related to location and transportation. On a similar note, Donatella advocated for more flexibility in terms of location by encouraging professionals to offer their services on a mobile basis. It would be more convenient for youth if they could meet with their provider in the community and didn't have to travel to and from in-person meetings. Marley also elaborated on the virtual treatment suggestion by recommending that agencies offer free 'self-serve' educational resources about mental health online.

> Even if they put in an online class, you know? Even [store] and places, they're putting up free online classes on mental health and stuff. So even if it wasn’t the full program, just coping skills that could be used and published and accessible, it would be way easier.
>
> – Marley

All of the recommendations put forth by the participants are worth considering, though some may be more complicated than others to put in place. Some would depend on complex variables such as public policy, organizational procedures, and funding, and further research would also be needed to determine their feasibility. Others, however, seem relatively easy to follow and could be implemented by mental health professionals themselves.

CONCLUSION

As evidenced in this research, young people aged 16 to 24 encountered a significant number of barriers that deterred them from seeking professional mental health care and harmed their access to and engagement in such services. Those related to their own cognition included poor mental health literacy, negative attitudes and beliefs, as well as the symptoms of their mental health concern(s). Youth also confronted barriers associated to the people they were surrounded by, such as unsupportive family members, friends, and peers. The most commented on category of barriers was the one pertaining to the service itself; the participants reported struggling with service inaccessibility and inadequacy, inappropriate treatment environments, challenges in terms of location and transportation, unaffordable treatment, long wait times, insufficient information and involvement, and negative experiences. These young people also identified barriers related to the professionals who provide treatment, including concerns about their reactions and weak therapeutic relationships. In terms of barriers imposed by society, the stigma that surrounds mental health and its treatment was a significant obstacle.

Conversely, the participants encountered several facilitators that favoured their help-seeking and improved their ability to access and continue receiving treatment. On the individual level, these included mental health literacy, knowledge of services, and positive attitudes and beliefs. In terms of their network, youth reported that having pre-existing relationships with professionals and supportive friends, peers, and parents were helpful. As for the factors related to the service, the participants appreciated when treatment was easily accessible, affordable, conveniently located, and practical. A facilitator to engagement associated with the professional was a strong therapeutic alliance between the client and their provider. As for societal factors, the youth shared that it was easier to reach out for help and participate in services when they felt that mental health and treatment were normalized or destigmatized.

In addition, the results of this study suggest that the barriers that young people encountered in their efforts to access and engage in mental health care were detrimental to their level of satisfaction with the service as well as their progress in treatment. On the other hand, facilitators of access and engagement increased the participants' satisfaction and positively contributed to the progress that they made over the course of their treatment.

In order to facilitate this populations access to and engagement in mental health services, the participants recommended a targeted program; simplified search and request processes; greater accessibility and availability; more advertisement, education, and awareness; shorter waiting periods, as well as reduced costs for treatment. They encouraged providers to establish a genuine connection with those they serve and incorporate anti-oppressive practices into their work with them. The youths also suggested that professionals take a more proactive approach towards this age group by actively providing them services on a routine basis rather than expecting young people to solicit the help for themselves.

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ANNEX A – Interview guide

Can you tell me about the mental health concern you are dealing with (name of diagnosis (if applicable), presenting symptoms, how long you've been living with it, etc.)?

If currently in services:

- What services are you receiving?
- When did you start with them (age)? / How long have you been involved with them?
- How often are you meeting with your provider?

Is it your first time accessing services?

- If not, was the previous time before you turned 16 or after?

If not currently in services:

- What services did you receive?
- When did you start with them (age)? / How long were you involved with them?
- How often were you meeting with your provider?
- How long has it been since you were actively involved in treatment?

Can you describe the process / what steps you took to get services?

Would you describe that process as easy or difficult? How come?

What made it more difficult for you to reach out for help?

What made it easier for you to reach out for help?

What made it harder for you to access services?

What was helpful / made it easier when you were accessing services?

You've been involved in treatment for (X amount of time) now; how is that going?

Do / did you find it easy or difficult to stay engaged in the treatment? How come?

What makes / made it more difficult for you to stay involved in treatment?

What makes / made it easier for you to stay involved in treatment?

Do you think that the barriers you encounter(ed) during access and involvement influence(d) your level of satisfaction? How so?

Do you think that the facilitators you encounter(ed) during access and involvement influence(d) your level of satisfaction? How so?

Do you think that the barriers you encounter(ed) influence(d) the outcome of your treatment / your progress? How so?

Do you think that the facilitators you encounter(ed) influence(d) the outcome of your treatment / your progress? How so?

What recommendations would you make to agencies / service providers to make it easier for young people to access services?

What recommendations would you make to agencies / service providers to make it easier for young people to maintain their involvement in treatment?

ANNEX B - Recruitment poster

Young People's Access to and Engagement in Mental Health Services

Are you experiencing a mental health concern and interested in participating in a study?

We are recruiting individuals who:

- **Are between 16 and 24 years old;**
- **Are experiencing a mental health concern;**
- **Have been involved in mental health services for a minimum of 2 months; and**
- **Speak English**

As a participant, you will be asked to attend a 60- to 90-minute individual interview, via video-chat, during which you will be asked about your experience accessing and engaging with mental health services.

Participants will be compensated with a 15$ Cineplex e-gift card!

Participants will be selected on a first come, first served basis.

Please contact Bailey Newell at Bnewe077@uottawa.ca for more details!

This study is being conducted through the University of Ottawa and independently from the agencies through which the participants are being recruited, as such, your participation or not in this study will not influence the services you receive. This study is also being conducted independently from the platforms through which participants are being recruited.

ANNEX C – Analysis guide

Barriers and facilitators to access and engagement		
Individual	Barriers	
	Facilitators	
Network	Barriers	
	Facilitators	
Service or treatment	Barriers	
	Facilitators	
Provider	Barriers	
	Facilitators	
Society	Barriers	
	Facilitators	

Effects on satisfaction	
Barriers	
Facilitators	

Effects on progress	
Barriers	

Effects on progress	
Facilitators	

Recommendations

ANNEX D – Consent information form

Consent Information Form

Title of the study: Barriers and Facilitators to Young People's Access to and Engagement with Mental Health Services

Primary researcher:	**Supervisor:**
Bailey Newell	Marc Molgat
School of Social Work	School of Social Work
Faculty of Social Science	Faculty of Social Science
The University of Ottawa	The University of Ottawa
BNewe077@uottawa.ca	Marc.Molgat@uottawa.ca

Invitation to Participate: I am invited to participate in the abovementioned research study conducted by Bailey Newell, under the supervision of Marc Molgat. This study is being conducted as part of Bailey Newell’s Major Research Paper.

Purpose of the Study: The purpose of the study is to identify the barriers and facilitators that young people face in their access to and engagement with mental health services. In addition, it will investigate the effects of these factors on the perceived outcomes of and the level of satisfaction with the services. Finally, it intends to explore the ways in which young people believe that their access to and involvement with mental health services could be facilitated.

Participation: My participation will consist essentially of attending a virtual and individual 60-90-minute-long interview, which will be audio- and video-/screen-recorded. During the interview, I will be asked questions about my access to and involvement with mental health services. I will discuss the factors that facilitated and complicated my search / request for services as well as those that facilitated and hindered my ongoing attendance and participation in these services. The questions will also address my level of satisfaction with the treatment and its outcome, as well as the relationship between these and the aforementioned factors. In addition, I will discuss the ways in which my access and engagement could have been facilitated. The timing of this interview will be determined based on my preferences and availability.

Risks: My participation in this study will entail that I share personal and potentially sensitive information with the researcher; this may cause me to feel uncomfortable, upset, stressed, or sad. It may generate feelings of anxiety or dissatisfaction. I have received assurance from the researcher that every effort will be made to minimize these risks. I will be allowed to take the time that I need to answer the questions and take a break if needed. I can also choose not to answer any of the questions. Should I no longer wish to participate, I can withdraw from the study at any time without suffering any repercussions. I will also be provided with a list of resources that I can contact if I need support after the interview.

Benefits: My participation in this study will lead to a better understanding of the factors that influence youth's access to and engagement with mental health services. In addition, it will demonstrate how these factors affect young people's satisfaction with the services and the way they view their outcomes. My participation will also provide a new perspective on the issue though my suggestions on how to make accessing and participating in these services easier. As a result, the organizations who provide these services may be able to reflect on how to better adapt their services to accommodate the needs of youth.

Confidentiality and Anonymity: I have received assurance from the primary researcher that every effort has been made to safeguard my confidentiality and anonymity. My name and any identifying information will not be included in the notes taken during the interview, the transcription of the interviews, nor in the publication of the research project. A pseudonym will replace my real name in the publication of the study, and only the research team (Bailey Newell and Marc Molgat) will have access to the document that links my name to the pseudonym. If I mention specific people and / or agencies during my interview, they will also not be named in the research project's publication. The audio- and video- recording of this interview will also not be published. The primary researcher will guarantee the confidentiality and anonymity of the data. However, given the nature of virtual chats, it cannot be guaranteed that the conversation will not be overheard within my location. As such, it is recommended that I choose a quiet location, where there is a minimal risk of others being present. I understand that the content of the interview will only be used for the purpose of the primary researcher's (Bailey Newell) research project.

Conservation of Data: The recordings of the interviews and their transcriptions will be kept in a secure manner. They will be stored in a password protected file on the primary researcher's (Bailey Newell) laptop, which is also password protected. They will also be kept on a password protected USB key, which will be kept in the primary researcher's locked locker on the University of Ottawa campus. The notes taken during the interview will also be kept in this locker. Only the primary researcher (Bailey Newell) and their supervisor (Marc Molgat) will have access to this data. At the end of the study, the recordings of the interviews and their transcriptions will be deleted from the primary researcher's laptop. The USB key with this data and the notes taken during the interview will then be given to the supervisor (Marc Molgat) to be placed in a locked space. They will be conserved for a period of five (5) years, then deleted or shredded.

Compensation: I will be provided with a 15$ Cineplex e-gift card in exchange for my participation. Should I choose to withdraw from the study, I will still receive this compensation.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. The mental health services that I am currently receiving do not depend on my participation in this study. My participation in this study will not have any negative consequences on my current and / or future access to such services. If I choose to withdraw from the study, this will not have any negative consequences on my current and /or future access to or involvement with such services. If I choose to withdraw, all data gathered until the time of withdrawal will be deleted and destroyed.

Acceptance: I agree to participate in the above research study conducted Bailey Newell of the School of Social Work in the Faculty of Social Science at the University of Ottawa, under the supervision of Marc Molgat.

If I have any questions about the study, I may contact the researcher or their supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5
Tel.: (613) 562-5387
Email: ethics@uottawa.ca