RESEARCH ARTICLE

Who asked you? Young People and practitioners identify ways to facilitate access to mental health supports [version 1; peer review: 1 approved with reservations]

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Abstract

Background: Despite representing the highest level of total population mental health burden, young people are the least likely to seek help from mental health services. It has been suggested that service design can influence the likelihood that young people will look for help, but little is known about how young people would like a service to be designed. This study addresses a gap in research regarding how mental health services can be designed to facilitate access for young people.

Methods: A collective intelligence, scenario-based design methodology was used to facilitate stakeholders to identify and prioritise ways to improve youth mental health services. In total, 74 15–17-year-olds from three geographically diverse schools in Ireland worked to identify barriers to help-seeking and to generate and prioritise options in response to barriers. Nine practitioners with experience of working in youth mental health services rated all options in terms of both potential impact on help-seeking and feasibility for service implementation.

Results: A total of 326 barriers across 15 themes were generated by youth stakeholders, along with 133 options in response to barriers. Through a process of voting, young people identified 30 options as the most impactful for improving access to mental health services. Of these options, 12 were also rated by practitioners as having both high potential impact and high feasibility. These 12 options focused on four areas: making services more familiar and welcoming; providing specialist mental health input in schools; improving parental understanding; and improving the visibility of appropriate supports.

Conclusions: The results of the current study inform mental health service innovation and development, in particular, by highlighting potentially impactful and feasible ways to adapt existing mental health services to improve young people’s help-seeking behaviour.
Keywords
collective intelligence, participatory research, adolescent mental health, mental health service design, help-seeking for mental health difficulties, barriers and facilitators

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Introduction

Youth mental health is a major public health concern

Adolescence is a critical period in the development of lifetime mental health. With the exception of dementia, the majority of all population mental health disorders are known to develop between 14 and 25 years of age (WHO, 2017). Untreated mental health difficulties during adolescence can affect cognitive, emotional, and social development (Alaie et al., 2019; Fusar-Poli, 2019) and increase the risk of mental, social, and economic adversity in adulthood (Fryers & Brugha, 2013). The prevalence of mental health difficulties for young people worldwide is estimated to be between 10–20% (WHO, 2017). Despite representing a disproportionately high level of total population mental health burden, young people are the demographic group least likely to seek help from available mental health services (WHO, 2017). The steady rise in prevalence and severity of young people’s mental health difficulties (WHO, 2017) coupled with young people’s reluctance to seek help presents a major public health concern that will have long term implications for society unless it is urgently addressed.

Prevailing approach to improve help seeking is to change young people

Research suggests that if young people could be encouraged to seek help early, this early intervention could reduce the risk of chronicity and progression to more severe and secondary disorders across the lifespan (Fryers & Brugha, 2013; Kessler et al., 2007; Klein et al., 2005; Weissman et al., 2006). Theoretical models have attempted to explain why some people do not seek help for mental health problems. These models describe the interplay of personal, societal, and contextual factors that influence the help-seeking process (Morrison, 2016). Rickwood and colleagues (Rickwood et al., 2005; Rickwood & Thomas, 2012) proposed an influential model that accounts specifically for the needs of young people seeking help for their mental health difficulties. The model describes a sequential process that unfolds within the individual as they move from recognition of the difficulty, expression of the difficulty, identifying sources of help and, finally, their willingness to disclose their difficulty. It focuses on the internal thought processes a young person experiences while weighing the psychological cost of asking for help against the perceived benefits of receiving treatment. Models such as these, however, include no contextual variables open to manipulation in the environment and do not account for critical sources of influence, such as service design and provision (Mitchell et al., 2017). Importantly, although the design features and practices of a healthcare service may influence help seeking, these variables have received less attention in help seeking research (Morrison, 2016).

A recent systematic review acknowledged the need to understand more about systemic and structural influences on young people’s help seeking in relation to mental health services (Radez et al., 2021). This review highlighted four themes organising key barriers and facilitators to young peoples’ help-seeking: (1) individual factors; (2) societal factors; (3) the therapeutic relationship; and (4) systemic/structural factors. Almost all studies (96%) included in this review reported barriers and facilitators related to individual factors such as limited mental health knowledge, negative perceptions of help-seeking, and a limited ability to verbalise the need for help. Social factors such as stigma and embarrassment were also reported in 92% of the included studies. Barriers and facilitators involving the therapeutic relationship, such as confidentiality concerns and reluctance to trust professionals, were reported in only 68% of studies. Even fewer studies (58%) documented barriers and facilitators related to systemic and structural issues; however, a number of specific issues were identified, including logistical challenges, transport issues, and the availability of and access to professional help.

Initiatives and interventions to improve young peoples’ help seeking for mental health difficulties also tend to target internal, individual, and relational-societal factors, often targeting, for example, mental health literacy and stigma (Aguirre Velasco et al., 2020; Xu et al., 2018). Notably, systematic reviews highlight stigma as a barrier to help seeking for mental health difficulties (Clement et al., 2015). Large scale public anti-stigma campaigns can increase mental health literacy, decrease stigma (Henderson et al., 2013), and improve attitudes towards help seeking (Shahwan et al., 2020). However, systematic reviews have also reported that these interventions do not increase actual help-seeking behaviour amongst young people (Henderson et al., 2013; Hom et al., 2015; Xu et al., 2018).

Improving help seeking by changing the system

In efforts to improve help seeking, it has been argued that a change in the prevailing emphasis on changing young people’s beliefs and attitudes is needed. Specifically, it has been proposed that a more effective and efficient approach involves changing the design and delivery of mental health services. The Behavioural Model of Healthcare Utilization (see Extended data; Durand et al., 2021) illustrates the healthcare system’s direct control over how services are provided and, importantly, how service provision is more amenable to change than individual beliefs and attitudes (Andersen, 2008). This is consistent with recommendations that changing key aspects of service system design is a more efficient focus for national initiatives attempting to increase help seeking behaviour (Aday & Awe, 1997). Figure 1 illustrates how two dimensions of Andersen’s model (i.e., resources and organisation) influence how a service is provided to the individual. Resources of the system include the personnel, equipment, buildings, and materials required to provide the service. Organisation involves what the system does with those resources in the process of providing care. It is important to note these components of organisation and resources do not operate separately, but are inter-related, and thus changes in one component can affect changes in another component. If mental health service organisations seek to increase help seeking by making the service more accessible, an increase in resources (e.g., supporting increased volume and distribution of services) is needed. At the same time, making organisational structures more effective and efficient in addressing a range of different help seeking requests and client issues, may help over time to reduce and optimise the percentage of total resources needed to address each individual request.
Pathways to care
Mental health services for young people in Ireland are provided using the internationally recommended (NICE, 2011) stepped care approach. This approach involves tiers of service catering to increasing level of needs. It requires all service users to enter the healthcare system at tier one, or what is often called primary care or entry level services. A fundamental foundation to delivering quality stepped healthcare is ensuring that people look for help when difficulties present, specifically, by making entry level services efficient, effective, easy to access (WHO, 2008), and age appropriate (Eapen & Jairam, 2009).

It has been argued that young people in Ireland do not access entry level mental health services because they are generally not age appropriate (McGorry, 2013; Ombudsman for Children’s Office, 2017) and are not designed to meet their needs (McMahon et al., 2019). A scoping review of service-related barriers to accessing youth mental health services found pathways to access are often complicated and involve long waiting times (Anderson et al., 2017). A systematic review highlighted these cumbersome access pathways as a key barrier to help seeking and acknowledged a lack of research regarding their influence (MacDonald et al., 2018).

In addition to potentially complicated and cumbersome access pathways, unlike adults, young people often need adult assistance to access mental health services. A young person is often confronted with a two-gated process to access help: first a parent, then a general practitioner (GP) (Dooley et al., 2019; Radez et al., 2021). Parents, too, can be reluctant to seek specialist help for their child. This may be due to stigma (Sayal et al., 2010; Vallance et al., 2011) or related to the design and practices of the healthcare system (Reardon et al., 2017). Wait times, navigating the system, issues of confidentiality, knowledge of mental health difficulties, and negative attitudes and beliefs of the effectiveness of treatment were the most significant barriers reported in a systematic review of parental barriers (Reardon et al., 2017).

Empowering young people
Empowering young people to seek help within a readily accessible mental health service is an ideal that requires dedicated design thinking. Research has found that young people are less likely to seek help if they perceive it to be their parents’ or teachers’ choice (Radez et al., 2021). This preference for self-reliance is well-documented in relation to young people’s help seeking (Gulliver et al., 2010). One solution involves providing support directly to the young person through online supports and school-based mental health service facilitates.

School-based mental health support puts the help where the young people already are, removing potential organisational barriers associated with understanding, navigating, and gaining access to the services of a service outside of the school context. There can be an expectation, however, that school-based support should involve teachers in identifying young people’s mental health difficulties (Rothì et al., 2008). Teachers often feel ill-equipped to do so (Anderson et al., 2019) and there is no conclusive evidence that teacher-led support works (Werlen et al., 2019). Specialist outreach services such as Jigsaw in Ireland provide school-based wellbeing programmes that have been integrated into some school curriculums (Rogers, 2016). Programmes such as these may be effective in reducing stigma and increasing mental health literacy but do not necessarily increase help-seeking (Henderson et al., 2013; Hom et al., 2015; Xu et al., 2018). Currently in Ireland, school-based mental

Figure 1. System related determinants of help-seeking in the behavioural model of health service utilisation.
health support often involves guidance counsellors, who are school staff and often teachers as well. They are not mental health professionals but are expected to triage any mental health issues to appropriate mental health services. Even if guidance counsellors and teachers are confident and capable of performing this challenging task, young people are reluctant to seek help from school staff and have a preference for independent counselling within their school (Doyle et al., 2017). Evidence suggests that, given the right circumstances, young people are comfortable with the idea of mental health services being provided in their school (Doan et al., 2020) and are more likely to access these services when they are placed at school rather than in other organisational contexts (Kern et al., 2017; So et al., 2019). Research also suggests that when mental health services are placed in schools it can both improve outcomes and decrease the use of tier two, secondary level services (Mason-Jones et al., 2012; Salerno, 2016).

The internet offers another pathway to care that can facilitate young peoples’ preference for self-reliance. Online supports overcome key help seeking barriers by offering anonymity, flexibility, and immediacy (Anderson et al., 2017; Pretorius et al., 2019). However, a recent systematic review revealed that young people have concerns about the integrity and confidentiality of online supports, and that this type of support may also encourage treatment avoidance (Pretorius et al., 2019). Rather than an exclusive and direct source of treatment, online support is mostly advocated as an adjunct to offline support, and as a way to increase the motivation toward formal help seeking (Pretorius et al., 2019).

Asking young people how to change the system

One effective way to ensure mental health services meet the needs of young people is to fully involve young people in the research and design process. Participatory research emphasises the sharing of power within the research process (van der Riet & Boettiger, 2009). It helps to bridge gaps between research and practice, empowering people to gain control in research processes that affect their lives and communities (Jagosh et al., 2012). As those developing and delivering youth mental health services are adults, it is particularly important to empower and include the unique perspectives and design ideas of young people in the development process. Indeed, giving young people a voice in their service design is an integral part of best practice guidelines (Department of Children and Youth Affairs, 2015; Hawkes, 2018; National Youth Mental Health Task Force, 2017). Providing ways to deliver on these best practice guidelines is critical for ongoing system design, innovation, and development.

Collective intelligence

Stakeholder engagement in this research project was vital to ensure that the recommendations that were being put forward were considered to be relevant, feasible, acceptable and useful for those that they were intended to help. Collective intelligence (CI) refers to the shared knowledge and consensus that emerges as a result of a group of people working together, through the facilitated implementation of a specific range of methodologies, to understand and address a complex problem (Hogan et al., 2020). Having this expanded view of a problem situation can enhance collaborative understanding, lead to innovative solutions to address the problem, and support creation and implementation of selected design options (Warfield, 2006). This type of participative group thinking and shared decision-making is particularly important when the stakeholders in the problem situation have diverse backgrounds and a wide range of knowledge, experiences and perspectives. For this project, it was essential that young people felt that their voices and opinions were being listened to and respected as much as other stakeholders. Warfield’s CI methodology/approach offered an engaging way for young people’s thoughts and opinions to be encouraged, openly discussed, collated and prioritised, with continual checking in by the research team to ensure the integrity of the data.

Addressing gaps in understanding

Prominent researchers in the area of youth mental health services highlight the need to increase understanding of ways to facilitate access to services (Birchwood & Singh, 2013; MacDonald et al., 2018; McGorry et al., 2013). To address current gaps in knowledge and inform potential service innovation and development, the current study aimed to (a) identify young peoples’ perceptions of service-related barriers to access of mental health services, (b) generate and select options to overcome these barriers from a youth perspective, and (c) report mental health practitioners’ ratings of the potential impact and feasibility of young peoples’ options. As the Behavioural Model of Healthcare Utilization outlines specific healthcare service design factors that influence help-seeking, it was chosen as a guiding conceptual framework for the current study. In particular, this study focused on what the model describes as ‘the organisational features of a health service system’s design,’ which influence help-seeking, namely the access to and the structures of the system.

Methods

Ethics

Ethical approval for this research was obtained from National University Galway’s Research Ethics Committee (reference: 19-Apr-08). All participants received an information sheet that provided the background of the study and a detailed explanation of what participating in it would involve. Informed written consent to take part in the study was then obtained from all participants and their guardians. Participants also provided written confirmation regarding their consent to the workshop being audio recorded.

Design

This qualitative study used a CI, scenario-based design (SBD) approach. SBD uses a narrative description of a potential scenario that a system user may encounter in order to provide concrete context in relation to the problem a user may face, to highlight the needs of a potential user, and to help raise questions about the appropriateness of the system and requirements to meet user needs (Carroll, 2000).

CI methods build on Warfield’s applied systems design approach (Warfield, 2006), where diverse stakeholder and
domain expert knowledge is synthesised to develop an understanding of a complex problem situation, and where options are identified to address the problem. This scenario-based CI approach has been used in a wide variety of community and organisational development projects (Broome, 1995; Hogan et al., 2016), and in studies engaging youth stakeholders in system design projects involving multiple stakeholder groups (Domegan et al., 2016). Using the scenario-based CI approach in the context of stakeholder engagement can help to support high quality, consensus-based problem-framing and idea generation, as it includes a set of methods and tools, as well as a facilitated thought and action mapping process, that helps groups to develop outcomes that integrate contributions from individuals with diverse views, backgrounds, and perspectives (Hogan et al., 2015; Warfield & Cardenas, 1994). For this study, the scenario of a teenage male experiencing mild mental health difficulties was used to centre the workshop participants in the problem space.

Sample

Sample size. There is no widely accepted optimal sample size for CI research. Therefore, for the youth cohort, guidance provided by Braun & Clarke (2013) was followed to ensure our sample was sufficient. Specifically, participants are more likely to engage and contribute when groups contain between 4 to 8 participants and the saturation of ideas will likely occur, for a large study, with a sample of 10 or more groups (Braun & Clarke, 2013). This study involved a purposive sample of 74 youth participants who formed eleven groups, where each group consisted of 4 to 8 members. For the practitioner cohort, we aimed to recruit as large a sample as possible whereby the population from which we could recruit was limited to clinical psychologists who had worked with youth within the regional service to which we had access.

Selection of schools. In an effort to increase the generalisability of the sample, schools with a diversity of socioeconomic backgrounds were targeted. The sample drew from three schools representing a diversity of communities: one suburban Dublin school, one urban school in Galway city, and a rural school in County Galway. Three school principals, known to the researcher, received information outlining the purpose and scope of the research, a description of the workshop process and an invitation for their school to participate. All agreed to their school taking part. Both the principals and the school’s transition year coordinators received a copy of the study information sheet and consent/assent forms. The transition year coordinators then identified one transition year class and invited the students in that class to take part in the study.

Eligibility criteria. Eligibility criteria for the youth cohort were being aged between 15–17 years, enrolled in a transition year programme at one of the included schools with sufficient command of the English language to understand the instructions for and to participate in the relevant workshop independently. For the practitioner cohort, only clinical psychologists with experience of working with youth within existing services in the West of Ireland (i.e., the group to whom the research team had negotiated access via the Director of Psychological Services) were considered eligible.

Recruitment procedure. For the youth cohort, prior to the date of the workshops, the lead researcher (AC) visited the class, explained the research, provided and discussed the study information sheet and the consent/assent forms and emphasized the voluntary nature of participation. Participants were asked to discuss participation with their guardian(s) and if agreeable to participation, return consent/assent forms signed by both themselves and a guardian, to the class teacher. Students who returned the appropriate consent forms were invited to take part in the workshops. For the practitioner cohort, the Director of Psychological Services for the Western Region of Ireland disturbed an email asking psychologists working with youth for the nationalised health service in that region to take part in the research. In this email, the practitioners received a study questionnaire and a narrated presentation explaining the research, and asking for their participation.

Procedure

The workshops took place in October and November of 2019. As outlined in Figure 2, the CI-SBD method involved three distinct phases.

Phase 1: Developing an understanding of the situation. In order to support SBD and CI thinking amongst youth stakeholders in relation the problem situation, the youth cohort were provided with relevant contextual information on mental health services and a potential service user scenario. Specifically, an overview of mental health services and a scenario case was provided during a 45-minute in-class presentation, which outlined what an entry level service is, details on local service provision, and an overview of mental health difficulties that are supported in entry level services.

Following guidelines provided by Rosson & Carroll (2002), a scenario was developed that offered a concrete example of a potential service user, without specifying fixed ideas regarding the barriers that would be encountered or ways to facilitate engagement with a service. The scenario described the details and background of a teenage male who was experiencing symptoms of a mild mental health difficulty and whose friends and family were noticing changes to his mood and behaviour. The scenario was designed to elicit a holistic consideration of challenges young people may encounter and produce creative and specific ways a service could encourage their help-seeking.

Immediately after the presentation, participants were asked to complete a worksheet which prompted them to generate a list of barriers to accessing entry level mental health service for young people (see Extended data; Durand et al., 2021).

Upon completion of each idea generation session, a list of barrier statements was compiled from student worksheets. Duplicate ideas were removed from the set and the paired comparison method (Warfield & Cardenas, 1994) was used by three researchers (AC, MJH, OH) to identify themes of
conceptually similar barriers. The paired comparison method involves the comparison and discussion of a number of generated ideas with the intent of clustering them into agreed categories based on similarity. This enables the group to identify a consensus regarding the number of distinctly different issues involved and to see an overview of the issues within each category. Each cluster (or theme) was assigned a concise label that captured the essence of the barriers within.

For the purpose of presentation in a subsequent session with youth cohort participants (see Phase 2), each theme heading was printed in a large bold font on a coloured A4 card. Each of the barrier statements were printed on A4 sheets and tacked onto A0 sheets. The A4 coloured theme heading was attached to the top of the A0 sheet, which could be posted on display walls and used to present the field of barriers to participants.

Phase 2: Developing a collective basis for improvement. One week after the barrier generation session, youth participants took part in a three-and-a-half-hour workshop facilitated by the researchers (A.C. & O.H.). In each school, workshops took place in a space larger than a standard classroom (e.g., the school library, study hall). Each room contained 6-8 pods, configured as a set of tables surrounded by chairs, and each pod could accommodate 4–6 people seated facing one another. An audio recorder was placed in the centre of the room to record the clarification of ideas presented by each pod in turn. The A0 sheets displaying barrier statements were arrayed on the surrounding walls, with the coloured theme heading displayed above each set of barriers.

In the first stage of the workshop, participants were invited to take 10 minutes to walk around the room to review the full set of barriers and to consider the appropriateness of the themes and any ideas that may have been missed. Participants were instructed to write any additional barriers on an A4 sheet and add to the relevant category.

In the next stage of the workshop, participants were asked to select the barriers they believed to be most critical. Each participant was given a sheet of red dot ‘voting’ stickers which were to be used to select barriers. The number of voting stickers given to each participant was equal to that of the number of themes on the wall, plus an additional three voting stickers. Participants were asked to circumnavigate the room, visit each theme of barriers in turn, and place one red voting dot on the barrier they considered most important. After selecting one barrier from each theme, participants were then asked to place their remaining three red dot votes on three additional barriers, from any category, again selected three additional barriers they considered most important from the remaining set.

The participants were then arranged into smaller groups of 4 to 6 members per group. Each group was assigned one theme that included 20 or more barriers or two themes that included fewer than 15 barriers. Participants were instructed to review and discuss the barriers in their assigned theme with members of their group and to begin writing down, on worksheets provided, options to overcome barriers. Groups were asked to pay particular attention to any barriers that had received votes. Participants were then invited to take a 15-minute break, where refreshments were provided.

After the break, groups were given 10 minutes to continue to generate options. They were then asked to write each of their options on an A5 sticky note and then attach it to the corresponding barrier statement on the idea wall. Each group, in turn, stood next to their theme and presented their options to all participants at the workshop. The facilitator asked questions to clarify options and encouraged dialogue from all participants. Once all groups had presented their options, participants were each provided with three voting stickers and were asked to select the three most impactful options from across all themes.

When workshops were completed, all barriers and options from across the three CI sessions were collated and entered into an Excel spreadsheet, along with the vote count for each. Workshop audio recordings were transcribed for further analysis. Data were coded by three independent coders (AC, MJH, OH). An inductive approach to the analysis was taken, whereby themes were identified from the raw data. An exploratory approach to textual data analysis was employed for this
study, with qualitative content analysis informing the adopted analytical strategy (Elo & Kyngäs, 2008; Elo et al., 2014). Computer-assisted software was not used. Analysis was conducted manually by the team and the phenomena description was achieved by following relevant guidelines, which included stages of preparation, organisation, and report writing (Elo & Kyngäs, 2008). Specifically, after immersing themselves in the data, the researchers engaged in the process of open coding and category creation using the Paired Comparison Method (Warfield & Cardenas, 1994). The paired comparison method involves an iterative process of idea comparison, dialogue, and consensus decision-making amongst members of the facilitation team, whereby all ideas in a set are compared to generate clusters of similar ideas. In the current study, the CI facilitation team (AC, MH, and OH) collated all responses and performed a paired comparison of all barrier statements, in a face-to-face meeting. Pairs of barriers were systematically assessed for conceptual similarity in turn, during an exhaustive process of comparative analysis. These conceptually similar barriers were then grouped under higher order categories. A similar process was used in the analysis and categorisation of options. A description of findings resulted from abstraction as well as the generation of categories and subcategories.

**Phase 3: Rating options for change.** Phase 3 involved working with mental healthcare practitioners to gather their perspectives regarding the potential impact and feasibility of the options generated by participants in Phase 2. Options that received two or more votes across all Phase 2 CI sessions were presented to the practitioner cohort for rating via email. Practitioners used a five-point Likert scale (very low, low, average, high, very high) to rate each option for its potential impact and feasibility to improve help-seeking for entry level mental health services. A narrated presentation explaining the research and requesting participation accompanied the questionnaire. The questionnaire and presentation are provided as Extended data (Durand et al., 2021).

**Results**

The results below include (a) barriers to accessing entry level mental health services identified by youth cohorts, (b) options generated by youth cohorts to overcome these barriers, and (c) ratings of the impact and feasibility of options by the practitioner cohort. Findings are reported in line with the consolidated criteria for reporting qualitative research (COREQ) checklist (see Extended data; Durand et al., 2021).

**Sample characteristics**

The study included a total of 83 participants: 74 participants forming a youth cohort; and 9 participants forming a practitioner cohort. The youth cohort were recruited from three schools representing a diversity of communities: a suburban Dublin school (n = 23); an urban school in Galway city (n = 28); and a rural school in County Galway (n = 23). The student population in Galway city and Galway County included both males and females; the suburban school in Dublin was an all-male school. All youth participants were transition year students aged between 15 and 17 years with a sufficient command of the English language. All participants in the practitioner cohort were Clinical Psychologists practicing in the west of Ireland with experience of working in youth mental health services.

An email invitation to participate was distributed to 25 psychologists working in Early Intervention, CAMHS, and Primary Care Psychology in HSE’s CH02 area (counties Galway, Mayo, and Roscommon). Nine psychologists responded, all of whom subsequently completed the questionnaire.

**Organisational barriers to access**

Young people identified 301 barriers to access, which were arranged across 15 themes, that are described in Table 1. A Table outlining all barriers identified within each theme is provided as Extended data (Durand et al., 2021).

Figure 3 lists a set of 12 barriers that received ten or more votes. These 12 barriers represented more than a third (35%) of the total votes cast. These barriers highlight four general areas that related to (a) stigma, (b) discomfort with asking for help, (c) insufficient services, and (d) a lack of information about services.

**Generating options to address barriers**

Young people generated a total of 133 options to address barriers, 130 of which were unique options. Of these 130 options, 75 received no votes, 24 received one vote, and the remaining 30 options received two or more votes. Table 2 displays the 30 options that received two or more votes. A table of all 130 options, their corresponding barriers and comments obtained from audio recordings can be found in Extended data (Durand et al., 2021).

**Developing a framework for action: impactful and feasible solutions**

To develop a starting point for action, the 30 options receiving two or more votes from young people were presented to the practitioner cohort. The practitioner cohort rated 12 of these options very high or high for both feasibility and impact. These 12 options highlighted four general areas for service adaptations to improve help-seeking: (a) making services feel more homelike and familiar, (b) providing mental health specialist input through schools, (c) improving parental awareness, and (d) increasing the visibility of appropriate supports. Figure 4 illustrates the 12 options within the four areas for action under two general sub-headings (1) organisational access or (2) organisational structures. Practitioner ratings and comments for all 30 options can be found in Extended data (Durand et al., 2021).

**Organisational access**

**Visibility of appropriate supports.** Both youth and practitioner cohorts agreed that a single, national, confidential, free, and easy-to-remember telephone number would be impactful and feasible and would improve help seeking by signposting where to go for help. Young people described a combination of both online and face to face options as ideal. They suggested, “they
### Table 1. Themes developed from identified barriers.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Definition of Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atmosphere</td>
<td>Feelings evoked from the aesthetic of the service structure and process.</td>
</tr>
<tr>
<td>Fear of Judgement</td>
<td>Consequences for service user and for family and friends of acknowledging mental health difficulty due to stigma.</td>
</tr>
<tr>
<td>Service Design &amp; Location</td>
<td>Suitability of the service structure and the service process.</td>
</tr>
<tr>
<td>Addressing the Problem</td>
<td>Capability and capacity to acknowledge mental health difficulties and belief that support might help.</td>
</tr>
<tr>
<td>Time</td>
<td>The amount of time required to receive support.</td>
</tr>
<tr>
<td>Accessibility</td>
<td>Challenges reaching the service building or obtaining the service.</td>
</tr>
<tr>
<td>Communication</td>
<td>Capability and capacity to share feelings and concerns about mental health difficulties</td>
</tr>
<tr>
<td>Advice</td>
<td>Advice on the service structure and process.</td>
</tr>
<tr>
<td>Education &amp; Information</td>
<td>Access to reliable information about mental health difficulties and available services</td>
</tr>
<tr>
<td>Mental Health Knowledge</td>
<td>Reliable information source about mental health symptoms, what is normal, treatment and prognosis.</td>
</tr>
<tr>
<td>Doubtful</td>
<td>A concern of overreacting.</td>
</tr>
<tr>
<td>Not Enough Help</td>
<td>Insufficient number of services and specialists.</td>
</tr>
<tr>
<td>Not Important</td>
<td>The invalidation of mild mental health difficulties.</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>Uncertainty regarding effectiveness of treatment versus waiting for it to go away on its own</td>
</tr>
<tr>
<td>Inconvenient</td>
<td>Resources required to use service structures and to navigate the service process.</td>
</tr>
</tbody>
</table>

### Figure 3. Barriers receiving 10 or more votes.
<table>
<thead>
<tr>
<th>Theme</th>
<th>Barrier</th>
<th>Option</th>
<th>Votes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Communication</strong></td>
<td>People don’t want to share their feelings</td>
<td>Bringing a friend with you to a support group gives you something to count on during the group no matter what happens, reducing the anxiety of something going wrong</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Afraid to ask [parents]</td>
<td>Make parents more understanding</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Boyfriends / girlfriends</td>
<td>They should love you for whatever you are and always respect you</td>
<td>2</td>
</tr>
<tr>
<td><strong>Fear of Judgement</strong></td>
<td>Seems to be a big deal</td>
<td>Educate young people through their teachers</td>
<td>2</td>
</tr>
<tr>
<td><strong>Advice</strong></td>
<td>Reputability of psychologist</td>
<td>Rate my psychologist website</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Don’t know what advice is best</td>
<td>Educate teachers and parents properly so advice is correct and consistent</td>
<td>5</td>
</tr>
<tr>
<td><strong>Education &amp; Information</strong></td>
<td>Not being able to find anywhere to go</td>
<td>Numbers that people can text or call to talk to people about their current situation</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>It’s not advertised so you need to decide it yourself</td>
<td>Ads on social media</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Little advertising - very few know about it</td>
<td>Put up posters in places where there are teens -- like schools, shops and hospitals. Telling kids what to do. Make them colourful, unusual, to make it stand out</td>
<td>6</td>
</tr>
<tr>
<td><strong>Mental Health Knowledge</strong></td>
<td>Not enough education in schools and at home as to what mental health difficulties there are and how to get help</td>
<td>Provide talks in secondary schools starting from first year and provide information to parents about mental health. Have a larger part of the SPHE course be about mental health and have it be mandatory for each year, to have a talk with a psychologist / counsellor in order to be taught about mental health difficulties from someone who deals with it regularly.</td>
<td>4</td>
</tr>
<tr>
<td><strong>Doubtful</strong></td>
<td>Your parents could get annoyed or make fun of you for wanting to go</td>
<td>Give parents a training day</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>People may be telling you you’re just stressed</td>
<td>Teach people how to express themselves to make it easier for others to understand and help</td>
<td>2</td>
</tr>
<tr>
<td><strong>Accessibility</strong></td>
<td>Door is locked [not open when need it]</td>
<td>24-hour facilities [give option of face to face – facetime? Or online]</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Having to talk to a GP</td>
<td>“Vibe check” [mandatory mental health check in school]</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Complicated Set up</td>
<td>Screening for severity [at schools]</td>
<td>5</td>
</tr>
<tr>
<td><strong>Atmosphere</strong></td>
<td>The services are intimidating, the design is nerve-wracking</td>
<td>Therapy horses</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Scary</td>
<td>Therapy dogs</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Scary</td>
<td>The patient and parent go straight into the office and the psychologist will enter after their last appointment in a spare office. To have multiple offices.</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>No amount of &quot;rainbow&quot; design makes the buildings feel less daunting</td>
<td>[put the service] by the sea, have a fascinating design, walls with mirrors etc., unique doors and interior</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>If staff aren’t very friendly</td>
<td>10/10 personality, good craic, fun, understanding, will make TikToks</td>
<td>2</td>
</tr>
<tr>
<td><strong>Service Design &amp; Local</strong></td>
<td>Open during school hours</td>
<td>Change working hours to suit school hours (after 4 and weekends)</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>In a hard-to-reach place</td>
<td>Psychologists that work in schools</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Far-away if not living in city centre</td>
<td>Build more centres around rural and urban Irish towns and cities to make the centres more accessible for those living in all areas of Ireland</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Daunting</td>
<td>make patients feel more at home, tea/coffee, biscuits, music, comfortable</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Being at the bottom of a 2-year waiting list</td>
<td>More days open means less time spent on waiting lists</td>
<td>2</td>
</tr>
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</table>
should just call it [i.e., the information service] a word,” and “make it national.” Suggested names for this national phone number included: [1850] “SHUTUP,” “MENTAL,” “HELPME,” “SOS,” “HELPUS,” “CALLME,” “IMHERE,” “WEHEAR,” “HEARUS,” and “LISTEN.” Social media was identified as a more relevant way than television or radio to increase young people’s awareness of available and appropriate supports. Young people described how social media campaigns should have “short and snappy messages” and “show someone who is a celebrity who has had problems” and how this person should be discussing their story and how the services work. Unique, striking, and novel posters placed in high student traffic areas were also agreed to be viable options for improving visibility of supports and thereby increasing help-seeking.

Parental awareness. Practitioners agreed with young people that improving parents’ awareness of mental health difficulties and their ability to understand their children’s difficulties would be a good way to improve young people’s help-seeking. Young people described how “people from [the] HSE (Health Service Executive) could come in and give parents information so they could give their children advice.” This was suggested as a way to overcome the barrier young people identified of parents not taking young people’s mental health concerns seriously, or thinking their child is just looking for attention. The provision of information and training for parents from a mental health specialist was suggested to “educate teachers and parents properly so advice is correct and consistent.”

Mental health specialist input in school. According to both youth and practitioner cohorts, having specialist mental health input in school would normalise the use of mental health services, and some youth participants suggested this would “make them regular, so people aren’t afraid to go to them.” Young people suggested this should include mandatory classes for students and group discussions about mental health difficulties “probably before 4th year as well […] [preparing] for stress of 5th year and 6th year.” The practitioner cohort agreed this would improve help-seeking and would be very feasible to implement. Some practitioners commented this should begin at a younger age, possibly even in 1st year, explaining, “This is a time of transition, and it can be difficult for young people.”

Both cohorts also agreed help-seeking could be increased by providing specialist input in school to improve young peoples’ communication skills. Young people noted difficulties broaching the topic of mental health with others and an inability to accurately communicate their concerns. They suggested improving communication skills could help them express themselves and be specific by providing, “words they could use, instead of just saying I’m sad […] on social media.” They suggested that support to “teach people how to express themselves, make it easier for others to understand and to help” would improve their ability to ask for help.

Many practitioners rated school-based options as high or very high impact (e.g., placing psychologists in schools, screening for severity in schools, educating young people through teachers, mandatory mental health knowledge through social, personal and health education [SPHE] classes, and ‘vibe checks’), but these options received lower feasibility ratings. Comments by professionals highlighted a lack of resources and difficulties for existing school staff to provide this type of specialist service. Some comments suggested an increased role for National Educational Psychological Services (NEPS) or for clinical psychologists in providing this support as an alternative to teachers providing this service, but there was scepticism regarding obtaining the appropriate resources to do so.

Organisational structures

Homelike and familiar. Young people and professionals agreed expectations of a warm welcome (“should be friendly, have good manners, [be] comforting […] makes conversation, doesn’t make it awkward”) would likely improve young people’s help-seeking. It was agreed that playing music and providing tea, coffee, and biscuits would be a feasible way to set “a more home-like” and relaxed atmosphere. To increase

<table>
<thead>
<tr>
<th>Theme</th>
<th>Barrier</th>
<th>Option</th>
<th>Votes</th>
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<tbody>
<tr>
<td>Effectiveness</td>
<td>Is it worth it - will it help?</td>
<td>Create more in-depth guides on the procedure of the appointment, session, through general guides in test and through introductory videos allowing one to become familiar with the staff / building without having to go in first, thus reducing anxiety</td>
<td>4</td>
</tr>
<tr>
<td>Not Enough Help</td>
<td>Long wait times could lead to teen backing out</td>
<td>Know how long it will take - have an online website</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Long wait to see psychologists may put people off going</td>
<td>Psychologists would be working longer hours</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Scared that they could have a bigger problem than they thought</td>
<td>Group discussion on information for mental health in school during transition year (TY)</td>
<td>2</td>
</tr>
<tr>
<td>Inconvenient</td>
<td>Hard to get an appointment</td>
<td>More psychologists on a shift at once = more patients seen</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Cost</td>
<td>It’s free and have more in the community so there is less travel costs for patients</td>
<td>2</td>
</tr>
</tbody>
</table>
the familiarity of a service it was suggested services should each develop a video, “giving a better run through of the procedure.” Young people suggested a video could introduce staff, give a tour of the premises, and give an indication of the service user experience, to “make it familiar beforehand, […] bring down the unfamiliarity [that] causes the anxiety […] [so that young people] would feel more open to making that call.”

Discussion

While early uptake of support services reduces the chronicity and progression of mental health disorders, young people do not commonly seek help for mental health difficulties. To curb the increase in total population mental health difficulties, mental health care systems need to understand how to facilitate young people to access their services. The current study addresses gaps in the literature regarding ways to improve access by (a) exploring ways to facilitate access, (b) focusing on ways to adapt the service, rather than change the young person, (c) asking young people to generate options addressing identified barriers to access, and (d) asking practitioners to engage with options selected by young people, in particular, to rate their potential impact and feasibility. A number of key findings emerged from the current study which advance our understanding of service access barriers and facilitators as well ways to potentially maximise effective and efficient use of resources. Practitioners’ ratings of the impact and feasibility of young peoples’ option to facilitate access suggest a possible framework for action.

Organisational barriers to seeking treatment

Young people in the current study identified a number of prominent barriers to access, including potential stigma, a discomfort with asking for help, insufficient quantity of services, and a lack of awareness of available services. These barriers to access have been identified in previous research, specifically, in relation to mental health services operating outside of Ireland (Gulliver et al., 2010; MacDonald et al., 2018; Radez et al., 2021; Rickwood et al., 2015). The current study highlights that young people in Ireland perceive similar barriers to accessing mental health services and the findings further suggests the need for greater collaborative international efforts to reconceive of the design and delivery of mental health services for young people.

Solutions to overcome organisational barriers

The health service system can redesign and control the organisational conditions that impede or facilitate young peoples’ use of mental healthcare. To increase access, young people and practitioners in this study proposed organisational redesign focused on making available supports more visible, providing specialist mental health input through schools, and training parents to be more understanding. Furthermore, to reduce the fear of attending mental health services, both young people and practitioners in this study proposed organisational structures should be adapted to be more welcoming and familiar.

Figure 4. Options practitioners rated as viable solutions to improve access.
Improving visibility of available supports

If a service seeks to encourage engagement from potential users, ensuring people know where the service is located and how to use it is a fundamental requirement. Many of the young people in this study discussed the difficulty of understanding where to go or how to begin accessing mental health supports. This is consistent with findings by Ireland’s national My World Survey (Dooley et al., 2019) where only 36% of adolescents were aware of the national adolescent entry level outreach service ‘Jigsaw.’ Research indicates this lack of awareness of where and how to find help is also a barrier to access of services outside of Ireland (Chen, 2018; McCann & Lubman, 2012).

Participants in the current study suggested a single, national, confidential, and easy-to-remember phone number would improve help-seeking by signposting where to go for help. The wide variation of regional outreach services and types of support offered in Ireland makes looking for help difficult and confusing. Having one source that integrates the information for all services throughout the country would alleviate the confusion, provide a source of trusted advice regarding appropriate supports, and take pressure off local service advertising budgets.

Much of the media presence for improving awareness of supports in Ireland takes place via television and radio and occasionally Facebook, which young people in this study indicated would not reach them. According to young people in this study, messages targeting adolescents need to be via social media. Instagram, Snapchat, or TikTok were suggested as the platforms with the farthest reach. The credibility of the message was identified as crucial. The message needs to be relevant, interesting, and short, perhaps utilising influencers with experiences of the mental health services. Research suggests this type of targeted messaging improves awareness of mental health supports and can increase numbers accessing help (Rice et al., 2018).

Specialist mental health input through schools

Providing mental health support in school removes many of the key barriers to access for young people such as awareness of where to go, parental and GP gatekeepers and the logistical inconveniences associated with transport and time. Young people in this study described specialist mental health support in school as likely normalising the experience of accessing support and providing a source of consistent and reliable mental health knowledge. Research suggests young people can be comfortable with mental health supports being placed in school (Doan et al., 2020) and when placed there, they are more likely to engage with the supports (Kern et al., 2017).

When seeking help for mental health difficulties, young people want to talk to someone they know and trust (Radez et al., 2021), but are uncomfortable disclosing difficulties to school staff (Doyle et al., 2017). In Ireland, young people have indicated they prefer school mental health support to be delivered by independent mental health professionals that are not school staff (Doyle et al., 2017). Practitioners in the current study rated options involving mental health support in school (e.g., school psychologists, screening for severity in schools, ‘vibe checks’) as high in impact, but low in feasibility. Consistent with previous research (Anderson et al., 2019; Werlen et al., 2019), practitioners noted difficulties faced by existing school staff in identifying mental health difficulties and supporting student mental health. Practitioners described how a lack of resources would likely limit the feasibility of placing a mental health professional in schools. However, if resources could be made available, both youth and practitioner cohorts believe young people would benefit from the support provided by a mental health professional in their school who is independent from school staff.

Participants of this study also recommended a mental health specialist to provide regular education and facilitate discussion groups relating to mental health in school to improve help seeking. This could be achieved, for example, if more schools in Ireland incorporated Jigsaw’s successful mental health promotion programme into their curriculum, as it provides both mental health education and a discussion format as recommended (O’Reilly et al., 2015). At the same time, education alone may be insufficient in promoting help seeking. Notably, the My World Survey (Dooley et al., 2019) indicated young people in Ireland are aware of mental health problems and have good insight regarding their mental health, but 22% of sixth year students reported needing professional help they did not seek. This is consistent with international findings that programmes to increase mental health literacy improve knowledge and attitudes about mental health difficulties (Anderson et al., 2019), but do not increase the likelihood a young person will look for help (Gulliver et al., 2012).

Research has highlighted young peoples’ preference for informal supports for their mental health difficulties (Rogers, 2016). At the same time, Jigsaw’s research has suggested there is a gap in young peoples’ knowledge regarding the benefits of formal treatment (Rogers, 2016). Mental health specialists could play a role in encouraging the acceptance of formal supports by facilitating discussions in school. These discussions should cover what formal support is, where to get it, what to expect and the benefits of early treatment.

Young people in the current study reported they find it difficult to talk about their mental health issues. They suggested specialist support at school to “teach people how to express themselves, make it easier for others to understand and to help,” as this would improve their ability to ask for help. In Ireland, 60% of young people report they would talk about their mental health difficulties (Dooley et al., 2019). While this represented a majority of young people, it also points to a very large percentage (40%) of young people who feel uncomfortable broaching the subject. Increasing young people’s expressive competence and communication skills may improve their ability to begin the conversation regarding help-seeking (Rickwood et al., 2007). This type of support could be an effective addition to school mental health promotion initiatives. Development of such an addition may be best served by a multidisciplinary input of mental health, health promotion, group dynamics, and communications professionals.
Improving parental understanding
The provision of information and training to parents was proposed as an option to overcome the barrier of parents’ perception that a young person is overacting or attention-seeking when reporting mental health difficulties. Young people reported that training provided to parents by mental health specialists would ensure “advice is correct and consistent.” General parenting skill programmes are recommended to improve young people’s mental health (EU, 2008) and parental attendance is significantly higher when these programmes are provided in schools (Atkins et al., 2003). Compelling evidence suggests these types of programmes improve outcomes for young people (Barlow & Coren, 2018) and they may also decrease the risk of intergenerational mental health difficulties (Manning & Gregoire, 2009). As parents are important gatekeepers for facilitating access to formal supports (Webster-Stratton et al., 2011), building their capacity to understand mental health difficulties and support early treatment could offer an effective way to improve young people’s engagement with mental health services. Practitioner comments in the current study suggest, however, that the parents likely to benefit most from training and support are often the parents least likely to attend training. When designing this type of training programme, it would be important to investigate ways to encourage, motivate, and facilitate parents to access training and to address key parental barriers regarding how to navigate the system, confidentiality, recognising mental health difficulties, and the benefits of treatment.

Familiar and welcoming atmosphere
A priority for change for young people in this study involved what they perceived to be the “intimidating,” “scary,” and “institutional” atmosphere of existing services. Previous research concurs and recommends adapting services to be more youth-friendly to improve young people’s willingness to attend (Hawkes, 2018; MacDonald et al., 2018; Rickwood et al., 2015). Previous participatory research in Ireland suggested welcoming colour schemes, simple language when describing the service, and the importance of the right balance between professionalism and perceived relevance of staff (Illback et al., 2010).

Young people in the current study characterised “youth-friendly” as a place that seems more “like home,” where fun, understanding and friendly people greet you, refreshments are offered, and music is playing in the background. To date, no research has examined the effect on help seeking of improving service atmosphere. There is, however, increasing acknowledgment of the importance of service user’s experience and the need to offer an atmosphere that helps clients to feel comfortable (Sweeney et al., 2018). Some changes (e.g., use of music, colour, interior decoration) may be relatively inexpensive but potentially impactful, while others may require additional staff training and potential changes in service culture to enhance and sustain the potential for greater fun, understanding, and friendly interactions. Overall, these changes may entail a relatively small investment of resources and may be deemed cost effective and impactful if a transformation of service atmosphere succeeded in improving help seeking and positive perceptions of young people attending the service.

Young people also described the importance of knowing what to expect when considering making the first step towards asking for help. Young people and professionals agreed the provision of online videos introducing the staff, service and process would be a useful way to familiarise young people with a service and make the idea of attending less daunting. This provides an opportunity for gradual exposure which is an effective technique to reduce anxiety (Kaplan & Tolin, 2011) and may be the mechanism underlying why young people with prior experience of using a service are more likely to be comfortable with accessing that service again (Gulliver et al., 2012). Some regional services have made efforts to post staff pictures and biographies on their websites, which may be helpful. This study suggests, however, that more may be required. A clear and detailed video of the user experience and an introduction of staff would likely remove some elements of uncertainty regarding attending a service. The development of a communication template would make it easier for services to produce a consistent and professional video of what to expect from attending their services.

Health system resources
The gap between need and availability of mental health support services for young people continues to be a major problem (Aguirre Velasco et al., 2020). Increasing the number of young people who access mental health services would increase the strain on healthcare system resources, which are already overstretched. Comments by practitioners in this study suggest that those who work in these services are so conditioned to expect a lack of resources that solutions requiring any additional resources were simply deemed unfeasible.

It is possible that energy is not put into increasing help-seeking because services are unable to cope with the numbers they already have and no change in resourcing is expected. However, in addition to bolstering existing service provision, providing resources that aid young people in accessing mental health services early should be perceived as an investment, not a cost. Allocating resources towards support for those with the greatest need and the greatest capacity to benefit from the investment offers the best long-term return on investment. Early investment would provide improvements in total population psychosocial functioning and health and a decrease in the number of those needing costly care now and in the future.

It is also possible that appropriate adaptations to organisational practices would increase efficiencies and thus lower resource requirements in the long term. For example, adaptations such as providing services in schools could remove the
substantial costs incurred from providing mental health services in a separate building. An integration of service provision, such as the development of a single information source as suggested in the current study may also offer a more efficient use of resources than funding separate service advertising and information budgets.

Strengths and limitations
A key strength of the current study is the use of collective intelligence methods that incorporate a participatory research and system design perspective that acknowledges, respects, and values the unique perspective of participants. At the same time, this approach involved a number of potential limitations. For example, the research involved young people working in groups as classmates. It is possible results are influenced by a social desirability and conformity bias, although this is less likely a feature of idea generation as it involved independent idea writing. However, open voting in the school workshops may have involved elements of social desirability, even in the context of explicit instructions to review independently in advance of selection and not be influenced by the votes of others in the room.

The current study also involved a non-clinical sample and thus did not include the perspective of those who have more experience of using the services. A non-clinical sample, however, provided information often missing from previous help seeking research which is the experience of young people who may wish to access the service.

Conclusions
Young people do not feel comfortable with accessing mental health services and this is a major public health concern. The way a service is provided influences a young person’s help-seeking behaviour and may be more amenable to change than attitudes. Instead of the prevailing approach to help seeking, focusing on adjusting young people’s beliefs and attitudes, the current study adds to the body of research suggesting it may be more effective and efficient to change how mental health services are provided. If we want young people to seek treatment for their difficulties, mental health services need to adapt to facilitate young peoples’ needs.

This study addresses a gap in the understanding of how young people would adapt mental health services and highlights options young people consider potentially impactful in making the services easier to attend. Participants in this study proposed a starting point for adaptation of existing mental health services in Ireland, specifically, by recommending four areas in which to make 12 viable changes to services to improve young peoples’ ability to gain access and to reduce the fear of attending. Further research exploring the effects of implementing these adaptations would help to extend our understanding of how service design changes influence help seeking behaviour and the uptake of entry level mental health services.

Finding the resources to support young peoples’ mental health continues to be a major challenge. Directing resources towards making access easier offers the potential for long term improvements in the effectiveness of services and in the health of the population, which should be viewed not as a cost but as an investment.

Data availability
Underlying data
Raw data are not publicly available as the transcripts cannot be sufficiently de-identified by redaction. Data will be made available by reasonable request to the corresponding author (anncolleran1@gmail.com). A request is considered reasonable where the intended use for the data is clearly outlined, and where this intended use does not violate the protection of participants, or present any other valid ethical, privacy, or security concerns.

Extended data

This project contains the following extended data:
- E1 Anderson Model of Health Care Utilization.png
- E2 Worksheet to prompt the generation of barriers.docx
- E3 Narrated presentation emailed to practitioner cohort.docx
- E4 The questionnaire emailed to practitioner cohort.pdf
- E5 All barriers and corresponding options categorised by theme.pdf
- E5 Ratings and comments by youth and practitioner cohorts regarding youth cohorts most voted solutions.pdf

Data are available under the terms of the Creative Commons Attribution 4.0 International license (CC-BY 4.0).

Acknowledgements
The authors would like to acknowledge and thank all the participants who gave of their time by participating in this research.


Ombudsman for Children’s Office: Submission to the Seandad Public Consultation Committee on Children’s Mental Health Services in Ireland. 2017. Reference Source


WHO: Integrating Mental Health into Primary Care. 2008. Reference Source

WHO: Mental health: massive scale-up of resources needed if global targets are to be met. 2017. Reference Source

Thank you for the invitation to review this article. The topic is important and timely and the article is well written. The use of collective intelligence methods and system design perspective is a strength of the article and I have not seen previous publications make use of this approach to mental health service design with young people.

The literature review is up to date and previous publications of primary relevance to the research are considered. However, when discussing pathways to care in Ireland I think that it would be appropriate to consider the requirement for young people (under the age of 18) to have parental permission before accessing mental health services. It must surely be a barrier to service access for some young people when parents are unable or unwilling to grant permission.

The final paragraph on page 4 needs to clearly distinguish between services that are designed to support mental health and well-being (such as the Jigsaw Peer Education Programme or mental health literacy programmes) and those which are designed to provide an intervention to young people who are distressed. A similar distinction needs to be made in the Discussion in the section on ‘Specialist Mental Health Input Through Schools’.

There is an interesting tension in the article between the young people’s concern about support for mental health difficulties provided by teachers but a wish to have a service that is readily accessible. The authors note that ‘given the right circumstances, young people are comfortable with the idea of mental health services being provided in their school’. It might be helpful to provide a brief example of what such a service might look like as they do exist in other countries.

Method: The professionals were also participants in the study and it would be appropriate to include the description of their recruitment and professional background in the section on Sample, rather than in the Results. I would also like to see more information on how the questionnaires were distributed to the clinical psychologists and how they were returned by the psychologists to the research team. The information in the section ‘Developing a framework for action: impactful and feasible solutions’ would also be better in the method than in the Results.
When describing the school participants, some explanation of ‘Transition Year’ is needed for an international readership.

Discussion: Jigsaw is described as ‘the national adolescent entry level outreach service’. I don’t think that this is quite accurate. Although Jigsaw’s online services and information are available to all young people, they don’t currently have a presence in every county (based on the information on their website). Nor does Jigsaw fit my understanding of an ‘outreach’ service (providing a service in a location other than where it is primarily situated).

In relation to the recommendation for a single, national, confidential, and easy-to-remember phone number it would be appropriate to mention the national 50808 service. Although this was launched in June 2020 after the data for this study was collected, it is currently up and running and appears to achieve some of the aims inherent in the recommendation.

The authors note the importance of social media in providing information about mental health to young people. The authors could mention SpunOut.ie which provides extensive youth friendly information on a range of issues relevant to young people, including their mental health across a wide range of social media platforms.

Strengths and limitations: The authors state that their study involved a ‘non-clinical sample and thus did not include the perspective of those who have more experience of using the services.’ Did the authors gather data on whether the young participants had ever accessed mental health services? It is not mentioned in the eligibility criteria. If they did not then this statement should be omitted.

The fact that the professional sample only included clinical psychologists is a limitation of the study, particularly as the provision of services within schools is one element of the recommendations. Educational psychologists who work within the school system would be in a better position to comment the feasibility of providing services via schools. It would also have been ideal to include GPs in the survey as they are the main providers of primary care and are noted in the article as a gateway to specialist services.

Minor issues - typo throughout the article: "young peoples" - should be "young people's". Page 14 "service user's experience" should be "service users' experience"

Is the work clearly and accurately presented and does it cite the current literature?
Yes

Is the study design appropriate and is the work technically sound?
Yes

Are sufficient details of methods and analysis provided to allow replication by others?
Yes

If applicable, is the statistical analysis and its interpretation appropriate?
Not applicable

Are all the source data underlying the results available to ensure full reproducibility?
Yes

Are the conclusions drawn adequately supported by the results?
Partly

**Competing Interests:** No competing interests were disclosed.

**Reviewer Expertise:** Young people’s mental health and help seeking.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.