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# "When you're in the office, it means you managed to get somewhere": An interpretive descriptive study of the perceptions of adolescents accessing primary care for mental health services

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ABSTRACT

*Objective:* Primary care offers an entry point into the health care system for adolescents experiencing mental illnesses. This study explored the perceptions of adolescents with an anxiety or mood disorder accessing primary care for mental health services.

*Methods:* Qualitative interpretive descriptive design was employed. Participants ages 15–18 years (n = 10) were recruited from a mid-sized city in Canada utilizing flyers and social media advertisements. Data were collected between August and December 2019. Data generation methods included photo-elicitation, demographic survey, and semi-structured interviews. Analysis was guided by a health care access framework and ecological model.

*Results:* Adolescents perceived the process of accessing primary care for mental health services as complex and beginning prior to entering the primary care environment; a novel conceptual framework was developed to depict the process. Adolescents described three stages in this process: feeling uncertain about their concerns and requiring help; seeking informal support from parents and friends to initiate help-seeking; and receiving mental health services through primary care.

*Discussion:* A novel conceptual framework to depict the process of access for adolescents is proposed. Primary care practitioners require awareness of the access process adolescents conceptualize prior to deciding to seek help in primary care, as well as the need to foster their emerging adulthood in care. Targeted interventions to enable early intervention include providing information about mental health services available during routine interactions.

## 1. Introduction

Mental illnesses are one of the most common causes of disability in Canada[1] and affect approximately 1 in 5 children and youth in Ontario, Canada, per year.[2] Adolescents, which can include individuals ages 12–19 years old, are particularly susceptible to mental illnesses given adolescence is a formative time when one experiences several developmental changes and transitions as they develop their emerging adulthood.[3] While access to publicly funded mental health services for children and youth occurs in several different settings including primary

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care, hospital emergency departments, schools, and virtual services,[2,4] most mental health care for children and youth outside of hospitals occurs within primary care.[2]

In Canada, primary health care is offered through publicly-funded services for individuals across the lifespan. Primary care is can be an ideal setting for early identification and intervention before mental health symptoms worsen,[5] as it is where children and youth have ongoing contact with their primary care practitioners.[6] Although there are multiple points of access to receive mental health services, primary care is often seen as the first point of entry into the health care system.[7] Despite this important role of primary care, nearly 45 % of Ontarians under age 24 years who present to the emergency department for a mental health crisis have never had prior contact with a physician for their concern.[2] This suggests a lack of early identification of mental health concerns, resulting in preventable acute distress.[2,5] Moreover, it is known that the experiences adolescents have with health care services at this formative time can impact their attitudes towards service providers and choices about health care in the future.[8,9] To understand the challenges in primary care delivery of mental health services for adolescents experiencing anxiety or mood disorders, it is important to explore the experiences and perceptions of adolescents who have accessed these services for their concerns.

Access to health care is often defined in the literature as one of two concepts: first, the potential to receive services, or second, the actual entry of a person or group of people into the health care system.[10,11] Penchansky and Thomas[12] argued for access to be defined as the fit between the health care service user and the services, suggesting a dynamic relationship between health care service providers and service users.[11] Penchansky and Thomas[12] distinguished five dimensions of access as follows: availability, accessibility, accommodation, affordability, and acceptability. A sixth dimension of access, awareness, was proposed by Saurman.[13] Together, these six dimensions are well suited to explore the complex factors influencing access to health care from the perspective of service users and have the potential to expand beyond general barriers and facilitators, which are often discussed in the literature.[12,13] In addition, the ecological model[14] can help to explore the influences of environmental factors in an adolescent's life that may impact primary care access. This enriches the access framework by exploring the individual, social (e.g., family, friends) and organizational (e.g., primary care) levels of influence on access (see Appendix A for definitions of the access dimensions and levels of influence).

Most existing evidence has highlighted the needs of adolescents and parents to enable improved access to primary care. Some of these considerations include: feeling comfortable and respected,[15,16] emphasizing the confidentiality policy,[17,18] decreasing perceptions of stigma,[17,18] and gaining a holistic understanding of the adolescent's life.[17,18] Although several studies have discussed access barriers and facilitators,[15,19–24] these two concepts alone fail to comprehensively delve into the multiple dimensions of access that adolescents perceive when attempting to receive appropriate care. Moreover, few studies have examined access in the Canadian context, or included a concrete definition of access and its dimensions.

This qualitative study aimed to explore the perceptions of adolescents, living with an anxiety or mood disorder, of accessing primary care for mental health services.

## 2. Methods and theory

This interpretive descriptive study received [Hamilton] Research Ethics Board approval (project #[# 6005]) in June 2019. Interpretive description is useful for natural inquiry of a real-world problem identified by experience, and to provide answers relevant to clinical practice.[25,26] This methodology supported capturing the nature of experiences of adolescents, within the context of accessing primary care for mental health services as a person experiencing an anxiety or mood disorder. Inclusion criteria were: (a) aged 14–18 years, (b) residing in [Hamilton], Ontario, where the research was being conducted, (c) self-reported anxiety and/or mood disorder, (d) having a primary care practitioner (e.g., physician or nurse practitioner), (e) visiting primary care within the past 12 months for a mental health concern, and (f) English-speaking. Exclusion criteria were: (a) non-English speaking, (b) actively experiencing acute mental health distress which could impact safety and ability to give informed consent, and (c) having an existing or previous patient-nurse relationship with the first author (primary researcher). The first author, [L.D.], identifies as a woman and is a registered nurse. At the time of the study, [L.D.] was a graduate student with experience providing primary care to adolescents, and mental health care to adults with acute and chronic mental illnesses. [L.D.] had no previous relationships with the study participants.

In attempt to minimize overrepresentation of any gender, purposive sampling of gender and snowball sampling were employed. Gender refers to the socially constructed role of females, males, and gender-diverse individuals, including how they view themselves and others in society.[27] Recruitment included advertising with flyers at various public service or health care sites in the city, and online using paid advertisements targeting youth aged 14–18 years on the social media platforms Facebook and Instagram. Potential participants contacted [L.D.] through social media, text message, or a phone call for eligibility screening and to learn more about the study background, purpose, and the researchers. If the adolescent was eligible, a time to meet was determined. No potential participants were screened out. During the initial meeting with [L.D.] the following was discussed: study methods including the photo-elicitation project and interview, confidentiality, and written informed consent. To accurately judge if participants were able to understand the nature of the research and the risks involved, after the study was described potential participants were asked to explain in their own words what the study was about, potential risks, and reasons why they wanted to participate. This helped assess competence by displaying understanding, retention of information, and freedom of choice.[28] Parental consent was not sought as it was seen as a possible risk to recruitment, as adolescents may not discuss mental health concern with their parents.[29] Adolescents were provided instructions regarding the photo project, discussing that they are to take photos of things which represented their experiences accessing primary care. Subsequently, a second time to meet was established to provide participants time to take photos between sessions. [L.D.] conducted a one hour audio-recorded guided interview. Interviews were conducted in a public setting (e.g., a coffee shop) chosen by each participant where adequate privacy could be achieved (i.e., sitting away from other people). This was determined by the participant, and the public setting was chosen to support the adolescent in feeling safe meeting with an adult they had no prior connection with. Adolescents were allowed to bring a support person if chose, who did not participate in the interview. Two participants opted to bring a friend for support.

Data were generated between August and December 2019. Data generation methods included: a participant demographic survey, photo-elicitation, semi-structured interviews, and field notes and reflexive journaling post-interviews. Photo-elicitation, an arts-based approach, can be helpful for communicating health issues which face societal stigma such as mental illness.[30] Wang[31] noted this approach also reinforces the notion that adolescents are the "experts on their own lives". Semi-structured individual in-person interviews asked participants open-ended questions about their experiences and the photos taken. Questions were informed by the guiding access framework with consideration of the possible ecological model levels of influence (see Appendix B for interview guide). Interview questions were refined after the first two interviews. $20 gift card honorarium was provided for each meeting and a $2 payment for every photo shared. In total, 13 photos were taken by four participants; the other participants stated they either did not have time to take photos, or were not able to identify things which depicted their experiences. In keeping with interpretive description, the final sample of 10 participants was deemed appropriate as

several recurring themes were evident in the data and a common understanding of the experience across participants was achieved.[28] All participants participated in an interview. There were no drop-outs.

Analysis was conducted after the first interview and continued concurrently with subsequent data generation to build relational findings.[32,33] NVivo 12 software[34] was used to help organize the data, including photos with their captions. Open coding was used to form categories. An initial deductive analysis process was used to categorize the codes within the guiding access framework, nested within the ecological model. For example, the six accessibility concepts were nested within each level of the ecological influence. However, as coding occurred outside of these categories, a subsequent inductive analysis process was employed to search for explanations of emerging findings beyond the access and ecological framework. Rigor strategies employed followed four criteria for naturalistic inquiry by Lincoln & Guba[35] including the use of source and analyst triangulation, audit trails, and constant comparison for stability of analysis.[32] The primary researcher was responsible for analysis of the data, however, the additional researchers participated in review of the emerging analysis throughout the process. Gender-neutral pseudonyms were used to protect participant identities.

## 3. Results

Adolescents in the study perceived accessing primary care mental health services as a process which occurred over time, using terms such as "journey", "path", and "road to recovery" to describe their experiences which began outside of primary care (Fig. 1). The overarching theme "It's not about the end – it's about the road" encompasses adolescents' perceptions of access as a dynamic process, and describes the path involved in arriving at primary care. This process involved three phases as part of the access journey: "It was all in my head", "I needed help", and "I wanted to be seen as a person". Table 1 provides the self-reported demographic characteristics of the 10 participants, ages 15 and 18 years.

While some of the findings aligned with the access dimensions outlined by Penchansky and Thomas[12] and Saurman,[13] many did not, suggesting factors outside of the dimensions often discussed in the literature. These factors correlated with some levels of influence within the ecological model.[14] Additionally, it is noteworthy that participants used language that did not necessarily coincide with the access dimensions and levels of influence in the guiding framework and model, and instead reflected conceptualizations of the adolescents themselves. Based on these results, a novel conceptual framework was developed and used to illustrate an adolescent's journey through the process of access in their own words (Fig. 2).

**Table 1**
Self-reported participant demographics and service use.

| Variables | N = 10 |
|---|---|
| **Age** | **n** |
| 15 | 2 |
| 16 | 1 |
| 17 | 4 |
| 18 | 3 |
| **Gender identity** | |
| Girl/woman | 6 |
| Boy/man | 2 |
| Non-binary | 2 |
| **2SLGBTQ+** | |
| Yes | 3 |
| No | 7 |
| **Ethnicity** | |
| Caucasian | 9 |
| Black, Indigenous, or Person of Colour | 1 |
| **Self-reported mental illness*** | |
| Anxiety disorder | 5 |
| Depressive disorder | 1 |
| Bipolar disorder | 1 |
| Obsessive compulsive disorder | 1 |
| Anxiety and depressive disorder | 3 |
| **Entry point to access mental health care** | |
| Primary care | 5 |
| Therapy or counselling | 3 |
| Acute care | 1 |
| School | 1 |

* Categories not mutually exclusive

### 3.1. *"It was all in my head."*

Adolescents described a difficult, internalized process early in their access journey, prior to entering primary care. Most participants (n = 9) reported that although they felt something was wrong, they did not know they were experiencing a mental illness and needed help, as they felt uncertainty about the symptoms they were feeling.

> "I had a lot of difficulty getting help. Cause, I wasn't sure if I actually needed it or if it was all in my head." (Quinn)

**Fig. 1.** Photos by Blake and Harper depicting the process of access as a road or path.

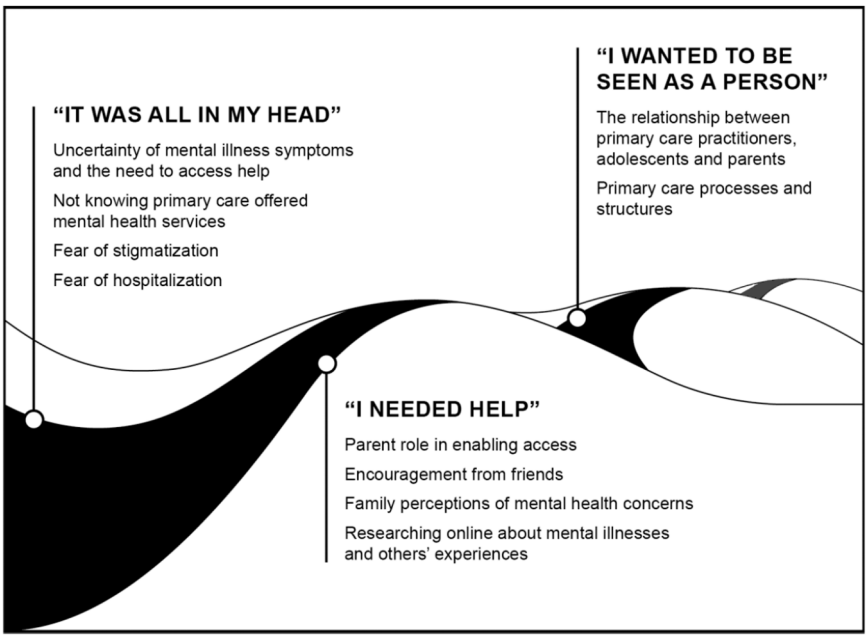


**Fig. 2.** The process of access to primary care for mental health services: "It's not about the end – it's about the road".

Prior to getting help, all participants (n = 10) noted they were unaware that primary care offered mental health services and did not know where to access help for their concerns. Some (n = 5) believed that to receive mental health services they would need to go directly to a psychiatrist, therapist, or hospital, and that primary care only managed physical health concerns.

> "I didn't think you went to your doctor's, I thought you went straight to a therapist… I thought [primary care] was just for [physical] sickness." (Alex)

Although the notion of stigma of mental illnesses was raised at different points in the access process, adolescents (n = 8) predominantly described vulnerability and fears of stigmatization through the first major theme. Adolescents expressed their fears of how others would judge them or react, which contributed to a hesitancy to seek help.

> "Telling people how you feel or what's going on in your head is like 'How are they going to react? Are they going to see or treat me any different?' " (Quinn)

Quinn's photo (Fig. 3) symbolized the notion of feeling isolated due to having a mental health concern, stating:

> "The dark brown flower amongst the green ones is to me a symbol of loneliness or being out casted as different, not really fitting in anywhere, because of what you're feeling inside."

Most participants (n = 5) also described feeling vulnerable and fears of hospitalisation when considering whether to talk to someone about their mental health. This was depicted in Fig. 4 in which Blake described vulnerability as:

> "You're locked up, you [would] have to open and tell people all your dark secrets right? …. And a lot of people are kind of scared of being hospitalized involuntarily …. Like, how honest can you be before you're sent away?" (Blake)

In summary, "It was all in my head" depicts adolescents' perceptions of an internalized process where they felt uncertain, displayed a knowledge gap regarding what services for mental health were available, and expressed fears of stigmatization and/or hospitalization if they decided to seek help. This theme is depicted as a valley in the conceptual framework because adolescents perceived this phase to be challenging; they reported feeling alone in their experiences of mental illnesses and felt unsure about what to do.

**Fig. 3.** Photo by Quin symbolizing the notion of feeling isolated due to having a mental health concern.

### 3.2. *"I needed help."*

This theme describes the second phase of seeking help on their recovery journey. It involved taking initial action by obtaining support from other people and learning that they can access help from primary care. Most participants (n = 9) reported that their parents and friends played an important role in helping decide to access services. They reported their parents helped push them to seek care and provided

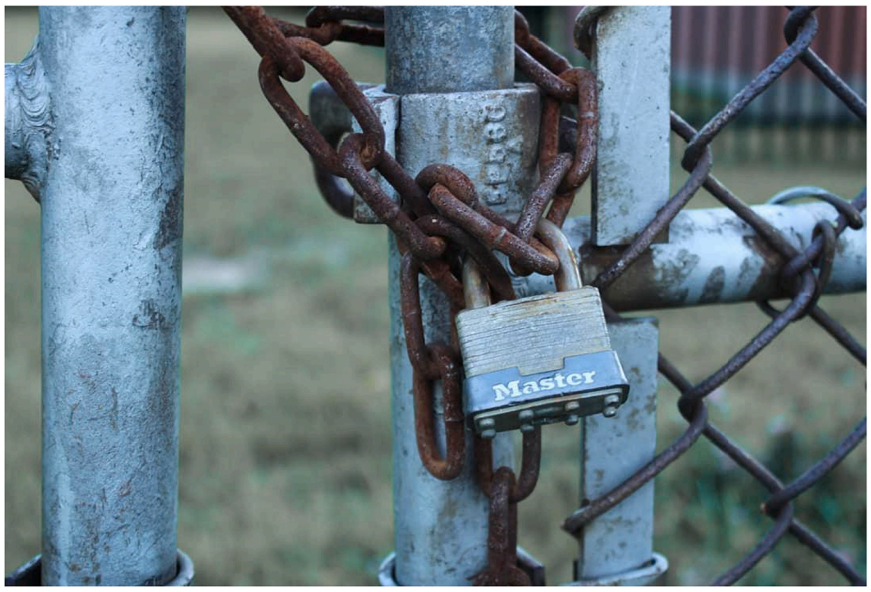


**Fig. 4.** Photo by Blake depicting feelings of vulnerability.

instrumental support through helping to book appointments and providing transportation.

"I never considered [going to the doctor's] myself until my parents kinda forced me to." (Teagan)

"I have a friend that has anxiety and she told me she went to the doctors, and they diagnosed her. It really helped. So, I thought that would be good for me." (Ryley)

Some participants (n = 5) described how their families' perceptions of mental health concerns could positively influence their own perceptions of accessing help; however, they could also perpetuate stigma posing a barrier to accessing help.

"[My mom] was 100 % supportive… she struggled when she was a kid too. And my dad did too, it's in the family." (Amari)

"My dad, he's like 'You're not actually depressed.' Or with my grandparents… they think mental health is a myth." (Jamie)

Some participants (n = 3) reported that they used the Internet to learn how other people had obtained help for mental health concerns. This helped inform them that primary care provides support for mental health concerns.

"There's a lot of stories [online]. There's people's success stories or people who are depressed, but it was motivational to hear that things

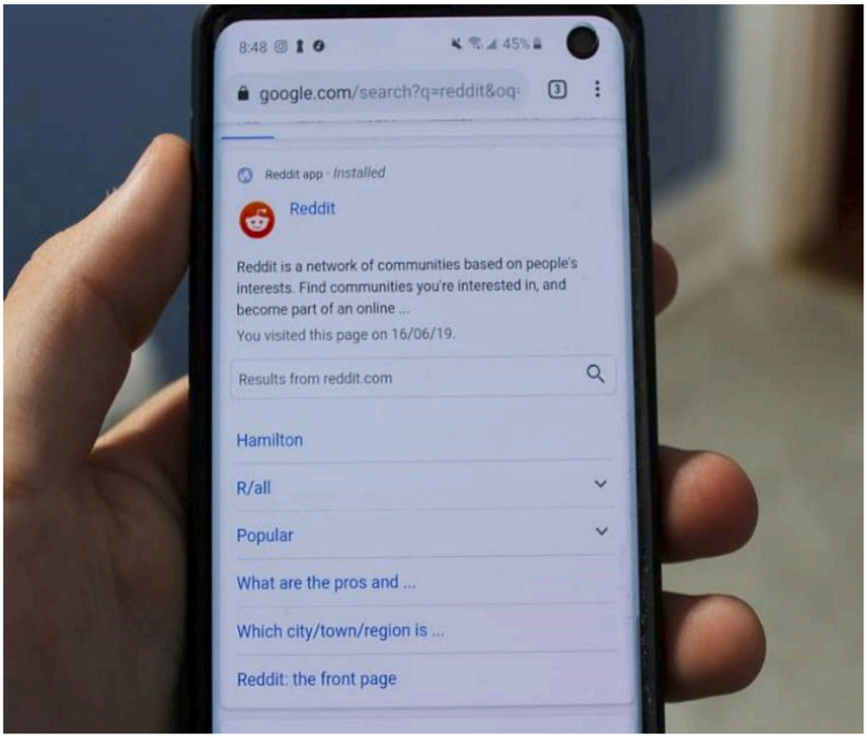


**Fig. 5.** Photo by Blake depicting utilizing the Internet to learn about others' experiences obtaining help for a mental health concern.

can get better… By looking at success stories I was like, "well might as well [try to get help]", right?" (Blake, Fig. 5)

The second theme "I needed help" described adolescents coming to recognize the need to obtain support and health care for their mental health concerns, and subsequently externalizing their concerns to decide how to access help. A hill represents this theme in the proposed framework, as it depicts an upward process of overcoming obstacles and adolescents becoming motivated as they decided to move towards seeking help in primary care.

### 3.3. *"I wanted to be seen as a person."*

Finally, adolescents described the process of accessing primary care for their mental health concerns, and what they valued most about those services. Most adolescents (n = 9) wanted their primary care practitioners to support their development through emerging adulthood. They described wanting to be seen as a person, rather than being identified by their mental illness or age. They also wanted a client-centred approach where providers offered them choices and believed in their capacity to make good decisions for themselves.

"I wanted to be treated like I wasn't just a kid. I wanted to be seen as a person instead of a person who has anxiety or depression… I am growing up here too. I'm not a little sapling." (Harper, Fig. 6)

Most participants (n = 8) discussed the client-centred care considerations that were important for them, including providers being supportive and non-judgmental. This included providers giving adequate time during appointments and validating adolescents' concerns. Additionally, participants expressed a need for education related to the symptoms and causes of mental illnesses, and advice on how to maintain positive mental health.

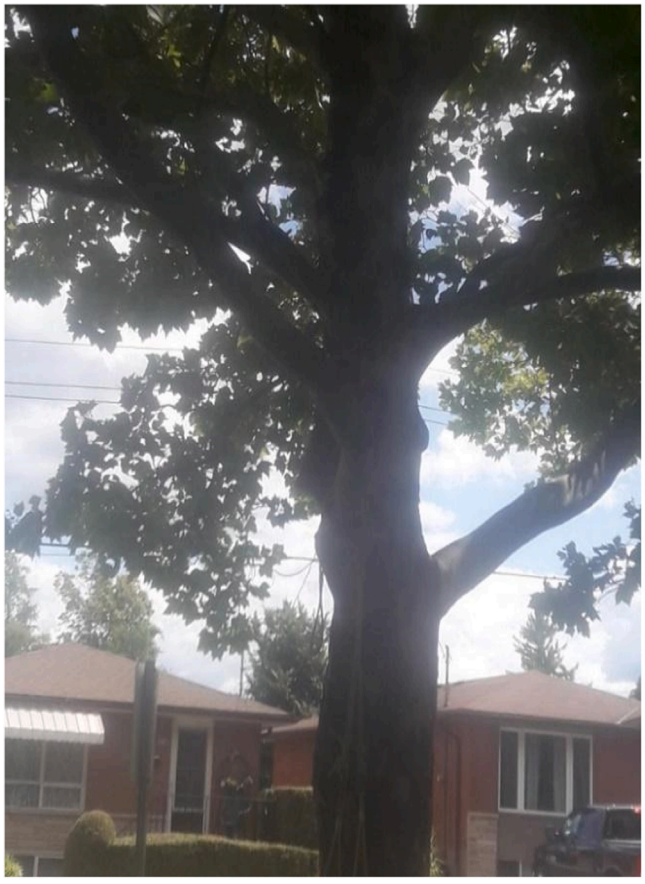

**Fig. 6.** Photo by Harper symbolizing wanting to be seen as a person.

"She did tell me that there are people with chemical imbalances, and that made a lot more sense to me." (Teagan)

Participants (n = 7) described the critical need for policies related to confidentiality and enforcement as part of facilitating a safe care environment. Some adolescents (n = 3) also reported a perception of not being taken seriously by their primary care practitioners, due to age and stigmatization. Having known their primary care practitioner throughout their life could be viewed positively and facilitate trust; however, it also could pose a barrier as adolescents' may worry how their primary care practitioner may negatively perceive their concerns.

"Just accept what they're feeling; don't downplay or invalidate their emotions. Just because you can't see, doesn't mean it's not there." (Jamie)

Most participants (n = 8) reported the need for their primary care practitioners to facilitate appropriate referrals to other relevant services that were tailored to their needs. This was achieved by being knowledgeable about available services, explaining the purpose of the referral, and following up on referral status to ensure that it was helpful for the adolescent.

"It was very important for me not to feel like [the practitioner] was trying to pass me off to someone else when she gave me referrals… It was 'We are going to make an appointment a couple days after you go and see this person and you are going to tell me how it went.' " (Teagan)

Adolescents discussed the processes and structures of primary care and how services were organized that influenced how care was, or was not, tailored to the needs of an adolescent experiencing a mental health concern. Most adolescents (n = 9) reported the importance of continuity of care providers.

"When you're just seeing the same doctor over and over again you can build a connection and build trust. Changing the doctor and regimen throws off the balance… it's kinda scary thinking like 'I am going to go and tell a complete stranger that I am having a relapse.'" (Harper)

Most participants (n = 8) perceived the need for improved marketing and communication of primary care mental health services targeted specifically for adolescents, considering that they struggle to know where to access help.

"[Practitioners] should tell the patients they can come talk to them for help, even if the patients haven't shown any signs of depression… It's most important to put [advertisements] in schools and somewhere where kids go. Because you don't know until somebody tells you." (Jamie)

The final theme "I wanted to be seen as a person" described adolescent's unique needs when accessing primary care for mental health services. It also identified their need to feel supported in their emerging adulthood and experiences of their mental health concerns using a client-centred approach. This was also depicted as a hill in the framework, which displays the upward process and the notion that there can be continued challenges once receiving mental health services.

## 4. Discussion

A key finding of this study was that adolescents perceive accessing primary care for mental health services as a difficult and complex process, rather than a one-time event. Additionally, adolescents perceived access as a dynamic process that begins before entering primary care and involved external influences outside of primary care. The overarching theme "It's not about the end – it's about the road" described adolescents' perceived importance of individual recovery and personal journeys when moving towards and entering primary care. This finding is

supported by existing literature which emphasized that youth mental health access journeys begin "long before they receive formal care from a primary health care provider".[36] The current study adds the unique perspectives of access from the viewpoint of adolescents, utilizing their own words, and their perceptions of challenges in reaching primary care for mental health services in an urban Canadian context. Additionally, the novel conceptual framework developed here presents a new contribution to the current literature on this topic.

The process of access depicted in the theme "It was all in my head" revealed that adolescents feared how people would view them and the potential for discrimination if they disclosed that they were experiencing a mental health concern. This aligns with other evidence which discussed adolescents' fears of how they will be perceived if they access primary care for mental health services,[17] including by their health care providers.[37] It was evident in the current study that adolescents have a narrow understanding of mental illnesses and their symptoms. Insufficient knowledge about mental illnesses in adolescents has been reported in the literature by others.[37,38] The current study found that at first, adolescents were unable to recognize that they were experiencing a mental illness and were subsequently unable to identify the need to access health care. A novel contribution to the literature was the finding that the fear of being hospitalized was seen as a barrier to accessing primary care for mental health services. Adolescents described that they worried they would be immediately admitted to a mental health facility, further disrupting their life and possibly introducing additional stigma. Furthermore, the current study adds qualitative evidence on how fears of stigmatization and hospitalization, as well as inadequate mental health literacy, contributed to feelings of isolation and uncertainty in adolescents experiencing an anxiety or mood disorder.

Adolescents perceived "I needed help" as the stage in the access process when they move from problem recognition, to externalizing their concerns, seeking informal support, and deciding a course of action. It was identified that family, friends, and online resources can have a positive or negative impact on adolescents' decisions to seek help from primary care. Some adolescents perceived that their parents were supportive; the role of parents in access for adolescents can range from recognizing problems and seeking help[39] to decision-making in care.[40] However, the current study found that some adolescents also felt that their families perpetuated societal stigma which could worsen their fears of being judged, creating a barrier to accessing help. Adolescents also perceived friends as important supports, who may recommend seeking primary care for mental health services based on their own experiences. An important contribution of the current study is that adolescents can be motivated to seek care when learning about other people's positive experiences through family, friends, or online platforms.

The final theme "I wanted to be seen as a person" and final phase of the access journey described the process of receiving mental health services in primary care. This theme had the most alignment with the guiding access framework and previous literature, as most of the existing evidence has explored access as an interface between the client and the service or care provider. Ambresin and colleagues[41] have also outlined the importance of youth-friendly health care strategies including: staff attitudes such as honesty and active listening; supporting autonomy; and enabling involvement in care. Evidence in the current study parallels the importance of a recovery orientation when providing mental health services to adolescents. Recovery-oriented mental health care as defined by the Mental Health Commission of Canada[42] includes the principles of "enabling choice, encouraging responsibility and promoting dignity and respect… Taking into account their developmental stage". Adolescents highlighted the need to outline the confidentiality policies, and what information could be disclosed to their parents, which has been described in the literature.[17–19] Adolescents stated that they would have accessed services sooner if primary care had better advertised that they provide mental health services, including advertising within schools which has also been previously discussed.[17]

Finally, adolescents reported the importance of care that acknowledged their developmental age and life stage, emerging adulthood. This included supporting their developing autonomy by treating adolescents as equals and involving them in the decision-making of their plan of care (e.g., medications, referrals to other mental health services). Adolescents also wanted primary care practitioners not to treat them "like a kid" through supporting their need to be seen as independent and capable. This finding adds to the current evidence describing adolescents' perceptions of accessing primary care for mental health services and speaks to the importance of shared decision making. Learning to make independent decisions is critical during emerging adulthood.[43] Therefore, this study also supports the notion that primary care can play an important role in helping adolescents develop their autonomy and independence as they transition from adolescent into their emerging adulthood.

### 4.1. Strengths and limitations

Strengths of this study include the utilization of interpretive descriptive qualitative methods, which assisted in aligning recommendations for clinical practice, as well as the use of a clear definition of access and its' dimensions to support transferability of the findings. Utilizing photo-elicitation provided compelling evidence for the internalized processes perceived by adolescents during access. To the authors' knowledge, this is one of the first studies examining access to primary care for adolescents experiencing an anxiety or mood disorder in an urban setting in Canada. Limitations associated with the sample and sample size impact the transferability of the findings, since no adolescents under age 14 participated, and only one participant identified as Black, Indigenous, or Person of Colour. Adolescents self-reported their anxiety or mood disorders, which may impact the accurateness of the sample demographics. Additionally, there is limited transferability to adolescents living in rural or remote communities in Canada who different and greater barriers to access. The project was initially guided by an access framework[12] and ecological model,[14] which did not wholly account for the access processes described by adolescents that occur prior to entering the care setting. Subsequently, this allowed for consideration of a new proposed conceptual framework to describe experiences of the access process.

### 4.2. Implications (see appendix C for key implications summary)

Primary care practitioners must provide information to adolescents about mental health concerns and services offered in primary care for these concerns during routine interactions to support early intervention. Routinely assessing for mental health concerns would also support early intervention. When determining a plan of care, practitioners should implement an individualized and person-centred approach that acknowledges adolescents' unique access journeys, helps cultivate their emerging adulthood, and supports their personal motivating factors to seeking care. Adolescents also require opportunities to make shared decisions and want their input to be valued as they develop independence and autonomy. Primary care practitioners should also seek to develop improved relationships with parents, as parents can play an important role in enabling access to the mental health care system for adolescents. Improving primary care mental health services through meeting the needs of adolescents has the potential to improve their satisfaction with care and can be associated with improved recovery outcomes.[42]

There is a need for more qualitative research examining the perceptions of specific populations, such as adolescents living in rural settings. Adolescents who identify as non-binary or masculine, and/or identify as 2-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and/or other sexual and/or gender orientations/identities have been underrepresented and their perceptions need to be further explored.[44] The inclusion of diverse cultures and ethnicities is also important to investigate perceptions of access, as there can be

differences in beliefs about mental illnesses and seeking help, as well as vast inequities in the opportunities to access appropriate mental health care services.[45,46] Although this study's findings have provided new information about access prior to entering primary care, studying the perceptions of adolescents who have not accessed primary care for mental health concerns could provide further insight into barriers to access. Studies investigating perceptions of access should continue to provide a clear definition of access and how it will be employed in the study to improve knowledge gained in this field. Future studies should also consider employing arts-based approaches in their methodology when studying adolescent mental illness, as it allows for a medium that can convey difficult to express emotions or information.[26]

From an educational lens, health care professional training programs must ensure their curriculum includes additional information on understanding emerging adulthood as a pivotal transition period in an adolescent's life. This training must include a focus on identification to support early intervention for adolescents when attending primary care for routine visits or physical health concerns. Specific education should also be provided on how to develop therapeutic relationships with adolescents as outlined previously. For adolescents' school-based education, there is a need for mental health literacy curriculum to include illness recognition and types of support available for these concerns.

## 5. Conclusion

In conclusion, this study found that access to primary care for mental health services for adolescents is a difficult and complex process that involves different stages which begins prior to entering primary care. The novel access framework created here allows for a client-centric view of access, enabling a greater understanding of adolescents' perceptions of access and challenges they face. Implications of this work for primary care practitioners include utilizing the understanding of access as a process beginning before entering the care environment to improve early identification and intervention. Primary care practitioners should ensure care is adolescent-centred by understanding their unique care needs and viewing adolescents as capable and independent, further supporting their emerging adulthood during a critical transition period in their life.

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## Ethical statement

This statement is in relation to our original research article: "When you're in the office, it means you managed to get somewhere": An interpretive descriptive study of the perceptions of adolescents accessing primary care for mental health services. In conducting this research, all procedures were performed in compliance with relevant laws and institutional guidelines and have been approved by the appropriate institutional committee. As identified in the manuscript, this research study received Hamilton Integrated Research Ethics Board approval (project #6005) in June 2019. Consent was obtained from all participants as outlined in the manuscript.

## CRediT authorship contribution statement

**Naomi Thulien:** Validation, Conceptualization. **Gillian Mulvale:** Supervision, Conceptualization. **Rebecca Ganann:** Supervision, Conceptualization. **Ruta Valaitis:** Supervision, Funding acquisition, Conceptualization. **Lisa De Panfilis:** Resources, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization.

## Declaration of Competing Interest

The authors declare the following financial interests/personal relationships which may be considered as potential competing interests: Lisa De Panfilis reports financial support was provided by Registered Nurses Association of Ontario. Lisa De Panfilis reports financial support was provided by Canadian Nurses Foundation. If there are other authors, they declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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## Appendix A. Guiding framework and Model

*Access dimensions by Penchansky and Thomas,[9] Saurman[10]*

Availability[9]: "The relationship of the volume and type of existing services (and resources) to the client's volume and types of needs. It refers to the adequacy of the supply of physicians … and other providers." (p.128)

Accessibility[9]: The relationship between the location of supply and the location of clients, taking account of client transportation resources and travel time, distance and cost." (p.128)

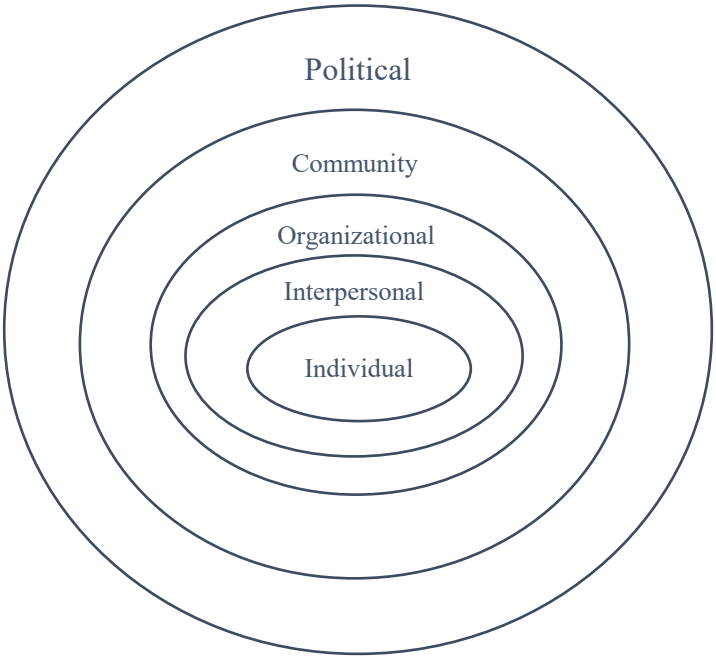
Accommodation[9]: "The relationship between the manner in which the supply resources are organized to accept clients (including appointment systems, hours of operation, walk-in facilities, telephone services) and the clients' ability to accommodate these factors and the clients' perception of their appropriateness." (p.128)

Affordability[9]: "The relationship of prices of services and providers' insurance or deposit requirements to the clients' income, ability to pay, and existing health insurance." (p.128)

Acceptability[9]: "The relationship of clients' attitude about personal and practice characteristics of providers to the actual characteristics of existing providers, as well as to provider attitudes about acceptable personal characteristics of clients." (p. 129)

Awareness[10]: "A service that was aware of the local context and population needs could provide more appropriate and effective care, and patients could better access and use such services if they were simply aware of them in the first place." (p.37)

*Ecological model by McLeroy and colleagues*[11]




## Appendix B. Interview guide

*Session 2: Semi-structured interview guide*

- Can you tell me about your experiences so far with getting help from your family doctor or nurse practitioner? *Probe: When did you first talk to a health care professional about your mental health concerns?*

  Photos
- Can you tell me a little bit about this picture? Why did you take this picture? *Probe with their caption:* Was *this something that helped you or made it harder to get help?*

Access dimensions questions to consider for discussion

1. Accessibility: Tell me about how easy or not easy it was to physically get to your family doctors or nurse practitioners' office for your mental health concern? What made it hard or easy? *Probe: How did you get there? How far is it from your home?*
2. Acceptability: I want to know how you felt about the characteristics of your family doctor or nurse practitioner. What are they like? How were they when you talked about your mental health concern? *Probe: What was it about their personality or how they treated you that made it better or worse?*
3. Affordability: Can you describe any costs for you as part of getting help for your mental health concern? *Probe: Did it cost you anything to get help? Such taking a bus or a taxi? Did your doctor or nurse recommend anything that cost you money?*
4. Accommodation: Tell me how your family doctor or nurse/s' office made accommodations to you and what you wanted/needed? How did they change their services to meet your mental health needs? *Probe: How long did you have to wait to get an appointment? Did you take time away from school or work to go? Did anyone talk to you about what would happen at your appointment?*
5. Availability: Do you think there were enough services offered to help you and your mental health concern? *Probe: Did you need more services? Such as…*
6. Awareness: Tell me about how if you knew you could try to get help from your family doctor or nurse practitioner's office for your mental health concern? *Probe: What lead you to going to there for help? What would helped you know where to get help from?*

If not previously addressed:

- Could you tell me a little bit about who else was part of you getting help for your mental health concern? *Probe: Did anyone in your family help/ parents? Friends? Teachers or people at* your *school?*

If relevant, is there anything about your cultural background, gender, or about your sexual orientation that was part of your experience with getting help for your mental health concern? And how your family doctor or nurse treated you?

Is there anything else you would like to tell me about your experiences getting help for your mental health concern?

If you had a magic wand, what would your best scenario for getting help from your family doctor or nurse practitioner for a mental health concern look like?

(Paraphrase things they have said and summarize their ideas).
Do you feel that what I said has described your experiences?

## Appendix C. Key implications summary

| Category | Key Implication |
|---|---|
| Primary Care | • Provide information to adolescents about mental health concerns and services offered in primary care during routine interactions<br>• Routinely assessing for mental health concerns<br>• When determining a plan of care, implement an individualized and person-centred approach that acknowledges adolescents' unique access journeys, helps cultivate their emerging adulthood, and supports their personal motivating factors to seeking care<br>• Provide adolescents opportunities to make shared decisions as they develop independence and autonomy<br>• Develop improved relationships with parents |
| Research | • Inclusion of adolescents who identify as non-binary or masculine, and/or identify as 2-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and/or other sexual and/or gender orientations/identities<br>• Inclusion of diverse cultures and ethnicities<br>• Inclusion of adolescents who have not accessed primary care for mental health concerns<br>• Provide a clear definition of access and how it will be employed in the study<br>• Consider employing arts-based approaches in the methodology when studying adolescent mental illness |
| Education | • Health care professional training program curriculum should include additional information on understanding emerging adulthood as a pivotal transition in an adolescent's life<br>• Health care professional training program curriculum must include a focus on identification to support early intervention for adolescents as well as how to develop therapeutic relationships<br>• Adolescents' school-based education should include mental health literacy curriculum to include illness recognition and types of support available for these concerns |

## Data availability

The data that has been used is confidential.

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