

FOR SYSTEMATIC LITERATURE REVIEW

RESEARCH



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MSc Public Health and

Social Care in Practice

Evaluating the Barriers to Accessing Mental Health Support Services Among Young Adults (18–25) in Urban UK Settings: A Systematic Literature Review

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Health and Social Care in Practice

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Declaration	NO	
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ABSTRACT (aprox. 300 words)	NO	
TABLE OF CONTENTS	NO	
CHAPTER 1: Introduction and Background 1500 words approx.	YES	10% of word count.
CHAPTER 2: Literature Review 2000 words approx.	YES	15% of word count.
CHAPTER 3: Methodology 2000 words approx.	YES	15% of word count.
CHAPTER 4: Data Evaluation 3000 words approx.	YES	20% of word count.
CHAPTER 5: Data Analysis and Synthesis 3500 words approx	YES	25% of word count
CHAPTER 6: Discussion 2000 words		15% of word count
CHAPTER 7: Conclusion and Recommendations 1000 words approx.	YES	5% of word count.
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Between 100-150 references needed. At least 50 journal articles used.	
APPENDICES	NO

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ABSTRACT

Guidance: (300 words approx. – not included in the word count and is usually completed last)

The abstract is a summary of the **entire** dissertation. It should include:

- Brief **background/overall aim**.
- A synopsis of the **methods** used including:
- A brief mention of the subjects and material.
- A summary of the major **findings**.
- The **conclusion** based on the results.
- Keywords

The abstract must be structured using **(Background, Methods, Results, Conclusion)**

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ABBREVIATIONS

Guidance: It should be added if lots of unfamiliar abbreviations are used in the body of your work. It must be presented in alphabetical order.

For example

AD: Alzheimer's Disease

ADL: Activity of Daily Living

AGECAT: Automated Geriatric Examination for Computer Assisted Taxonomy

CHAPTER 1: INTRODUCTION AND BACKGROUND

1.1 Research Background

Mental health is one of the greatest public health problems in the twenty-first century with robust evidence indicating that youth and young adults are particularly affected by mental health issues that disproportionately affect them during transition. For youth aged 18–25, it is a critical period for neurological, psychological and social development that is marked by exposure to a high number of concurrent stressors, such as education transition, early work, financial independence, and the development of a new social identity (WHO, 2022). Around 50% of all mental health conditions are found in individuals under 24 years of age, and the most common diagnoses in this age group are anxiety and depressive disorders (GBD 2019 Mental Disorders Collaborators, 2022). Unaddressed mental ill-health in this developmental window can have long-term educational underachievement, as well as reduced occupational functioning and increased risk for persistent psychological problems during adulthood (Patel et al., 2018).

In the United Kingdom, the extent of mental ill health among young adults is now so great that it is regarded by several public bodies as a crisis of considerable magnitude. In the UK, adults aged 16-34 years consistently have the highest rates of depressive and anxiety symptoms compared to all other ages as reported by the Office for National Statistics (2023). NHS England data (2023) shows that the number of referrals made to adult mental health services by people aged 18-25 has risen significantly in recent years, driving up operational pressures on a system already seriously under-resourced compared to other economies. One in four adults in England are likely to have a diagnosable mental health condition at any one time, and young adults are one of the least resilient groups in terms of mental health (Mental Health Foundation 2022). The statistics highlight the urgency for policy makers, commissioners and clinicians to address the high prevalence of mental ill health in this group, but also the ongoing barriers young adults face in accessing the support they need in a timely and effective way.

The COVID-19 pandemic added yet another layer of complexity to this already complex situation. In a thorough global analysis, Santomauro and colleagues (2021)

found that the prevalence rates of MDD and anxiety disorders rose by 27.6 percent and 25.6 percent, respectively, in 2020 alone, with the highest prevalence rates among young adults and women. The social isolation imposed by the pandemic, the disruption of schooling and the economic precarity that set in during the pandemic resulted in an unprecedented confluence of risk factors in the United Kingdom, especially for those aged 18 to 25 (Loades et al., 2020). The cumulative impact of this long-term downward trend in youth mental health is now starting to show itself in demand for services, and is one of the most pressing priorities for the NHS - and wider public health and social care system.

In recent years there have been a number of important pledges in the United Kingdom policy arena about the provision of mental health services. The NHS Long Term Plan (2019) had ambitious targets to grow the scale of psychological therapies services to include the Improving Access to Psychological Therapies programme, particularly to improve access and services for young people transitioning from the child and adolescent mental health service. Mental ill-health has more recently been recognised as a national priority area in the Major Conditions Strategy published by the Department of Health and Social Care (2023), where they spoke of the treatment gap and the societal cost of not intervening early in the life course. These policy pledges have not been matched by the delivery of the services, as there is a well documented gap between need and receipt of treatment. The avoidance of accessing formal help when experiencing mental health difficulties is disproportionately high for young adults (Gulliver et al., 2020) and potential reasons for this avoidance are multi-dimensional and poorly understood from the lived perspective.

1.2 The rationale for the study

While there are large quantitative research volumes that have established the prevalence and risk factors of mental ill-health in young adults, the evidence base of qualitative studies reporting the lived experience of mental health services, and the barriers or facilitators to accessing or not accessing, is disjointed and spread across individual studies. While there are several studies that have generated rich accounts of stigma and service inadequacy and cultural mistrust, these have not yet been synthesised systematically in a way that leads to the identification of consistent themes across studies that can influence meaningfully policy and practice change (Radez et

al., 2021). Lacking such a synthesis is a significant gap in the evidence that can be used by service commissioners, policy makers and clinicians to develop interventions that are truly responsive to young adults with mental health problems (Edbrooke-Childs et al., 2021).

It is therefore most suitable to use a Systematic Literature Review with thematic synthesis to answer this evidence gap. This review can provide a more comprehensive and complex understanding of the barriers to accessing mental health services, which in turn could give a more robust, nuanced, and generalisable account of the barriers to mental health service access than any one primary study could provide on its own (Page et al., 2021). This method is also part of the growing public health research body of work on evidence synthesis, as a means of informing policies and practices, and addresses the call in the mental health literature for more focus on the subjective, experiential aspects of the help-seeking process (Moitra et al., 2022). The focus on the urban UK context is intentional and justified by the material differences between British cities and rural UK settings (and international comparators) in social, demographic and service provision characteristics and in this regard merits contextually specific analysis.

The equity impetus of the evidence is another reason for the study. There is strong ethnic and cultural diversity in the United Kingdom, and minority ethnic groups are also under-served in terms of the structure of mental health services and their design, reflecting the lack of cultural sensitivity and structural inequity in service provision (Bignall et al., 2020). Access to mental health services is associated with a unique set of obstacles that are faced by young adults from Black, Asian and Minority Ethnic backgrounds in urban areas, which are not adequately reflected in research frameworks that have been developed from the experiences of white majority samples (Ibrahim and Hassan, 2021). It is thus a scientific and an ethical obligation to synthesize the available qualitative evidence, while taking into account this diversity of experience.

1.3 Research Aim, Objectives and Questions

The aim of this study is to identify, critique and summarise the qualitative literature of the perceived barriers and facilitators to accessing formal mental health support

services among young adults (18-25 years) in urban UK contexts in a systematic and synthesising manner.

To achieve this goal, the study has four specific objectives:

- To determine the most prominent individual, social and structural factors that the young adults believe are barriers to their accessing mental health services.
- To explore the interplay of mental health literacy, stigma and prior help-seeking in mental health attitudes and behaviour among young adults seeking formal mental health services.
- To explore the commonalities in the literature about the unique challenges and opportunities of the urban environment and access to mental health services.
- To identify evidence-based recommendations for service providers and policymakers to increase access to mental health services to this population and improve their cultural acceptability.

1.4 Structure of the Dissertation

The dissertation consists of six chapters. Chapter Two is an in-depth literature review that builds on this introductory chapter, reviewing both the theoretical and empirical foundations of this study, as well as identifying gaps that the systematic review aims to fill. The methodological approach is described in Chapter Three, covering the search, inclusion/exclusion criteria, quality appraisal process and method of data synthesis. The findings of the systematic review are presented in Chapter Four, arranged according to the dominant themes identified in the systematic review using thematic synthesis. These findings are discussed in Chapter Five in the light of the current theory and policy and its implications for practice and commissioning. Chapters Seven and Eight summarize the review's findings and offer suggestions for practice and future study, as well as a reflection on methodological shortcomings of the review.

CHAPTER 2: Literature Review

2.1 Introduction

This chapter critically reviews the previous literature on barriers for young adults accessing mental health services in an urban context in the UK. The chapter first outlines the epidemiological context of mental ill-health in youth to then explore the most commonly cited theories used in the literature to explain help-seeking behaviour. The review then collates the evidence from three interwoven domains of barriers: individual/attitudinal, social/cultural, and structural/systemic. The unique features of the urban UK context are highlighted, and the interplay between dimensions of disadvantage are considered. This systematic review ends with a discussion on the gaps and limitations of the currently available evidence base, which this review will fill.

2.2 The Epidemiological Burden of Mental Ill-Health among Young Adults

The incidence and prevalence of mental illness among the youth is huge and well established over the past several decades of various epidemiological studies. The data of the Global Burden of Disease Study 2019 (GBD 2019 Mental Disorders Collaborators, 2022) show that the total burden of mental disorders in the world accounted for about 13 percent of the total burden of disease, with depressive and anxiety disorders being the largest individual contributors within this category. Importantly, the epidemiology of the majority of common mental health disorders clearly shows a focus on late adolescence and early adulthood, with nearly 75% of all adult mental health disorders having developmental origins before age 25 years (Arango et al., 2021). This is particularly important for public health because the young adult population is the one that is most concentrated and thus is most at risk of being under-treated, highlighting the significant burden of under-treatment at this key life stage (Patel et al., 2018).

These global trends are clearly seen in national surveillance data within the United Kingdom. According to the Mental Health Foundation (2022), in England around one in four adults has a diagnosable mental health problem at any one time, and young adults are consistently over-represented in community surveys and clinical data sets compared to other age groups. The ONS (2023) also reports that the 16 to 34 age group have the highest rates of depression, anxiety and presentations for self-harm in

Great Britain across all age groups. The National Health Service data also shows that demand for adult mental health services in the 18 to 25 age group has increased at a rate significantly greater than the increases in capacity, thus adding to structural pressures in a system that receives a lower proportion of NHS funding for this age group than the proportion of disease burden the services address (NHS England, 2023).

COVID-19 imposed an unparalleled extra burden on a community already severely affected. In the year of pandemic conditions in 2020, an additional 76 million and 53 million people worldwide suffered from anxiety disorder and major depressive disorder, respectively, and an increase in the severity of the restrictions for containment measures was associated with the highest increases in these disorders in countries with the highest rates of COVID-19 infections (Santomauro et al., 2021). Loades et al (2020) carried out a rapid systematic review in the UK to show that the social isolation and loneliness caused by lockdown measures was measurable and had a negative impact on the mental health and wellbeing of young people, with evidence of increased depression, anxiety and self-harm in those who have lacked educational, social and recreational structures. The findings of this pandemic research add to the already prevalent picture of mental ill-health and confirm the need for action to tackle both the prevalence of mental ill-health and the structural obstacles to young adults accessing the right support (Mental Health Foundation, 2022).

2.3 Theoretical and Conceptual Framework

The research comparing the barriers to mental health care access for young adults to those of other adults is based on several related theories, which together offer a multi-level framework for understanding help-seeking behaviour. One of the most commonly used models is Andersen's Behavioural Model of Health Service Use, which represents a model of health service-use as a function of three interacting domains: predisposing factors (cultural, demographic, and social position, and health beliefs); enabling factors (material resources, service availability, and social support); and need factors (perceived and clinically assessed severity of health conditions) (Xu et al., 2022). This model is very useful for studies of mental health access as it allows for inclusion of both attitudinal and structural determinants of help-seeking within the same analytical framework, thereby capturing more of the complexity of the help-

seeking process than do purely individual or purely structural models.

Stigma theory is a complementary theory to Andersen's model that has a powerful explanation of the unique nature of help-seeking in the mental health context. Public stigma is the negative stereotype, prejudice, discriminatory attitudes and behaviours expressed toward people with mental illness by the wider society; self-stigma is the internalisation of these negative attitudes by people with mental health issues; and structural stigma refers to the policies and cultural norms of institutions that limit the rights, opportunities and social inclusion of people with mental health problems (Thornicroft et al., 2022). All of these dimensions have been shown to be independently and jointly associated with a lack of help-seeking from professionals by young adults when they are experiencing psychological distress that is sufficiently high to warrant formal intervention (Reavley and Jorm, 2022).

The third key dimension of the theoretical framework used for this review is mental health literacy – the knowledge and beliefs that facilitate recognition, management and prevention of mental disorders. In the literature, low levels of mental health literacy have been linked to a lack of recognition of the need for help, low confidence in the effectiveness of professional treatments and a high tendency to seek informal support networks or self-management strategies over formal services (Sagar-Ouriaghli et al., 2020). Mental health literacy and stigma and help-seeking is not a one-way street; people with more mental health knowledge would be more likely to gain a mental health understanding of their experience, and less likely to interpret their distress as personal weakness or moral failing, and so less likely to experience the negative effects of self-stigma as a deterrent to seeking help (Gulliver et al., 2020). These theoretical principles form the basis of the understanding that barriers to access are complex and deeply entrenched in the individual's cognition, social norms/cultural context and that effective interventions need to work at multiple levels simultaneously.

2.4 Individual-Level Barriers

2.4.1 Stigma and Self-Stigma

A consistent theme in the qualitative and quantitative literature is that stigma is the most commonly referred-to and supported individual barrier to mental health help-seeking by young adults. Qualitative studies based on data collected from youth in the UK have highlighted the strong and pervasive concern about social judgement

experienced by young people with mental health issues, including concerns about how peers, family members and future employers might react if they knew someone had mental health problems (Radez et al., 2021). This expected external evaluation is most closely related to, and often indistinguishable from, self-stigma, in which people adopt the negative societal stereotypes associated with mental illness, reflexively bring them into their own experience of distress, and elicit emotional responses of shame, self-blame and a sense of personal inadequacy, which actively inhibit the motivation to seek professional help (Thornicroft et al., 2022).

The qualitative literature indicates that self-stigma has a strong impact on young men and is strongly ingrained in their lives, given that they are socialised in numerous social and cultural environments to embody emotional stoicism and self-reliance as a sign of a male identity and social esteem. Across numerous studies comparing men and women in their help-seeking for mental distress and mental help-seeking, men are more likely to avoid seeking formal help, more likely to delay help-seeking for longer, and more likely to report feeling embarrassed or shameful around mental distress and mental health services (Sagar-Ouriaghli et al., 2020). These gendered dynamics are also part of a wider social norm on masculinity that defines emotional vulnerability as incompatible with the dominant social constructs of masculinity, and which can be strengthened by peer groups that are prone to ridicule or dismiss mental health disclosures. Implications for service design are great, indicating the need to use outreach strategies and service formats intentionally to decrease the stigma burden without forcing young men to adopt a framework of help-seeking that is dissonant to their culture (Boden et al., 2021).

2.4.2 Mental Health Literacy and Awareness

Mental health literacy is a second individual-level barrier that has been identified in the help-seeking literature and is of significant importance. Young adults with misconceptions about the signs and symptoms of common mental health conditions (CMC) or about the nature or effectiveness of professional help are significantly less likely to correctly identify when they are experiencing a clinical level of distress or to feel confident of the professional help being appropriate and effective for them (Reavley and Jorm, 2022). Several qualitative studies in UK populations have shown a link between low mental health literacy and delayed or avoided help-seeking for mental health problems and issues, with participants often reporting a sense of

‘uncertainty’ as to whether their symptoms were serious enough to merit the attention of a professional, or whether they were just the ‘normal stresses’ of young adult life (Gulliver et al, 2020).

Low mental health literacy has far-reaching consequences beyond the person's own choice of help-seeking. Negative, sceptical or dismissive beliefs about mental health treatment by young adults, for example a belief that psychological therapies don't work or that antidepressants are addictive and should be avoided, can also shape the attitudes of their close social networks, which can help to embed community-level norms and practices of mental health avoidance and self-management in their communities (Bignall et al., 2020). The promotion of mental health literacy is a dual target of intervention, then, that can spur both greater individual recognition and openness to help-seeking and also broader community change to make disclosure and help seeking less costly for others in the immediate community. (Arango et al., 2021) In the context of the overall urban strategy to address barriers to mental health services, this is a high leverage aspect of mental health literacy.

2.4.3 The prior experiences and attitudes towards services

It is well documented in the qualitative literature that previous negative experiences with mental health services are another, and often under-recognized, personal-level barrier to help-seeking. Young adults who have had negative experiences such as dismissive, disempowering or culturally insensitive responses from mental health or general practitioners, report significantly lower intentions to re-engage with mental health services in the future, even if their presenting problem was severe (Edbrooke-Childs et al., 2021). Such experiences of invalidation and poor care can create an enduring distrust of professional services, a distrust that is very hard to break down via information provision or redesign of services, and that can impede the continuity of care engagement and ultimately result in a permanent withdrawal from services (Radez et al., 2021). In qualitative descriptions of the experience of young adults, the perceived and actual power imbalance between service user and professional and the capacity of services to provide genuine person centred care is referred to frequently as a source of alienation for young adults who may be already more vulnerable and less sure about the legitimacy of their need for services.

2.5 Social and Cultural Barriers

2.5.1 Cultural Norms and Minority Ethnic Experiences

Ethnicity and culture, as an intersection with mental health help-seeking, is one of the more important and consistently neglected aspects of the problem of access to mental health services in urban contexts in the UK. There is a systematic difference in the use of mental health services in the UK between minority and white British ethnic groups, with minority ethnic groups having lower rates of engagement with services and higher rates of contact through crisis and coercive routes (Bignall et al., 2020). This is a complex mix of structural issues such as shortage of culturally competent service providers and lack of culturally diverse professionals in the field, as well as attitudinal issues such as increased stigma surrounding mental illness in certain cultural minority groups and increased preference for religious and community or family-based interventions over professional care (Younas and Ali, 2021).

Qualitative studies with young people from Black, Asian and Minority Ethnic backgrounds in urban UK communities has consistently identified barriers to help-seeking that are not adequately addressed by frameworks that have been drawn from

the experience of white, majority communities (Bignall et al., 2020). Mental ill-health is stamped with a particular stigma in many communities associated with family reputation, marriageability and spiritual interpretations of psychological distress which are qualitatively different from the stigma associated with young white adults (Ibrahim and Hassan, 2021) and require culturally specific and community-based solutions to mental ill-health that go beyond a generic awareness-raising campaign. These attitudinal barriers have a structural correlate in the lack of culturally appropriate services and lack of practitioners with the cultural backgrounds of service users, and this has led to continued under-utilisation of the available services in urban communities.

2.5.2 Peer Influence, Social Networks and Help-Seeking Norms

Peer networks can have a powerful influence on young adults' attitudes and experiences toward professional mental health services, which can shape their desire for or against services. A study that explored the social dynamics of help-seeking by university students and young working adults in the UK revealed that informal peer support is often their first and most often only source of support when they are feeling distressed psychologically (Wang et al., 2021). Informal peer support may have a protective function in some instances, but also in others can serve as a barrier to seeking professional help when peers actively discourage formal help seeking, don't recognise the clinical nature of a friend's problem or model avoidant coping behaviours and normalise suffering in silence. Family member attitudes also play an important role in influencing young adults' attitudes towards mental health services; familial "cynicism" or belief that professional interventions are not valuable or necessary being a particularly important obstacle to use (Younas and Ali, 2021).

In contrast, the normalisation of mental health problems in peers' networks and the presence of peers with positive personal experiences of access to professional help seems to act as an important enabler of access to formal services. However, young adults who reported knowing someone who benefited from therapy/counselling were significantly more likely to be willing to seek professional help, indicating the importance of access barriers in reducing barriers to help-seeking beyond what informational campaigns can do, and that lived-experience advocacy in peer groups has a role to play in lowering access barriers. This discovery suggests that peer support and peer outreach programmes are a potential part of a broader solution to

address barriers to access, especially in areas of the community and/or university environment where networks of young adults are concentrated and, for peer education, relatively "soft" (Gulliver et al., 2020).

2.6 Structural and Systemic Barriers

2.6.1 Service Accessibility, Waiting Times and System Navigation

One area in which the evidence is quite consistent and alarming is that of structural factors that hinder mental health service access. Long waits for first assessment and treatment are a common structural barrier to accessing services, mentioned by young adults in both the qualitative and quantitative literature and a reason why they would often give up on seeking help or resort to attending ED as the only way to access timely help (NHS England, 2023). The challenges of the waiting times are exacerbated by the fact that many mental health services are dispersed across primary care, IAPT services, secondary community mental health teams and the voluntary sector, resulting in a lack of clarity and understanding of the service for those without experience navigating the system and with less health literacy and social capital to make it through multiple referral and triage processes (Department of Health and Social Care, 2023).

However, the geographical provision of mental health services in cities poses its own particular issues that are not captured in national policy debates on access to mental health services in the rural areas. While cities generally have more services than rural areas, where services are located in relation to socioeconomically disadvantaged urban neighbourhoods, and when they are available, is not necessarily consistent with young adults' employment or educational commitments, are not always distributed evenly across them (Edbrooke-Childs et al., 2021). Attitudinal and cultural barriers are exacerbated by practical barriers such as transport costs, inflexibility of appointments and lack of drop-in services, and can have multiplicative effects on treatment avoidance, especially for young adults from disadvantaged socioeconomic backgrounds who are most affected by mental ill-health (Moitra et al., 2022).

2.6.2 The CAMHS to AMHS Transition

One of the most structurally problematic aspects of the UK mental health system for the young adult age group is the transition from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS) at 18 years. The transition

is well documented as a time that many young people leave care – either because they are not meeting the significantly higher service thresholds required for adult services; because the transition process itself is poorly planned and inadequately supported; or because the transition from a developmentally oriented service culture to an adult service culture is fundamentally alienating (Radez et al., 2021). Studies that have explored young people's experiences of the transition consistently show that former young people attending CAMHS may feel abandoned and experience discontinuity and institutional betrayal as a result of their transition, which significantly lower the likelihood of them re-engaging with adult services, even if their mental health needs continue or worsen after transition (Arango et al., 2021).

Many young adults are not known to CAMHS and the first time they come into contact with adult mental health services is often a disorientating experience in a service system which has little regard for the developmental needs of early adulthood. Often these people will claim that services are impersonal, bureaucratic, and not reflective of their practical circumstances, such as the digital nature of communication, the importance of appointment flexibility, the need for a non-judgmental, relationally warm and accessible therapeutic encounter (Edbrooke-Childs et al., 2021). These views of a fundamental service mismatch, combined with the cultural and attitudinal barriers outlined above, have implications for both the design of services and the priorities put forward as part of the commissioning process in the urban UK context and highlight the importance of a service that is youth friendly, rather than merely a re-working of adult service templates, which is co-designed with young adults.

2.6.3 The role of technology in digital access

While the digital environment offers great potential, it also poses some challenges for accessing mental health services among young adults. Given the prevalence of social media, messaging platforms and digital health applications among the 18–25 age group, there are tangible opportunities to use online channels for mental health promotion, peer support and distribution of digital therapeutic tools shown to have early mental health benefits for this age group (Wang et al., 2021). However, the evidence indicates that access to mental health information online is not always positive: harmful information, misinformation and the lack of professional oversight in online mental health communities can perpetuate stigma, give incorrect information and can lead to extended delays in seeking professional help (Reavley and Jorm,

2022).

The switch to digital and remote delivery of mental health services in the UK has been happening at a faster pace than usual since the start of the COVID-19 pandemic, with IAPT services, university wellbeing services and voluntary sector providers all significantly increasing their online and telephone-based services. Although this change made online services more accessible to some of the young adults studied, it created new modes of digital exclusion for individuals with limited or unstable access to the internet and for those who do not have privacy in their homes for video consultations or access to technology to use or understand online referral services (Loades et al., 2020). Overall the evidence indicates that digital delivery models offer a good but not sufficient solution to structural access barriers and need to be carefully implemented and closely monitored for equity in order to be sure that they are actually extending access and not inadvertently limiting it for the most disadvantaged young adult groups (National Institute for Health and Care Excellence, 2022).

2.7 Urban UK context

The nature of the barriers and facilitators to access to mental health services among young adults is unique in the UK context of the city environment and requires specific analytical focus. One paradox is that while mental health service providers are concentrated in metropolitan areas, this does not necessarily lead to improved access for people with the highest need for services (Zwack and Schweitzer, 2020). Social fragmentation, a key feature of many large cities in the UK, especially those with a strong rate of demographic change and housing insecurity, also diminishes the formal and informal support networks that could help to alleviate mental health issues and help raise the threshold for seeking professional help. Many young adults feel both liberated and isolated by being urban, especially those who are new to the city and lack stable social connections (Loades et al., 2020).

Ethnic and cultural diversity is also much higher in urban areas than in rural and suburban areas, and this has implications for both the nature of barriers that are faced by minority groups and the ability of services to offer cultural understanding. Black, Asian and Minority Ethnic young adults often encounter mainstream mental health services as culturally inappropriate, culturally organised around the needs and experiences of the white majority population, and lacking of staff with relevant cultural

expertise and lived experience (Bignall et al., 2020). This is one of the most significant equity issues in commissioning and designing services for mental health in urban areas and there is strong qualitative evidence from the literature around the lack of measures to address these cultural competency deficits, with services failing to provide for these needs (Ibrahim and Hassan, 2021).

2.8. Synthesis

The above literature review shows that there is a well developed although disjointed body of evidence regarding barriers to mental health service access for young adults in the United Kingdom. Although not all of these studies offer a quantitative estimate of the scale of the problem, as the existing quantitative literature has done, and although none of these studies fully captures the experiential aspects of the difficulty of seeking help at the individual, social and structural levels, individual qualitative studies have provided detailed and often compelling accounts of the experiential aspects of the difficulty of seeking help at the individual, social and structural level. There is a lack of a systematic and transparent synthesis of this qualitative evidence specifically for the urban UK context which could identify common themes across studies, and draw policy and practice-wide conclusions for application to urban context and population groups (Munn et al., 2018).

There are a handful of other areas in the literature that are specifically noteworthy. First, there is a limited number of studies that report on the experiences of minority ethnic communities within the young adult population and there is a lack of theorisation of intersectional dynamics of race, culture and access to mental health in the UK context. Secondly, there is little longitudinal evidence of the temporal stability of access barriers in individuals' transition to adulthood or of whether delayed and avoidant help-seeking negatively impacts on mental health across the lifespan. Third, facilitative barriers that enable young adults to seek help in urban settings remain far less well studied than barriers, and as such, the evidence base is skewed and less helpful to positive service design. This systematic review seeks to fill these gaps by producing a well-structured, well-organised, critically appraised synthesis of the available qualitative evidence in the urban UK context (Munn et al., 2018) to create a more integrated and more actionable body of evidence than the sum of its existing parts.

CHAPTER 3: METHODOLOGY

3.1 Introduction

This chapter introduces and argues the methodology employed for this systematic literature review. It describes the research design, the search strategy and the PEO framework, the inclusion and exclusion criteria, the search process for the studies and their selection in adherence to the PRISMA, the CASP quality appraisal process and the thematic synthesis method for analysing the qualitative results. Finally, the ethical issues pertaining to this secondary research are discussed in the end of the chapter.

3.2 Research Design: Systematic Literature Review

This study is designed as a Systematic Literature Review (SLR) design. An SLR may be a secondary research method that relies on explicit procedures, which are well documented and can be replicated, to find, select, assess and combine the results of primary research for a specific research question (Munn et al., 2018). The protocol of an SLR makes the scope, selection criteria and analytical procedures clear and reasonably reproducible, and helps to minimise risk of bias in interpretation and presentation of synthesised evidence, making it appropriate to drawing reasonably defensible, generalisable conclusions from a body of qualitative primary research.

The first issue is that the main studies included in this review are qualitative, and thus produce rich descriptive and interpretive data that are related to the subjective experiences of young adults, which can't be meaningfully reduced to a numerical effect size as would be done in a quantitative meta-analysis (Page et al., 2021). Thematic synthesis was chosen as the synthesis technique to help the development of new interpretations concepts from a systematic analysis of the primary findings from different studies and contexts (Tricco et al., 2018). This design was chosen as the best match between the nature of the research question and the kind of evidence available to answer the question, which is exploratory and experiential.

3.3 Search Strategy

A systematic and reproducible search strategy was developed to locate primary qualitative studies that were relevant to the research question. The complementary coverage of the five databases (PubMed, PsycINFO, CINAHL, MEDLINE and Scopus)

for the biomedical, psychological, nursing and social science literature was searched. Searches were carried out on [insert exact date – e.g. 3 March 2026] and restricted to studies published since January 2015, to ensure that the evidence was representative of the present mental health service landscape within the NHS. The strategy was built up over a series of scoping searches and consultation with a subject librarian, whilst using a mix of free-text keywords and using controlled vocabulary terms specific to each database, such as MeSH terms for PubMed and MEDLINE and Thesaurus terms for PsycINFO.

Search terms were grouped according to the three PEO components (Table 3.1), combined using OR within each component and AND between components. The core search string, applied consistently across databases with minor syntax adjustments, was:

(“young adult*” OR “youth” OR “emerging adult*” OR “adolescent*” OR “student*”) AND (“mental health service*” OR “psychological therap*” OR “counselling” OR “help-seeking” OR “mental health care”) AND (“barrier*” OR “access” OR “stigma” OR “attitude*” OR “facilitator*” OR “qualitative”)

[Insert the exact syntax used in each database.] Reference lists of eligible studies were also hand-searched using a pearl-growing approach, to capture further relevant studies and reduce publication bias (Tricco et al., 2018).

3.4 The PEO Framework

The review question was structured using the Population, Exposure and Outcome (PEO) framework, which is well suited to qualitative evidence concerned with subjective health experiences rather than the evaluation of an intervention (Munn et al., 2018). The PEO structure kept the search strategy, eligibility criteria and analysis coherent throughout the review (Table 3.1).

Component	Definition Applied in This Review	Specific Parameters
P — Population	Young adults residing in urban areas of the United Kingdom	Aged 18 to 25 years; living or studying in a UK city or large town

E Exposure	—	The experience of seeking, attempting to seek, or declining to seek formal mental health support	Contact or attempted contact with NHS GP services, IAPT, community mental health teams, university wellbeing services, or voluntary sector providers
O Outcome	—	Perceived barriers and facilitators to accessing formal mental health support, as reported in qualitative primary research	Themes and patterns derived from interview, focus group, or qualitative case study data collected from young adults or relevant health professionals

Source: Adapted from Munn et al. (2018)

The population component comprised young adults aged 18-25 in urban UK settings, reflecting both a critical period for mental health onset and the specific access barriers associated with urban contexts. The exposure component covered all experiences of seeking, attempting to seek, or declining formal mental health support. The outcome component encompassed the barriers and facilitators to accessing care reported in the qualitative primary studies (Munn et al., 2018).

3.5 Inclusion and Exclusion Criteria

Inclusion and exclusion criteria were defined a priori and applied consistently throughout the search process, to ensure that included studies were relevant, methodologically appropriate and recent enough to reflect the current UK mental health service context (Table 3.2).

Table 3.2: Inclusion and Exclusion Criteria Applied to Study Selection

Criterion	Inclusion	Exclusion
Population	Young adults primarily aged 18–25 residing or studying in the UK	Studies with predominantly younger (under 18) or older (over 25) samples as the primary focus
Study Design	Qualitative designs: semi-structured interviews, focus groups, ethnographic methods, qualitative case studies	Quantitative studies, randomised controlled trials, epidemiological surveys; mixed-methods studies where qualitative data cannot be separately extracted
Setting	United Kingdom, with particular emphasis on urban and metropolitan contexts	Studies conducted exclusively outside the UK; rural UK settings unless explicitly comparative with urban provision
Publication Date	January 2015 to present, to reflect the current NHS mental health service landscape post-Five Year Forward View	Studies published before January 2015
Language	English language publications	Non-English language publications
Publication Type	Peer-reviewed journal articles reporting primary qualitative data	Grey literature, editorials, conference abstracts, dissertations, review articles, commentary pieces

Source: Developed by the researcher in accordance with Munn et al. (2018) guidance

on systematic review eligibility criteria

Mixed-methods studies in which qualitative data could not be separately extracted were excluded, as this would compromise the integrity of a purely qualitative synthesis (Munn et al., 2018, p. 540). The January 2015 cut-off reflects the introduction of the NHS Five Year Forward View for Mental Health (NHS England, 2019); studies predating this are likely to reflect a service context substantially different from today's, limiting the transferability of their findings.

3.6 Study Selection and the PRISMA Process

Study selection followed PRISMA 2020 guidelines, a transparent and internationally recognised framework for documenting each stage of a systematic review (Page et al., 2021). After the database searches were completed, all citations were exported into Rayyan, where automated and manual de-duplication removed identical records retrieved across databases. The remaining unique records were screened in two stages.

In the first stage, titles and abstracts were screened by the researcher against the criteria in Table 3.2, with reasons for exclusion recorded. In the second stage, full texts of studies that appeared eligible were retrieved and assessed against the same criteria. Where eligibility was unclear, this was discussed with the dissertation supervisor and resolved by consensus. [Amend this description if a second independent screener was involved at either stage; it must accurately reflect the process actually undertaken.] The number of records identified, deduplicated, screened, assessed and included is reported in the PRISMA 2020 flow diagram (Figure 3.1), which also documents the number and stated reasons for exclusion at each stage of the process. Records identified through the reference-list search were screened using the same two-stage process.

3.7 Quality Appraisal

The methodological quality of included studies was appraised using a modified CASP Qualitative Checklist, a widely used and validated instrument for assessing qualitative research quality (Munn et al., 2018). Its ten questions, spanning six appraisal domains, were each rated yes, no or cannot tell. Each study was appraised individually by the researcher, with a brief justification recorded for every rating in a quality appraisal log

(see Appendix [X]) to support transparency (Table 3.3).

Table 3.3: CASP Quality Appraisal Domains and Their Relevance to the Review

Appraisal Domain	Key Questions Assessed	Relevance to This Review
Research Aim and Design Appropriateness	Is the qualitative methodology appropriate to the research question? Is the research design adequately described?	Ensures that included studies have a defensible methodological basis for their qualitative claims about barriers and facilitators
Recruitment and Sampling Strategy	Was the recruitment strategy appropriate to the research aims? Were purposive or theoretical sampling methods used and justified?	Assesses whether participant selection is likely to yield a representative range of perspectives from the target population
Data Collection Rigour	Were data collected in a way that addressed the research issue? Was data saturation considered?	Evaluates the depth and sufficiency of the primary evidence underpinning reported themes and findings
Analytical Rigour	Was the data analysis sufficiently rigorous? Is there a clear explanation of the analysis process?	Determines whether the interpretive conclusions drawn by primary study authors are adequately grounded in their data
Ethical Considerations	Has the relationship between researcher and participants been adequately considered? Is ethical approval described?	Confirms that primary data were collected within an ethical framework protective of participant wellbeing

Clarity and Credibility of Findings	Is there a clear statement of findings? Are findings explicit in relation to aims? Are limitations acknowledged?	Assesses the trustworthiness of individual study findings prior to their incorporation into the synthesis
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Source: Adapted from the Critical Appraisal Skills Programme (CASP) Qualitative Checklist

To ensure that appraisal ratings were not used to exclude studies but provided context and weight to the studies included in the synthesis, the studies were not excluded on quality grounds. Studies that received a lower methodological rating from one or more domains were kept as they did contain information, but were interpreted with due caution, and any significant quality concerns were noted when they relevant to a theme.

3.8 Data Synthesis: Thematic Synthesis

The included studies were used to qualitatively summarise the findings, which was conducted in three stages using a thematic synthesis method adapted from Tricco et al., 2018 for the rigorous synthesis of qualitative evidence. The first phase involved line-by-line coding of the findings and, if mentioned, verbatim quotes of the participants from each study, which resulted in descriptive codes that were as close to the participants' and the authors' words as possible, but not a theoretical structure. Coding was performed and documented by researcher using [insert software used, e.g. NVivo] or manually using a structured Excel matrix.

In the second phase, these codes were clustered into descriptive themes, which were the most salient and stable patterns found in the compiled studies, by a process of iteration that involved constant comparisons of coded data with the evolving theme structure. For example, codes that shared a common underlying concept, such as embarrassment, shame and fear of judgement, were combined together in a single descriptive theme, and then compared to the original study texts to ensure that it was representative of the primary data. The third phase, a higher order interpretation of the descriptive themes, was used to develop analytical themes: 'higher level conceptual interpretations not captured within the content of any individual descriptive study'

(Thomas and Harden, 2007, p. 266). The review then transitions from collating the findings to real synthesis and development of a theory about barriers to mental health service access for young adults in urban UK contexts (Tricco et al., 2018). Throughout all three phases, the researcher kept a reflective log of key coding and theming decisions, to support transparency and allow the analytical process to be traced back to the original data.

3.9 Ethical Considerations

This is a secondary research synthesis, that is a synthesis of published, peer-reviewed, human empirical studies, and as such is not directly conducted with human participants, therefore, ethical issues that would apply in an empirical study -- informed consent, participant risk, and anonymity -- do not apply. However, the ethical aspects were given careful consideration, including accurate reporting and nonselective distortion of results of primary studies, highlighting limitations and uncertainties of the evidence base, and being sensitive to the implications of the findings for the population groups described in the primary studies.

The ethics of this review were approved by the University's normal post-graduate taught ethics review process. The data handled was secondary and non-personal; research materials were kept securely on the University's password-protected OneDrive, which was accessible to the researcher only, and the academic supervisor (Munn et al., 2018).

CHAPTER 4: DATA EXTRACTION AND EVALUATION

4.1 Introduction

This chapter provides description of the data extraction and quality evaluation step of the systematic review. It outlines the common features of the studies that fulfilled the eligibility criteria outlined in Chapter Three, and details the appraisal undertaken for methodological quality in each of the studies. The chapter starts by defining what is meant by data extraction and outlines the data extraction form for this review. It then provides the reasons for using Critical Appraisal Skills Programme (CASP) checklist as the appraisal tool of choice rather than other tools, and an overview of the appraisal results for the studies included in the review, which were qualitative and mixed methods. The chapter concludes with brief summary that introduces the thematic synthesis presented in Chapter Five.

4.2 Data Extraction

Data extraction involves extracting the relevant information from each of the studies included in the study in a consistent and standardised manner so that the data can be compared and combined across studies (Munn et al., 2018). In developing the structured extraction form, prior to the search, the following factors were identified: author and year of publication, country and setting, study design, sample size/population, data collection method, analytic approach, and main findings reported by each study. The same format for each study minimized the risk that the reviewer would only see the results that supported their personal understanding of the subject (as is a common problem in review writing, Page et al., 2021).

In order to avoid any possible confusion in the categories, it was decided to pilot the extraction form on two of the papers supplied and to then use it on the rest of the paper set. This piloting phase is important because what it often means is that the findings of a qualitative paper are not presented in a standard results table, and the reader or reviewer must make decisions as to what does and does not constitute a finding, as opposed to background information, in a section of the paper called discussion (Tricco et al., 2018). It is important that these judgement calls not only be recorded in the extraction log (which was also agreed), but that the reasoning behind each entry in Table 4.1 is also recorded. The table below (Table 4.1) depicts the results of the full

extraction process for the eight studies that were found to meet all of the eligibility criteria.

Table 4.1: Characteristics of Included Studies

Study (Author, Year)	Country/Setting	Design and Method	Sample	Focus
Appleton, Elahi, Tuomainen, Canaway and Singh (2021)	England (West Midlands)	Qualitative, narrative interviews	15 young people and 15 parents covering 19 unique transition stories	Reasons why young people fall through the gap between CAMHS and adult mental health services
Appleton, Loew and Mughal (2022)	London and West Midlands, England	Qualitative, narrative interviews	14 young people and 13 parents/carers	Barriers and facilitators to primary care support after the CAMHS to AMHS transition gap
Barnett, Arundell, Matthews and colleagues (2021)	England (single university)	Qualitative, semi-structured interviews and focus groups	16 university students who had used mental health support	Student experience of accessing and receiving university mental health support
Priestley, Broglia, Hughes and colleagues (2022)	England (multi-university)	Qualitative, thematic analysis of co-creation panels	Student panel members from the University Mental Health Charters consultations	Student perspectives on how mental health support services at university could be improved
Rich, Viney,	Eight UK	Qualitative, semi-	20 medical students	Impact of medical

Study (Author, Year)	Country/Setting	Design and Method	Sample	Focus
Silkens, Griffin and Medisauskaite (2024)	medical schools	structured interviews, reflexive thematic analysis	with mental health difficulties	school culture on the development of mental ill health and on help seeking
Ghobrial, Samba, Burns and colleagues (2025)	England and Wales	Qualitative, semi-structured interviews, thematic framework analysis	29 Black, Asian and Latin American men who have sex with men	Intersection of ethnicity and sexuality in mental health experience and service access
Sheldon, Ezaydi, Desoysa and colleagues (2024)	England (University of Sheffield)	Mixed methods of using the candidacy framework	103 medical students surveyed, with a nested sample of 20 students and 10 healthcare professionals interviewed	Barriers to help seeking, accessing and providing mental health support for medical students
Osborn, Town, Bawendi, Stapley, Saunders and Fonagy (2024)	North and East London	Qualitative, semi-structured interviews	23 health service professionals	Professional perspectives on university student access to mental health services

Source: Developed by the researcher from the data extraction log (see Appendix 1)

Three of the eight studies concentrated on the transition from CAMHS to adult services, three studies were carried out in university settings and involved staff and student access generally, and two studies explored access among specific groups of students, including medical students and Black, Asian and Latin American men who

have sex with men. It is important to note that there are no studies that recorded the professional perspective instead of the young person's, but there is one study that recorded the perspective of the professional, rather than the young person, and that is the one by Osborn and colleagues (2024) – this is returned to in the next chapter and in the discussion in Chapter Six.

4.3 Introduction to Critical Appraisal and Paper Quality Assessment

Critical appraisal is a structured way of assessing the trustworthiness, relevance and results of a piece of research before it is adopted to inform practice or, as in this review, be amalgamated with other pieces of research (Munn et al., 2018). Appraisal in a systematic review should not be used to dismiss poor studies as a matter of course, but its aim is to determine the contribution of each study in the synthesis on a reasonable basis (Page et al., 2021). A good appraisal tool should include questions regarding the clarity of the aim of the research, the congruence between the aim and the method used, the recruitment of the participants, whether it seems likely that rich and trustworthy data were generated from the data collection method, whether data analysis was conducted with necessary rigor and transparency, and whether ethical issues were sufficiently explored. This type of appraisal is what distinguishes a systematic review from just a narrative summary of literature, as it reveals the foundation for conclusions drawn, according to Tricco et al. (2018).

4.4 Critical Appraisal Tools

There are a number of tools available for appraising qualitative health research, such as the CASP Qualitative Checklist, the Joanna Briggs Institute Critical Appraisal Checklist for Qualitative Research and the Mixed Methods Appraisal Tool (MMAT). We chose the CASP tool for this review because of its widespread use in public health and social care reviews, its lack of charge and its plain language, meaning it doesn't require specialist statistical training to use (Munn et al., 2018). The CASP checklist is structured around 10 questions that are rated as "yes," "no," or "cannot tell," and focus on research aims, methodology, design, recruitment, data collection, reflexivity, ethics, analysis, findings and value, and the nature of the study.

The CASP tool has limitations when compared to other tools. The checklist is also not scored numerically, making it difficult to obtain a simple ranking of studies by quality,

unlike the MMAT or other instruments, and can lead to a more subjective appraisal because it is possible to have a low score on the checklist and still have a high quality study. In addition to the broader questions, the JBI checklist poses more detailed questions regarding the philosophical stance of the researcher, these were deemed as unnecessary detail for the studies in this review, which were applied, practice oriented. Overall, the CASP tool was considered most proportionate, as it is not a tool used by academic methodologists, but rather it is designed for practitioners to consider the evidence as they evaluate it for making practical decisions, which is the purpose of this review (Tricco et al., 2018). The one study identified as being mixed methods, Sheldon et al. (2024), was appraised using both MMAT and CASP as MMAT is designed for studies that have both qualitative and quantitative elements.

4.5 Evaluation of Qualitative Studies

The eight studies included were rated independently by the researcher for each of the 10 CASP questions and these ratings along with justifications were documented in a quality appraisal log (see Appendix 2). A summary of the ratings is presented in Table 4.2.

Table 4.2: Summary of CASP Quality Appraisal Ratings

Study	Aims	Method	Design	Recruit.	Data coll.	Reflex.	Ethics	Analysis	Findings	Value
Appleton et al. (2021)	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Yes	Yes	Yes
Appleton et al. (2022)	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Yes	Yes	Yes
Barnett et al. (2021)	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Yes	Yes	Yes
Priestley et al. (2022)	Yes	Yes	Yes	Cannot tell	Yes	Cannot tell	Cannot tell	Yes	Yes	Yes

Study	Aims	Method	Design	Recruit.	Data coll.	Reflex.	Ethics	Analysis	Findings	Value
Rich et al. (2024)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ghobrial et al. (2025)	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Yes	Yes	Yes
Sheldon et al. (2024)	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Yes	Yes	Yes
Osborn et al. (2024)	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Yes	Yes	Yes

Source: CASP Qualitative Checklist ratings assigned by the researcher (see Appendix 2 for full justifications)

The evidence base is generally good as shown in the appraisal. Each of the eight studies had a clear research aim and this was matched to a qualitative or mixed methods design, and in all eight studies, the method of data collection was appropriate for collecting in-depth first-hand accounts, for example, narrative interviews used by Appleton et al. (2021) and semi-structured interviews used by Rich et al. (2024). Recruitment was less frequently reported. The sampling rationale for their sample of Black, Asian and Latin American students was clear and purposive, as seen by Ghobrial et al. (2025), whilst Priestley et al. (2022) provided less detail on how they ended up with the final sample, which was judged as not a strong point but a minor detail.

Reflexivity – whether the researcher described his/her own role and possible impact on the data – was the area judged most frequently to be Cannot tell. In health services research, for instance, the word limits for journal articles frequently result in a final product without the researcher positionality, despite having been explored in the study (Munn et al., 2018). Rich et al. (2024) was unique in that they employed reflexive thematic analysis and explained how their clinical and educational experiences influenced the meaning they gave to the data. The other seven studies were not in any way less reflexive in practice; this is not to say that reflexivity was not made visible to

the reader in these studies; rather, the researcher was aware of the distinction and took it into account when synthesizing the findings.

Ethical approval (usually via university or NHS research ethics committees) was reported in most studies, and informed consent procedures were described. One important consideration when evaluating the contribution of Osborn et al. (2024) to the synthesis is that the sample consisted of health professionals, not young adults reporting on their own mental health, meaning the ethical issues were more directed towards the health professionals' protection of their honesty than towards protecting the participants as a vulnerable group. No study was rejected due to quality criteria, as discussed in Chapter Three but this influenced the level of confidence attached to the conclusions of each study in the analysis reported in the following chapter (Page et al., 2021).

Analytical rigour was fairly well described in most of the studies so that the findings reported can be trusted with regard to the methods used to arrive at codes and themes from the raw data. Rich et al. (2024) and Ghobrial et al. (2025) both provide a detailed account of how the coding process was conducted in a manner that another reader could repeat it, whereas Priestley et al. (2022) provide a shorter account of the analysis because the aim of their paper was to report recommendations from co-creation panels, rather than to complete a thematic analysis. This disparity in the depth of reporting was not regarded as a failure of quality, as the objectives of the two kinds of paper are quite different, but rather as a factor to take into account when considering the more detailed papers when comparing them close to one another, as in the synthesis in Chapter Five. With regard to the value of the research domain, each study contained some discussion of implications for practice or policy, which led to the inclusion of practical recommendations in the synthesis in Chapter Seven instead of findings being reported purely descriptively (Munn et al., 2018).

4.6 Evaluation of Quantitative Studies

There were no quantitative studies that fulfilled the criteria outlined in Table 3.2, and the aim of the review was to find qualitative descriptions of the 'felt experience' of seeking mental health services. Therefore this section is not applicable and is included here only to confirm that this does not occur by chance, but as a direct result of the

inclusion criteria set (Munn et al., 2018).

4.7 Evaluation of Mixed Methods Studies

Sheldon et al. (2024) was the only study to include a qualitative component based on the candidacy framework and a quantitative component (survey) involving medical student help seeking that met the inclusion criteria. The Mixed Methods Appraisal Tool (MMAT) was used to evaluate this study to determine if the qualitative and quantitative sections of the study were well done and if they were integrated (Tricco et al., 2018). The results of the qualitative strand fulfilled the standards of MMAT, which include the formulation of a qualitative research question, a sufficient amount of data to answer the research question, and appropriate interpretation. The two strands were integrated in a satisfactory manner, as the authors applied the quantitative data to characterize the magnitude of unmet need and the qualitative data to describe or explain why the unmet need was occurring, as is acknowledged as one of the strengths in mixed methods research in health services research (Munn et al., 2018). As this study was qualitative, only the qualitative findings of this study were included in the thematic synthesis in Chapter Five.

It is important to recognise that when appraising a study that includes a mixed methods approach, there is an additional level of judgement that is required compared to appraising a purely qualitative study, as the reader must determine whether the use of the two methods together is a useful addition or simply a juxtaposition of two stand-alone pieces of research. For Sheldon et al. (2024), the quantitative survey provided a clear picture of the prevalence of unmet need amongst the sampled medical students and the nested qualitative interviews provided a much richer understanding of why students who described experiencing unmet need did not always seek support. However, the treatment of these as complementary evidence sources, rather than competing, was deemed to be the more defensible reading and was the approach that was adopted for the study's qualitative findings being included in the synthesis in Chapter Five.

4.8 Chapter Summary

In this chapter, the features of the 8 studies meeting inclusion criteria for this review were summarized and the process that was considered to evaluate the quality of these studies was described. The seven qualitative studies and one mixed methods study were assessed using the CASP Qualitative Checklist, and the MMAT was used in conjunction with CASP in the one mixed methods study; both of these were supported by the aims of this review. Researcher reflexivity was reported inadequately in some studies, but the appraisal identified a generally good evidence base including clear aims and suitable methods in all studies. There were no studies excluded from the review based on quality criteria but the quality appraisals were based on to guide the analysis of the findings and weighted according to quality. This chapter provides the background for the next, in which the findings from these 8 studies are synthesized in a theme.

CHAPTER 5: DATA ANALYSIS AND SYNTHESIS

5.1 Introduction

The results of the eight studies that were included in the review are presented for analysis and synthesis in this chapter. It starts with an explanation of the concept of thematic analysis and the type of thematic analysis employed to pull items together from different qualitative studies. The characteristics of the included studies are then restated briefly before the start of the main body of the chapter which outlines the themes and sub-themes that were derived from the data and then provides an explanation of how each theme is supported in each of the studies.

5.2 Thematic Analysis

Thematic analysis is a technique used to identify, classify and report patterns of meaning in qualitative data that were originally described by Braun and Clarke (2006) as a flexible method that can be used in a wide range of qualitative research. If thematic analysis is used not for a single dataset but for the findings which were already reported in a number of distinct primary studies, it is typically known as thematic synthesis, a term coined by Thomas and Harden (2008) to describe the use of thematic analysis in systematic reviews. Thematic synthesis was deemed appropriate to be used to combine the one mixed methods study (with qualitative results reported as descriptive statements) with the seven purely qualitative studies in this review for this reason.

The choice of thematic analysis of primary data or thematic synthesis of already published findings is important because it alters the nature of the raw data that is coded. The researcher worked with the findings and quotations already reported by the original study authors, in this case, a first interpretation, in primary thematic analysis the researcher worked directly with the transcripts or field notes, which were already once removed from the original study participants (Munn et al., 2018). Although this is an accepted method for systematic reviews of qualitative evidence, it does limit the scope of analysis of the present review because the amount of detail each original author reported.

5.3 Data Analysis Tool

Thomas and Harden (2008) proposed a three-stage thematic synthesis method which was adopted for this review. This approach starts with line-by-line coding of the findings section of each paper, then creates descriptive themes (higher order coding), which remain close to the original studies, and culminates in the creation of analytical themes (higher order coding) which are interpretations that are higher than any single study. This framework is selected as it has been developed specifically for combining qualitative evidence in systematic reviews, not adapted from analysis of primary data making it a good match for the aims of this review (Munn et al., 2018).

5.4 Characteristics of the Identified Studies

The eight studies that became part of the synthesis were all qualitative, one of which used both qualitative and quantitative approaches and only the qualitative portion was included in this analysis. All eight studies took place in England, with Ghobrial et al. (2025) having participants from Wales as well. Two studies looked at the transition from CAMHS to adult mental health services, three looked at more general settings within university, such as the work of Barnett et al. (2021) and by Priestley et al. (2022), and two focused on more specific populations, namely medical students, studied by Rich et al. (2024), and Black, Asian and Latin American men who have sex with men. Samples sizes have varied from 14 to 29 participants and the methods of collecting the data were semi-structured or narrative interviews with or without the presence of focus groups.

5.5 Emerging Themes from Included Studies

Analysis of the eight included studies identified four overarching themes with associated sub-themes, summarised in Table 5.1.

Table 5.1: Overarching Themes, Sub-themes and Contributing Studies

Theme	Sub-themes	Contributing Studies
Stigma, shame and self-reliance	Fear of judgement and exposure; normalising distress as ordinary stress	Rich et al. (2024); Ghobrial et al. (2025); Barnett et al. (2021); Priestley et al. (2022)
Feeling unseen by services	Loss of trusted relationships; being treated as a case rather than a person	Barnett et al. (2021); Appleton et al. (2021); Appleton et al. (2022)

Theme	Sub-themes	Contributing Studies
Structural and system barriers	Rigid transition thresholds; complex referral pathways; competing pressures of study or work	Appleton et al. (2021); Appleton et al. (2022); Osborn et al. (2024); Sheldon et al. (2024)
Culture, identity and facilitators of access	Intersectional stigma; peer support as protective; preference for private or alternative options	Ghobrial et al. (2025); Priestley et al. (2022)

Source: Developed by the researcher through thematic synthesis of the included studies

5.5.1 Theme One: Stigma, Shame and Self-Reliance

Stigma and self-treatment of distress were the most common barriers to treatment reported across the studies reviewed. Rich et al. (2024) identified an active concealment of symptoms and reluctance to seek assistance, driven by concerns that it would affect the ability to practise medicine and linked closely to the broader medical culture of students needing to overcome challenges, rather than seek support. A similar pattern was found among Black, Asian and Latin American men who have sex with men, for whom childhood socialisation into hypermasculine norms was associated with a strong preference for self-reliant coping, such that distress was sought in private long before seeking professional assistance was considered (Ghobrial et al., 2025).

Likewise, Barnett et al. (2021) reported that students at universities frequently de-normalized their own experiences, viewing them as normal stress, instead of as reasons for support which was further fostered by others using the same language to dismiss their own disclosures. Priestley et al. (2022) came to a similar overall finding from a different sample of students, claiming that campaigns against the stigma should go beyond promoting general awareness-raising and focus specifically on the moment a student first realizes its distress is serious. These four studies collectively demonstrate that stigma in this population is not only fear of being judged by others, but is also a reluctance to even label distress as a problem in the first place, that extends into accessing services well before they reach a structural barrier.

Another aspect of self-reliance that should be highlighted is that it was not defined as a lack of willingness to seek help in any of the four studies. Instead of being a personal decision to make when a crisis arises, Ghobrial et al. (2025) defined self-reliance as a learned behavior, reinforced in a multitude of contexts from family to peer groups and

society's expectations. The idea that pushing through difficulty was a norm, established and modeled by senior colleagues and not taught informally, is reminiscent of a similar process in medical education described by Rich et al. (2024), where the norm of pushing through difficulty was learned and modeled by senior colleagues, leading to a barrier that would later prevent students from seeking support. This separation is important because it focuses attention on the socialisation and culture that is the origin of the barrier rather than on a lack of competence in the young person.

5.5.2 Theme Two: Feeling Unseen by Services

The second theme was the emotional aspect of being through a system and not understood as a person. Barnett et al. (2021) captured this directly in a sub-theme they titled feeling abandoned, ignored or invisible: students commented on the long time between contacts and the lack of continuity from one contact to another. A more extreme version of this was reported by Appleton et al (2021) from young people who had exited CAMHS, including some who felt that they had been referred and rejected by adult services so many times they had come to the conclusion that their needs had ceased to be anyone's business.

In a related study, Appleton et al. (2022) reported that a lack of specialist advice means that young people in this gap were often left to manage them with little support from their GP, with some young people having the GP as the only stable point in an otherwise fragmented journey. This is in line with Barnett et al. (2021) finding of loss of relationship and both studies indicate that the continuity of a trusted relationship seems to be important to young people as much as the content of the care they receive. When a youth's first hand account of their sense of being let down is recorded, as in the work of Appleton and colleagues, the sense of being let down is expressed in strongly personal language, and thus is not a service planning problem, but a problem with real emotional cost to the young person concerned.

It is also important to note the differing experiences of this theme, depending on who recorded them. As reported by Osborn et al. (2024), professionals would frequently be informed of the fragmented system and would refer to informal attempts to make up for it, such as staying in contact with a student outside of their job description. It was

not evident in the young person centred studies by Appleton and colleagues where young people spoke of the disjointedness as something that happened to them rather than services trying to 'soften it'. This disparity in the authors' expectations and the actual experience of young people is also a finding from this review and indicates that it is not surprising to find that at an individual level staff are doing their best to offer the young person an experience of 'continuity'.

5.5.3 Theme Three: Structural and System Barriers

The third theme shows the more tangible obstacles in the way of young adults to the help they were seeking. Appleton et al. (2021) identified a 'hard boundary' between CAMHS and adult services, which did not consistently reflect the young person's clinical need, and Appleton et al. (2022) demonstrated that for young people who crossed this boundary they would frequently delay receiving an alternative pathway to care for a long time. While not from the perspective of young people, but of professionals, Osborn et al. (2024) discussed the variable nature of access to support, depending on the specific mix of pressures at that moment in the young person's life, their course demands, financial circumstances and the organisation of the local health system.

Similarly, Sheldon et al. (2024) used the same framework of candidacy for medical students and determined that the heavy time commitment of medical studies prevented many medical students from attending appointments during regular clinic hours, excluding them from services whether or not they had a need for these services. Rather, the barriers outlined in this theme are not emotional, perceptual or related to services and front doors, but rather to the architecture of services in terms of opening times, referral criteria and the split of responsibilities between various aspects of the service. Despite this, the research indicates a reinforcing effect between the different types of barriers, where the structural barriers and the more personal barriers outlined in the first two themes tend to reinforce one another because the young person who feels they are not visible to services is less likely to continue to follow a lengthy referral pathway.

This approach to access as a process of negotiation between what the young person can contribute to a service, including time, persistence and capacity to articulate a

need, and what the service is willing to recognize as worthy of their attention can be a helpful framework for summarising the theme in the work of Osborn et al. (2024) and Sheldon et al. (2024). This framing may help to shed light on the fact that the impact of the same structural barrier (e.g., narrow appointment window) can be quite different for different young adults, depending on their other commitments. Both types of medical students – those who have no flexibility in their study schedule (Sheldon et al., 2024) and those who recently came out of CAMHS with no fixed daily routine (Appleton et al., 2021) have rigid systems in place, and within their broader circumstances, this rigidity has different implications.

5.5.4 Theme Four: Culture, Identity and Facilitators of Access

The final theme comes together with research concerning the factors that affect the barriers for young adults and the factors that affect the path to overcoming these barriers. Ghobrial et al. (2025) identified a type of intersectional stigma, in which cultural norms around masculinity and community reputation were paired with sexual stigma and mental illness stigma, and that this created a more complex set of barriers to living with and speaking about mental illness than either of these stinging factors existed independently. The same study revealed peer support was a significant protective resource, with participants who had access to people who were open about their own mental health challenges being more likely to think about seeking help for themselves.

Similarly, Priestley et al. (2022) found that students wished for mental health support to be tailored to their priorities and be more flexible in its format and more visible in its student lived experience input into what this support might look like. Interestingly, Ghobrial et al (2025) also reported that some participants chose to access private mental health services rather than NHS provision, mainly due to perceived quicker access and quality of care, despite the fact that participants acknowledged that this was only offered to those that could afford it. It also brings an equity aspect into play with the other facilitators found throughout the review, as a facilitator for one group (in this case for paying for private care) can also be a barrier for other groups who do not have the same capacity.

The other aspect of this theme relates to the particular function of the visible representation. Participants were more likely to engage with mental health support when they saw someone who was from their cultural or community background who shared their openness with mental health care, indicating that representation is a facilitator not just because it reduces the stigma for mental health in general, but because the person in front of the young adult is from a similar cultural and community background and appears more credible and less likely to misunderstand the situation. This is a more targeted request than a broad one for cultural competence because it is geared towards seeing culturally relevant role models in outreach and service delivery as a tangible way of establishing trust, not just towards training.

5.5.5 Cross-Cutting Synthesis

If you look at the four themes together, you will see that there is a pattern present which no individual study could demonstrate. The individual level barriers outlined in Theme One are not unique to the structural barriers outlined in Theme Three; for example, a young person who has learned to interpret their own distress as ordinary stress as in Barnett et al. (2021) may be less likely to be confident enough to challenge a rejected referral as described in Appleton et al. (2021). Similarly, the relational loss in Theme Two seems to diminish the persistence of a young person when a structural barrier is present, implying that the three barrier related themes compound each other, but do not stand in isolation. Theme Four then reveals how each of these barriers is felt differently if identity, culture and access to money are considered and how Ghobrial et al. (2025) found that stigma, service mistrust and financial constraint can interact in a way that is much more difficult to navigate than each one of these barriers alone. The layered picture further helps to support the theoretical framework presented in Chapter Two in that it captures the confluence of predisposing, enabling and need related factors as described in Andersen's model, and because it demonstrates the individual accounts of stigma and the individual account of service design would only provide part of the picture if they were viewed in isolation.

5.6 Chapter Summary

In this chapter, the authors have summarized the eight studies that were a part of this review in four themes: stigma and self-reliance, feelings of being unseen, structural barriers in services, and the importance of culture, identity, and peer support for access. These findings are discussed in Chapter Three in the context of the theoretical framework and wider literature outlined in Chapter Two and the strengths and weaknesses of the review are considered as a whole.

CHAPTER 6: DISCUSSION

6.1 Introduction

the extent to which the new evidence and theory developed through the review supports, extends or challenges the current evidence and theory regarding barriers to mental health service access among young adults and then provides a critical analysis of the merits and limitations of the review.

6.2 Discussion of Key Findings

This finding that stigma and self-reliance act as a first line barrier is well-attuned to the tenets of stigma theory as presented by Thornicroft et al. (2022) who describe how stigma can be internalized as self-stigma and how this is a disincentive for help seeking before a person reaches a service. In the context of medical students, who had to suppress their symptoms out of fear of tainting their professional image, the argument put forward by Sagar-Ouriaghli et al. (2020) about the ability to resist internalisation in professional and high-pressure environments is evident in Rich et al. (2024). This review contributes to that picture in part to a more precise account of how it works: in the synthesis in Chapter Five, the notion of self-reliance is not just a personality trait, but something that is reinforced by the responses of other members of the profession, and by the responses of peers.

This also relates to mental health literacy as discussed in Chapter Two, where low literacy was cited as another barrier to stigma. The results from the present review indicate that the two are not distinct barriers but are more tightly linked together in that Barnett et al. (2021) found students dismissed the symptoms as "ordinary stress" - simultaneously holding a literacy gap (not recognising the symptoms as clinically significant) and a stigma-driven reluctance to label the symptoms as a mental health problem. Reavley and Jorm (2022) have discussed the need to address literacy and stigma simultaneously, and the evidence presented in this review directly supports this position; none of the studies included in this review discussed a barrier that was solely related to literacy, but was not also related to some component of stigma or self-judgement.

The theme of feeling "not seen" by services continues the exploration of negative experiences as a blocker to re-engagement from Chapter Two. The experiences of denied referrals in Appleton et al (2021) is a stark example of this impersonal and bureaucratic service contact and underscore the importance of Edbrook-Childs et al (2021) argument that the willingness to return to services is damaged. But the conclusions of this review have a dimension that is not reflected in the current literature: the loss of one "trusted" relationship rather than dissatisfaction with the service per se may be the factor which most severely threatens trust. The claim is more specific than the general one expressed by Edbrooke-Childs et al. (2021) that the experience is poor, and it implies that continuity of relationship should also be given more consideration in the design of future services than continuity of pathway alone.

The age based service boundary as a source of harm (Radez et al., 2021) was a theme that emerged repeatedly and strongly in this synthesis, complementary to the existing literature discussed in Chapter Two. The results from Appleton and colleagues in 2021 and 2022 demonstrate that this boundary is neither merely "administrative inconvenience" but can lead to a young person receiving no mental health support whatsoever for a prolonged period of time. While this is broadly in line with the concerns about transition raised in the NHS Long Term Plan (NHS England, 2019) that made this a named priority area, the fact that this barrier is still identified in more recent studies indicates it has not yet arrived at the ground level as a result of policy commitments made several years ago. Beyond the transition boundary, Osborn et al. (2024) and Sheldon et al. (2024) reveal that there are services issues that interact with ordinary aspects of daily life – like study timetables, financial stress – as well, which can be exclusionary as much as the CAMHS to AMHS boundary itself.

This pattern is also echoed in Chapter Two, which explored the provision of services in urban areas and suggested that urban services can be highly concentrated without equating this with good access for the people who most need them: Zwack and Schweitzer (2020) found this to be the case. The findings from Osborn et al. (2024) about the candidacy based findings may explain why this paradox occurs: the more services available in a city such as London, the more likely there is that a young person will not be aware of which service is intended for their specific situation; and the more

likely it is that the young person's care will be shared across multiple services, none of which have clear ownership. In this respect, urban abundance of provision and urban fragmentation of provision seem to be two sides of the same structural problem, rather than two distinct problems – a connection that this review here can make more directly than the studies as such taken individually in the second chapter.

Chapter Two's discussion of minority ethnic experience is enriched by the theme of culture, identity and facilitators. The barriers discussed by Bignall et al. (2020) were determined to be related to a lack of culturally competent provision, and the intersectional stigma identified by Ghobrial et al. (2025) demonstrates how this cultural barrier can compound other identity related stigma as in this case with sexuality stigma. This reinforces the argument put forward by Ibrahim and Hassan (2021) that generic service models are unlikely to be able to respond to the needs of minority communities, as is evident in this review, even culturally aware ones would need to take into account multiple aspects of a person's identity rather than trying to solve the problem of culture as a stand-alone issue. Concurrently, the presence of preferences and affordability of private care adds to the literature reviewed in Chapter Two the equity issue that private care may in practice have a greater impact on reducing disparities in use of services than it does in expanding use, as some participants preferred and are able to afford it.

Together, these observations confirm the multi-level theoretical framework proposed in Chapter Two, as the predisposing, enabling and need factors all cross-cut the studies synthesised and do not exist in isolation, but rather interact with each other and with the other factors (Xu et al., 2022). This review does not challenge the existing literature, but rather it brings the various threads of the literature into a more coherent narrative, the particular gap identified at the outset of this dissertation (Munn et al., 2018).

6.3 Strengths and Limitations

There are some advantages to this review. The search and appraisal process was clear and followed a pre-defined procedure in accordance with PRISMA (Page et al., 2021), which is recognized for improving the trustworthiness of conclusions drawn and the method of thematic synthesis was used instead of an informal narrative summary

of the literature (Tricco et al., 2018). Recent, England-focused primary studies, published mainly between 2020 and 2025, also ensure that the results are relevant to the current NHS service landscape and not an older, potentially-obsolete one.

The review is also quite restricted. Neither the synthesis nor the eight studies included are representative of a broad range of young adult experiences, as they were focused in university and medical education settings, and one study of a specific minority population. The focus on ethnicity or sexuality was addressed in only one study (Ghobrial et al., 2025), and so the findings of this review are limited in their evidence base and should be viewed as a secondary analysis to the rest of the synthesis. Moreover, Osborn et al. (2024) reported an account from a professional, not from the young person, so that one of the eight types of evidence is at one remove from the people experiencing the barrier. Lastly, because this is a single reviewer synthesis and not a double (independent) screening and coding process throughout, some interpretive bias cannot be ruled out, although the CASP appraisal process of Chapter Four was applied uniformly to mitigate this as much as possible.

Another restriction is the geographic extent of the evidence. Only the study by Ghobrial et al. (2025) included Wales, and none of the studies included Northern Ireland, which differs in some respects from the structures of mental health services in England. The results, therefore, cannot be extrapolated to other countries or to groups outside of England and Wales, which may have different mental health service structures. This urban focus is intentional and warranted in Chapter One but it also excludes any direct comparison rural group, so statements of a particular barrier being distinctly urban are based on comparison to the broader literature discussed in Chapter Two and not on a side by side comparison conducted in this review.

6.4 Chapter Summary

The four themes discussed in Chapter Five have been explained in relation to theory and literature provided in Chapter Two that has confirmed or extended the knowledge. It has also taken into account the strengths of the review's transparent review and its weaknesses relating to the focus of the evidence on students and the single reviewer. The next and last chapter is a discussion of the implications of these findings and

recommendations for practice, future research and a general conclusion to the dissertation.

CHAPTER 7: RECOMMENDATIONS AND CONCLUSION

7.1 Introduction

This last chapter explores the implications of the review and offers recommendations for practice and research, as well as a conclusion to the dissertation. Here there is no presentation of evidence or argument, but only a bringing together of what has been presented and established in the preceding chapters.

7.2 Implications of Findings

The implications of this review will be relevant to the design and delivery of mental health services for young adults in urban settings in the UK. If stigma and self-reliance are the first barrier put up before any structural barrier is encountered, then service improvements that focus solely on waiting times or referral pathways may not be of any benefit alone, as both Rich et al. (2024) and Ghobrial et al. (2025) found that many young adults would not approach a service in the first place. Likewise, the Barnett et al. (2021) and Appleton et al. (2021) findings that continuity of relationship is as important as continuity of pathway should be valued as a separate clinical outcome from pathway.

7.3 Recommendations for Practice

There are several subjective and objective barriers that were identified by Appleton et al. (2021) and then reiterated in the follow up study Appleton et al. (2022), one of which was the lack of a named point of contact working across the CAMHS to AMHS transition – not a hard administrative cut-off but a named point of contact. Staff training in university and primary care contexts should also include the unique ways in which professional and cultural norms may alienate young adults from expressing distress (see Rich et al., 2024 for a description of the medical culture). Lastly, services targeting young adults from minority ethnic and sexual minority communities should include the type of purposive, community-engaged outreach described by Ghobrial et al. (2025) as that is more likely to address the compounded, intersectional stigma uncovered in this review.

7.4 Recommendations for Future Research.

Future research could focus on those young adults who are neither currently in university, nor in medical education, but are otherwise outside of higher education, as this group was underrepresented in the studies available for this synthesis. In addition, more qualitative research is required that directly focuses on the voice of minority ethnic and sexual minority young adults, as only one study in this review explored this in detail, and more primary research on the subject would enable stronger conclusions to be drawn. Lastly, a forthcoming review could be useful in comparing the experience of CAMHS and AMHS transition in UK urban and rural contexts directly, as this review was only conducted in the former, and a future rural comparison would help inform whether the barriers found here would be found in rural contexts and would be different or the same.

7.5 Conclusion

This thesis aimed to identify, appraise and synthesise the qualitative research that has been conducted into the barriers to accessing mental health support faced by young adults (18-25) in urban settings in the UK. The research question was what these barriers are and how they interact with each other, and four specific objectives were set, covering: individual, social and structural barriers; the interplay of stigma and mental health literacy; the specific characteristics of urban settings; and the identification of evidence based recommendations.

Eight qualitative and mixed methods studies fulfilled the inclusion criteria and were appraised using the CASP Qualitative Checklist with the one mixed methods study also using the MMAT. These studies were synthesized into four main themes: stigma and self-reliance, feeling unseen by services, structural and system barriers, and role of culture, identity, and facilitators for access. Such themes did not exist as discrete and independent barriers, but rather acted in concert and made it more difficult for a youth to question a rejected referral or a set and solidified service line.

The findings are important because they indicate that enhancing access for young adults is not a one-dimensional issue, whether it's a public awareness campaign or a shorter waiting list or a streamlined referral form. The above evidence suggests

however that a mix of continuity of relationship, culturally appropriate outreach and attention to the pressures of being a student and working life, both delivered alongside, and not in place of, structural change of the CAMHS to AMHS boundary, is most likely to be effective. With existing national data showing significant levels of mental health need (Office for National Statistics, 2023), small steps in this direction could have a significant impact on the number of young adults who give up on mental health support before accessing it.

The review has synthesised a range of qualitative evidence previously to be found in individual studies and separate populations but, in doing so, has generated a more cohesive and coherent narrative of the reasons why young adults in these settings in the UK are less likely to seek mental health support than any one primary study could be expected to do on its own. The barriers that were identified are very real, multi-layered and – in some instances – preventable and will need services, commissioners and policy makers to take them seriously as much as the systems they are designed to serve.

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APPENDICES

Appendix 1: Data Extraction Log

This appendix presents the full data extraction record for each of the eight studies included in the systematic review, expanding on the summary presented in Table 4.1. Each entry follows the same structured format, covering the study aim, setting, design, sample, data collection and analysis methods, key findings, limitations noted by the researcher during extraction, and the specific relevance of the study to the review's objectives.

Extraction Record 1: Appleton, Elahi, Tuomainen, Canaway and Singh (2021)

Full reference	Appleton, R., Elahi, F., Tuomainen, H., Canaway, A. and Singh, S.P. (2021). "I'm just a long history of people rejecting referrals": experiences of young people who fell through the gap between child and adult mental health services. <i>European Child & Adolescent Psychiatry</i> , 30(3), pp.401-413.
Research aim	To explore the reasons why young people fall through the gap between CAMHS and AMHS and the effect this has on them and their families.
Country and setting	England (West Midlands), drawn from a longitudinal cohort study of young people reaching the CAMHS transition boundary.
Study design	Qualitative, using individual narrative interviews.
Sample	15 young people and 15 parents, representing 19 unique transition stories.
Data collection method	Narrative interviews conducted individually with young people and, separately, with parents or carers.
Analysis method	Thematic analysis, developed collaboratively by the research team.
Key findings relevant to this review	Reasons for falling through the gap were grouped into systemic problems, such as referrals being rejected by adult services, and problems with the quality of care received. Participants described feeling that responsibility for their care had been passed between services without resolution.
Limitations noted during extraction	The sample was drawn from a single regional cohort, so findings may not reflect the experience of young people in other parts of the country. The study does not report the ethnic composition of the sample in detail, which limits its usefulness for the intersectional theme developed in Chapter Five.
Relevance to review objectives	Directly addresses Objective One (structural barriers) and Objective Three (urban and service-specific features), and forms a central part of the structural and system barriers theme (Theme Three) and the feeling unseen theme (Theme Two).

Extraction Record 2: Appleton, Loew and Mughal (2022)

Full reference	Appleton, R., Loew, J. and Mughal, F. (2022). Young people who have fallen through the mental health transition gap: a qualitative study on primary care support. <i>British Journal of General Practice</i> , 72(719), pp.e413-e420.
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Research aim	To explore the experiences and perspectives of young people and parents or carers receiving primary care support after leaving CAMHS, and to identify barriers and facilitators to accessing that support.
Country and setting	England, across two counties, London and the West Midlands.
Study design	Qualitative, using narrative interviews, forming part of a longitudinal follow-up study.
Sample	14 young people and 13 parents or carers who had experienced poor continuity of care after reaching the CAMHS transition boundary.
Data collection method	Individual narrative interviews with young people and with parents or carers.
Analysis method	Thematic analysis, reported according to the Standards for Reporting Qualitative Research.
Key findings relevant to this review	General practice was frequently left to manage young people's mental health needs without specialist input following discharge from CAMHS. Some young people experienced their relationship with their GP as the only stable point of contact during an otherwise disjointed period.
Limitations noted during extraction	As with Appleton et al. (2021), the sample is drawn from a specific regional population that had already been identified as having fallen through a service gap, so it may not capture the experience of young people whose transition was more straightforward.
Relevance to review objectives	Supports Objective One and Objective Two, and contributes centrally to the structural barriers theme (Theme Three) and the relational continuity theme (Theme Two).

Extraction Record 3: Barnett, Arundell, Matthews, Saunders and Pilling (2021)

Full reference	Barnett, P., Arundell, L-L., Matthews, H., Saunders, R. and Pilling, S. (2021). 'Five hours to sort out your life': qualitative study of the experiences of university students who access mental health support. BJPsych Open, 7(4), e118.
Research aim	To understand how students experience the process of accessing and using in-house mental health support at university, the barriers and facilitators to treatment, and student recommendations for service development.
Country and setting	England, a single UK university.
Study design	Qualitative, using individual semi-structured interviews with a confirmatory focus group to validate identified themes.
Sample	16 full-time students who had used mental health services at their university.
Data collection method	Semi-structured interviews, followed by a focus group with a smaller number of participants to check the credibility of emerging themes.
Analysis method	Thematic analysis, taking a realist approach that stayed close to participants' own descriptions of their experience.

Key findings relevant to this review	Five higher order themes were identified: personalisation and informed choice, simplifying the process, feeling abandoned, ignored or invisible, stigma, and a perceived superiority of private and external services compared with the university's own provision.
Limitations noted during extraction	The study was conducted at a single institution, which limits how far the findings can be generalised to other universities with different support structures. The sample size of 16 is modest, though appropriate for the depth of qualitative interviewing used.
Relevance to review objectives	Central to Theme One (stigma and self-reliance) and Theme Two (feeling unseen by services), and also contributes to Theme Four through its findings on facilitators such as personalisation and informed choice.

Extraction Record 4: Priestley, Broglia, Hughes and Spanner (2022)

Full reference	Priestley, M., Broglia, E., Hughes, G. and Spanner, L. (2022). Student perspectives on improving mental health support services at university. <i>Counselling and Psychotherapy Research</i> , 22(1), pp.197-206.
Research aim	To elicit student perspectives and proposals regarding current issues and challenges around university mental health and wellbeing support services.
Country and setting	England, multiple universities, drawn from the Student Minds University Mental Health Charter consultation process.
Study design	Qualitative, using thematic analysis of six student co-creation panels.
Sample	Students participating in co-creation panels convened as part of the University Mental Health Charter consultations; individual-level demographic detail is not the focus of the published paper.
Data collection method	Facilitated co-creation panel discussions rather than one-to-one interviews.
Analysis method	Thematic analysis of panel discussion data.
Key findings relevant to this review	Panels identified existing challenges and opportunities relating to service access, strategy and delivery, and generated recommendations for a clearer, more coordinated and more inclusive approach to student mental health support.
Limitations noted during extraction	Because the paper reports the outcome of consultation panels rather than individual interviews, it gives less methodological detail on recruitment and analysis than the other qualitative studies in this review, which was reflected in the CASP ratings in Appendix 2.
Relevance to review objectives	Relevant to Theme One (stigma) and particularly to Theme Four (culture, identity and facilitators of access), since the study is oriented around student-generated solutions rather than only barriers.

Extraction Record 5: Rich, Viney, Silkens, Griffin and Medisauskaite (2024)

Full reference	Rich, A., Viney, R., Silkens, M., Griffin, A. and Medisauskaite, A. (2024). The experiences of students with mental health difficulties at medical
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	school: a qualitative interview study. Medical Education Online, 29(1), 2366557.
Research aim	To understand the impact of mental health difficulties on students' experience and training at medical school, using a qualitative approach.
Country and setting	United Kingdom, drawing on students from eight medical schools of varying size and location.
Study design	Qualitative, using in-depth semi-structured interviews and reflexive thematic analysis.
Sample	20 medical students with mental health difficulties, purposefully sampled to gain variety in the type of difficulty experienced and in demographic characteristics.
Data collection method	In-depth semi-structured interviews, analysed using NVivo software.
Analysis method	Reflexive thematic analysis, with explicit discussion of the researchers' own position in relation to the data.
Key findings relevant to this review	Three themes were identified: the culture of medicine as a contributor to mental ill health, help seeking behaviour shaped by fear of career damage and stigma, and the considerable negative impact of mental health difficulties on students' ability to learn and progress.
Limitations noted during extraction	The sample, while spread across eight medical schools, remains specific to medical education and may not transfer directly to young adults in other courses or outside higher education.
Relevance to review objectives	Central to Theme One (stigma and self-reliance), given its detailed account of professional culture as a driver of concealment and delayed help seeking.

Extraction Record 6: Ghobrial, Samba, Burns, Nicholls, Weatherburn, Lampe, Chu, Rodger and Witzel (2025)

Full reference	Ghobrial, A., Samba, P., Burns, F.M., Nicholls, E.J., Weatherburn, P., Lampe, F.C., Chu, I.Y-H., Rodger, A.J. and Witzel, T.C. (2025). Barriers and facilitators to addressing mental health needs among Asian, Black and Latin American men who have sex with men (MSM) in England and Wales: a qualitative study. PLOS Mental Health, 2(3), e0000231.
Research aim	To explore how the intersection of sexual orientation and ethnicity shapes mental health experience and service access for Asian, Black and Latin American men who have sex with men in the UK.
Country and setting	England and Wales, drawn from a qualitative sub-study of the SELPHI HIV self-testing trial.
Study design	Qualitative, using semi-structured interviews and thematic framework analysis.
Sample	29 participants, comprising 13 Black, 11 Asian and 5 Latin American men who have sex with men, purposively recruited to ensure sample diversity.
Data collection method	Semi-structured interviews, including a focused section on mental health, conducted between April and July 2020.

Analysis method	Thematic framework analysis.
Key findings relevant to this review	Data were organised into three meta-themes: background, culture and upbringing; sexuality and manifestation of mental health issues; and barriers and facilitators to accessing mental health services. Intersectional stigma restricted service access, hypermasculine socialisation encouraged self-reliant coping, and peer support and prior service use acted as facilitators, alongside a preference among some participants for private care.
Limitations noted during extraction	The sample was drawn from participants in a larger HIV prevention trial, which may mean the findings reflect a population already engaged to some degree with health services rather than a fully general population of Black, Asian and Latin American young adults.
Relevance to review objectives	Central to Theme Four (culture, identity and facilitators of access) and Theme One (stigma and self-reliance), and the main evidential basis for the intersectional analysis in Chapter Six.

Extraction Record 7: Sheldon, Ezaydi, Desoysa, Young, Simmonds-Buckley, Hind and Burton (2024)

Full reference	Sheldon, E., Ezaydi, N., Desoysa, L., Young, J., Simmonds-Buckley, M., Hind, D. and Burton, C. (2024). Barriers to help-seeking, accessing and providing mental health support for medical students: a mixed methods study using the candidacy framework. BMC Health Services Research, 24(1), 738.
Research aim	To explore experiences of barriers to accessing clinically effective, timely and appropriate mental health support for medical students, and the challenges to service delivery, using the candidacy framework.
Country and setting	England, University of Sheffield.
Study design	Mixed methods, combining an online survey with semi-structured interviews, structured around the candidacy framework.
Sample	103 medical students completed an online survey; a nested sample of 20 medical students and 10 healthcare professionals took part in semi-structured interviews.
Data collection method	Online survey using the CCAPS-34 measure and follow-up questions, alongside semi-structured interviews. A stakeholder panel of students and professionals also met to co-produce and interpret research materials.
Analysis method	Descriptive analysis of survey data; the qualitative interview data were analysed thematically, structured around candidacy.
Key findings relevant to this review	The intense time demands of medical training left many students unable to attend appointments during standard clinic hours, illustrating how ordinary features of student life interact with service design to restrict access regardless of clinical need.
Limitations noted during extraction	Only the qualitative strand of this study was carried into the thematic synthesis in Chapter Five, in keeping with the qualitative focus of the

	review; the quantitative survey findings were not synthesised. The single-institution setting limits generalisability to medical schools with different support structures.
Relevance to review objectives	Contributes to Theme Three (structural and system barriers), extending the candidacy based account first introduced by Osborn et al. (2024).

Extraction Record 8: Osborn, Town, Bawendi, Stapley, Saunders and Fonagy (2024)

Full reference	Osborn, T.G., Town, R., Bawendi, M., Stapley, E., Saunders, R. and Fonagy, P. (2024). University students' access to mental health services: a qualitative study of the experiences of health service professionals through the lens of candidacy in England. <i>Journal of Health Services Research & Policy</i> , 29(4), pp.230-239.
Research aim	To develop a better understanding of university students' access to mental health services by exploring the experiences of health care professionals who interact with students who have mental health problems.
Country and setting	North and East London, England.
Study design	Qualitative, using semi-structured interviews and reflexive thematic analysis informed by the principles of abductive analysis.
Sample	23 professionals working across university advice and counselling services, NHS general practice, crisis and psychological services, interviewed between June 2022 and January 2023.
Data collection method	Semi-structured interviews with professionals.
Analysis method	Reflexive thematic analysis, using the concept of candidacy to interpret the data.
Key findings relevant to this review	Access to support was described as highly dependent on a student's shifting personal circumstances, including course demands, financial pressure and how well the local health system happened to be organised at that particular time.
Limitations noted during extraction	This is the only study in the review that reports a professional rather than a young person's own account, which means the barrier is described at one step removed from the person actually experiencing it, a limitation discussed further in Chapter Six.
Relevance to review objectives	Central to Theme Three (structural and system barriers), and provides a professional perspective that complements the young-person accounts in the other seven studies.

Appendix 2: CASP Qualitative Appraisal Log (Full Justifications)

This appendix presents the full justification for each CASP rating summarised in Table 4.2. The ten questions are paraphrased from the CASP Qualitative Checklist and grouped under the domains used in Chapter Four: aims, methodology, design, recruitment, data collection, reflexivity, ethics, analysis, findings and value.

CASP Log: Appleton, Elahi, Tuomainen, Canaway and Singh (2021)

#	Question	Rating	Justification
1	Was there a clear statement of the research aims?	Yes	The paper clearly states its aim as exploring why young people fall through the gap between CAMHS and AMHS and the effect this has on them and their families.
2	Is a qualitative approach appropriate?	Yes	A qualitative narrative approach fits the exploratory, experience-based nature of the research question.
3	Was the research design appropriate?	Yes	Narrative interviews allow participants to describe the sequence and meaning of their transition experience in their own terms.
4	Was the recruitment strategy appropriate?	Yes	Participants were drawn from a known longitudinal cohort of young people who had reached the CAMHS boundary, giving a clear and traceable sampling frame.
5	Was data collection appropriate?	Yes	Interviews were conducted separately with young people and parents, offering two linked perspectives on the same transition event.
6	Has the researcher-participant relationship been considered?	Cannot tell	The published paper does not discuss the researchers' own position or possible influence on how participants presented their accounts.
7	Have ethical issues been considered?	Yes	The study sits within a larger ethically approved cohort study, and informed consent procedures are reported.
8	Was the data analysis sufficiently rigorous?	Yes	Themes were developed collaboratively by the research team using a recognised thematic analysis approach.
9	Is there a clear statement of findings?	Yes	Findings are presented as distinct themes, supported by illustrative material from participant accounts.
10	How valuable is the research?	Yes	The study identifies a specific, actionable service gap with direct relevance to policy and commissioning.

CASP Log: Appleton, Loew and Mughal (2022)

#	Question	Rating	Justification
1	Was there a clear statement of the research aims?	Yes	The aim of exploring experiences of, and barriers and facilitators to, primary care support after CAMHS is explicitly stated.
2	Is a qualitative approach appropriate?	Yes	Understanding perspectives and experiences of primary care support is well suited to narrative qualitative enquiry.
3	Was the research design appropriate?	Yes	Narrative interviews allow young people and parents to describe their experience of the transition gap in depth.
4	Was the recruitment strategy appropriate?	Yes	Participants were purposively recruited from a known population who had experienced poor continuity of care after CAMHS.
5	Was data collection appropriate?	Yes	Interviews with both young people and parents or carers were used, strengthening the depth of the dataset.

#	Question	Rating	Justification
6	Has the researcher-participant relationship been considered?	Cannot tell	Researcher positionality is not discussed in the published paper.
7	Have ethical issues been considered?	Yes	The paper reports ethical approval and informed consent procedures consistent with NIHR-funded research.
8	Was the data analysis sufficiently rigorous?	Yes	The study reports its methods according to the Standards for Reporting Qualitative Research.
9	Is there a clear statement of findings?	Yes	Findings are clearly organised around the role of primary care during the transition gap.
10	How valuable is the research?	Yes	The study has direct relevance to primary care commissioning and to service design during the CAMHS to AMHS transition.

CASP Log: Barnett, Arundell, Matthews, Saunders and Pilling (2021)

#	Question	Rating	Justification
1	Was there a clear statement of the research aims?	Yes	The paper states its aim as understanding how students experience accessing and using university mental health support.
2	Is a qualitative approach appropriate?	Yes	A qualitative design fits the aim of understanding process, barriers and facilitators from the student's own perspective.
3	Was the research design appropriate?	Yes	Semi-structured interviews, supported by a confirmatory focus group, allow both depth and a check on theme credibility.
4	Was the recruitment strategy appropriate?	Yes	Participants were recruited as students who had already used the university's mental health service, matching the study's aims.
5	Was data collection appropriate?	Yes	Individual interviews combined with a focus group provided a reasonably rich dataset for a single-institution study.
6	Has the researcher-participant relationship been considered?	Cannot tell	The paper does not discuss the researchers' own position in relation to the university service being studied.
7	Have ethical issues been considered?	Yes	The paper confirms that procedures were reviewed in line with relevant ethical standards.
8	Was the data analysis sufficiently rigorous?	Yes	A realist thematic approach is described, with themes kept close to participants' own accounts.
9	Is there a clear statement of findings?	Yes	Five clearly labelled themes are reported with supporting detail.
10	How valuable is the research?	Yes	The study gives specific and practical insight into service design at a single UK university, of direct relevance to this review.

CASP Log: Priestley, Broglia, Hughes and Spanner (2022)

#	Question	Rating	Justification
1	Was there a clear statement of the research aims?	Yes	The paper states its aim as eliciting student perspectives and proposals on improving university mental health support.
2	Is a qualitative approach appropriate?	Yes	Thematic analysis of consultation panel discussions fits the aim of drawing out student-generated ideas.
3	Was the research design appropriate?	Yes	Co-creation panels are an appropriate design for generating collective student recommendations, though they differ from individual interviews.
4	Was the recruitment strategy appropriate?	Cannot tell	The paper gives limited detail on how panel members were selected, so the representativeness of the sample cannot be fully judged.
5	Was data collection appropriate?	Yes	Facilitated panel discussion is a reasonable method for the stated aim of generating shared recommendations.
6	Has the researcher-participant relationship been considered?	Cannot tell	The paper does not discuss the facilitators' own position or influence on the panel process.
7	Have ethical issues been considered?	Cannot tell	The published paper gives limited explicit discussion of ethical procedures for the consultation process.
8	Was the data analysis sufficiently rigorous?	Yes	Thematic analysis of panel data is described and the resulting themes are clearly linked to recommendations.
9	Is there a clear statement of findings?	Yes	Findings are presented as a structured set of challenges and recommendations.
10	How valuable is the research?	Yes	The direct focus on student-generated solutions makes this study particularly valuable for the facilitators strand of this review.

CASP Log: Rich, Viney, Silkens, Griffin and Medisauskaite (2024)

#	Question	Rating	Justification
1	Was there a clear statement of the research aims?	Yes	The aim of understanding the impact of mental health difficulties on medical students' experience and training is explicitly stated.
2	Is a qualitative approach appropriate?	Yes	In-depth interviews are well suited to exploring the lived experience of mental ill health within medical training.
3	Was the research design appropriate?	Yes	Semi-structured interviews across eight medical schools allow comparison while retaining depth.
4	Was the recruitment strategy appropriate?	Yes	Purposive sampling was used to achieve variety in the type of difficulty experienced and in demographic characteristics.
5	Was data collection appropriate?	Yes	In-depth interviews, supported by NVivo-assisted coding, provided a detailed dataset.

#	Question	Rating	Justification
6	Has the researcher-participant relationship been considered?	Yes	The authors explicitly discuss their use of reflexive thematic analysis and their own clinical and educational backgrounds.
7	Have ethical issues been considered?	Yes	The study reports ethical approval and describes safeguards for a sensitive participant group.
8	Was the data analysis sufficiently rigorous?	Yes	Reflexive thematic analysis is described in detail, with a transparent account of theme development.
9	Is there a clear statement of findings?	Yes	Three themes are clearly presented with supporting detail from interviews.
10	How valuable is the research?	Yes	The study has direct value for understanding how professional culture shapes stigma and help seeking, a central theme of this review.

CASP Log: Ghobrial, Samba, Burns, Nicholls, Weatherburn, Lampe, Chu, Rodger and Witzel (2025)

#	Question	Rating	Justification
1	Was there a clear statement of the research aims?	Yes	The aim of exploring how sexuality and ethnicity intersect in shaping mental health experience and access is explicitly stated.
2	Is a qualitative approach appropriate?	Yes	Semi-structured interviews are appropriate for exploring intersectional and culturally specific experience.
3	Was the research design appropriate?	Yes	Thematic framework analysis is well matched to a study seeking to compare experience across three distinct ethnic groups.
4	Was the recruitment strategy appropriate?	Yes	Purposive sampling from within a larger trial was used specifically to ensure diversity across Black, Asian and Latin American participants.
5	Was data collection appropriate?	Yes	Semi-structured interviews with a dedicated mental health section provided focused and relevant data.
6	Has the researcher-participant relationship been considered?	Cannot tell	The paper does not discuss in detail how the research team's own background may have shaped the interview process.
7	Have ethical issues been considered?	Yes	The study operated within the ethical approval of the wider SELPHI trial and reports appropriate consent procedures.
8	Was the data analysis sufficiently rigorous?	Yes	Thematic framework analysis is clearly described, with data organised into three meta-themes.
9	Is there a clear statement of findings?	Yes	Findings are presented in a structured way, moving from background and culture through to specific barriers and facilitators.
10	How valuable is the research?	Yes	This is the only study in the review to address intersectional ethnic and sexual minority experience in depth, giving it particular value.

CASP Log: Sheldon, Ezaydi, Desoysa, Young, Simmonds-Buckley, Hind and Burton (2024)

#	Question	Rating	Justification
1	Was there a clear statement of the research aims?	Yes	The aim of exploring barriers to help seeking, access and provision for medical students using the candidacy framework is clearly stated.
2	Is a qualitative approach appropriate?	Yes	The qualitative interview strand is appropriate for exploring the reasons behind patterns identified in the survey.
3	Was the research design appropriate?	Yes	A mixed methods design combining survey and interview data is well suited to capturing both scale and explanation of unmet need.
4	Was the recruitment strategy appropriate?	Yes	A nested sample of students and professionals was recruited from the same institution as the survey, supporting integration of findings.
5	Was data collection appropriate?	Yes	Semi-structured interviews, alongside a stakeholder panel that helped shape the research materials, supported rich data collection.
6	Has the researcher-participant relationship been considered?	Cannot tell	The paper does not give a detailed account of the research team's own position in relation to participants.
7	Have ethical issues been considered?	Yes	The study reports institutional ethical approval consistent with health services research standards.
8	Was the data analysis sufficiently rigorous?	Yes	The candidacy framework is used consistently to structure the qualitative analysis.
9	Is there a clear statement of findings?	Yes	Findings are presented in relation to specific stages of the candidacy framework.
10	How valuable is the research?	Yes	The mixed methods design adds practical value by linking the scale of unmet need to specific explanatory barriers.

CASP Log: Osborn, Town, Bawendi, Stapley, Saunders and Fonagy (2024)

#	Question	Rating	Justification
1	Was there a clear statement of the research aims?	Yes	The aim of understanding professionals' experiences of student access to mental health services is explicitly stated.
2	Is a qualitative approach appropriate?	Yes	Semi-structured interviews are appropriate for exploring professionals' interpretive accounts of a complex process.
3	Was the research design appropriate?	Yes	Reflexive thematic analysis informed by abductive reasoning is well suited to developing the candidacy-based interpretation used in the paper.

#	Question	Rating	Justification
4	Was the recruitment strategy appropriate?	Yes	Professionals were recruited across a defined range of services in North and East London relevant to student mental health access.
5	Was data collection appropriate?	Yes	Semi-structured interviews over an extended recruitment period, from June 2022 to January 2023, gave the study a substantial dataset.
6	Has the researcher-participant relationship been considered?	Cannot tell	Researcher positionality in relation to the professional participants is not discussed in detail.
7	Have ethical issues been considered?	Yes	The study reports ethical approval appropriate to research involving professional rather than patient participants.
8	Was the data analysis sufficiently rigorous?	Yes	The use of abductive analysis alongside reflexive thematic analysis is described with reasonable transparency.
9	Is there a clear statement of findings?	Yes	Findings are structured around the concept of candidacy and clearly linked to supporting data.
10	How valuable is the research?	Yes	The professional perspective adds a distinct and complementary layer of value to the young-person-centred studies in this review.

Appendix 3: MMAT Appraisal - Sheldon, Ezaydi, Desoysa, Young, Simmonds-Buckley, Hind and Burton (2024)

The Mixed Methods Appraisal Tool (MMAT) was applied to this study in addition to the CASP log in Appendix 2, since MMAT includes questions specific to the quantitative and integrated components of a mixed methods design that CASP does not cover. The screening questions and the mixed methods specific questions are presented below, with the qualitative-specific MMAT questions omitted since these substantially overlap with the CASP domains already reported in Appendix 2.

Domain	Question	Rating	Justification
Screening	Are there clear research questions?	Yes	Separate questions are posed for the survey and interview strands, both linked to the shared aim of understanding barriers within the candidacy framework.
Screening	Do the collected data allow the research questions to be addressed?	Yes	The survey provides descriptive data on the scale of unmet need, while the interviews provide explanatory depth, together addressing the stated aims.
Quantitative strand	Is the sampling strategy relevant to address the research question?	Yes	Surveying all medical students at the institution gave a reasonably comprehensive picture of self-reported unmet need within that setting.
Quantitative strand	Is the sample representative of the target population?	Cannot tell	The response rate and representativeness of the 103

Domain	Question	Rating	Justification
			respondents relative to the full student population is not detailed in the available summary.
Mixed methods integration	Is there an adequate rationale for using a mixed methods design?	Yes	The authors explain that quantitative data on scale and qualitative data on explanation were both needed to address the research aim fully.
Mixed methods integration	Are the different components effectively integrated to answer the research question?	Yes	Quantitative findings on the scale of unmet need are used alongside qualitative findings on the reasons behind it, consistent with a convergent mixed methods design.
Mixed methods integration	Are the outputs of the integration adequately interpreted?	Yes	The candidacy framework is used consistently to interpret both strands together rather than reporting them as two separate studies.
Mixed methods integration	Are divergences between quantitative and qualitative results adequately addressed?	Cannot tell	The available summary does not describe in detail whether any tension between survey and interview findings was identified or resolved.

Note: Only the qualitative strand of this study, appraised in full in Appendix 2, was carried forward into the thematic synthesis reported in Chapter Five. The MMAT appraisal above is provided for completeness and transparency regarding the whole study.

Appendix 4: PRISMA 2020 Flow Diagram

The flow diagram below summarises the stages of identification, screening, eligibility assessment and inclusion described in Chapter Three, ending in the eight studies that form the basis of Chapters Four and Five. The figures for the identification and screening stages are presented here as an illustrative structure only, since they depend on the exact database searches, date of search and screening decisions carried out by the researcher, and should be replaced with the researcher's own recorded figures once the full five-database search described in section 3.3 has been run and documented. The final total of eight included studies is consistent with the studies appraised in Appendices 1 to 3.

Stage	Description	n (to be completed by researcher)
Identification	Records identified through database searching (PubMed, PsycINFO, CINAHL, MEDLINE, Scopus)	[insert n]
Identification	Additional records identified through reference list (pearl-growing) searching	[insert n]
Screening	Records after duplicates removed (Rayyan)	[insert n]
Screening	Records screened by title and abstract	[insert n]
Screening	Records excluded at title and abstract stage	[insert n]

Stage	Description	n (to be completed by researcher)
Eligibility	Full-text articles assessed for eligibility	[insert n]
Eligibility	Full-text articles excluded, with reasons (e.g. wrong population, wrong setting, wrong publication type, quantitative only)	[insert n, with reasons recorded in the exclusion log]
Included	Studies included in qualitative synthesis	8

Source: Structure adapted from Page et al. (2021), PRISMA 2020 statement. Figures in the identification and screening rows are placeholders and must be replaced with the researcher's actual recorded search and screening results before submission.

Appendix 5: CASP Qualitative Checklist - Questions Used for Appraisal

The following ten questions, paraphrased from the Critical Appraisal Skills Programme (CASP) Qualitative Checklist, were used to structure the appraisal reported in Table 4.2 and in the full justification log in Appendix 2. Each question was rated as yes, no or cannot tell for every included study.

1. Was there a clear statement of the aims of the research?
2. Is a qualitative methodology appropriate for addressing those aims?
3. Was the research design appropriate to address the aims of the research?
4. Was the recruitment strategy appropriate to the aims of the research?
5. Was the data collected in a way that addressed the research issue?
6. Has the relationship between the researcher and participants been adequately considered?
7. Have ethical issues been taken into consideration?
8. Was the data analysis sufficiently rigorous?
9. Is there a clear statement of findings?
10. How valuable is the research, and what does it add to the existing body of knowledge?

Source: Paraphrased from the Critical Appraisal Skills Programme (CASP) Qualitative Checklist, as referenced throughout Chapter Four.

Appendix 6: Illustrative Database Search Strategy

The table below translates the core search string reported in section 3.3 into example syntax for each of the five databases named in the search strategy. These are provided as a working template. Before submission, the researcher should run each search, record the exact date of search, and insert the actual number of results returned by each database in the final column.

Database	Example search syntax	Date run	Results (n)
PubMed	("young adult"[tiab] OR "youth"[tiab] OR "emerging adult"[tiab] OR "adolescent"[MeSH] OR "student"[tiab]) AND ("mental health service"[tiab] OR "psychological therap*[tiab] OR "counselling"[tiab] OR "help-seeking"[tiab] OR "mental health care"[tiab]) AND ("barrier"[tiab] OR	[insert date]	[insert n]

Database	Example search syntax	Date run	Results (n)
	"access"[tiab] OR "stigma"[tiab] OR "attitude*"[tiab] OR "facilitator*"[tiab] OR "qualitative"[tiab])		
PsycINFO (via Ovid)	(young adult* OR youth OR emerging adult* OR adolescen* OR student*).mp. AND (mental health service* OR psychological therap* OR counselling OR help-seeking OR mental health care).mp. AND (barrier* OR access OR stigma OR attitude* OR facilitator* OR qualitative).mp.	[insert date]	[insert n]
CINAHL (via EBSCO)	(MH "Young Adult") OR TI (young adult* OR youth OR emerging adult* OR adolescen* OR student*) AND TI (mental health service* OR psychological therap* OR counselling OR help-seeking OR mental health care) AND TI (barrier* OR access OR stigma OR attitude* OR facilitator* OR qualitative)	[insert date]	[insert n]
MEDLINE (via Ovid)	exp Young Adult/ OR (young adult* OR youth OR emerging adult* OR adolescen* OR student*).mp. AND (mental health service* OR psychological therap* OR counselling OR help-seeking OR mental health care).mp. AND (barrier* OR access OR stigma OR attitude* OR facilitator* OR qualitative).mp.	[insert date]	[insert n]
Scopus	TITLE-ABS-KEY (("young adult*" OR "youth" OR "emerging adult*" OR "adolescen*" OR "student*") AND ("mental health service*" OR "psychological therap*" OR "counselling" OR "help-seeking" OR "mental health care") AND ("barrier*" OR "access" OR "stigma" OR "attitude*" OR "facilitator*" OR "qualitative"))	[insert date]	[insert n]

Note: Syntax is adapted per database from the core search string reported in section 3.3 of Chapter Three, following standard conventions for each platform (MeSH terms for PubMed and MEDLINE, thesaurus terms for PsycINFO, subject headings for CINAHL, and field codes for Scopus). Search limits for publication date (January 2015 to present) and English language should be applied consistently across all five databases and recorded alongside the results