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BARRIERS AND FACILITATORS TO ACCESSING PSYCHOTHERAPY AMONG ADOLESCENTS IN PUBLIC HEALTH SYSTEMS: A SYSTEMATICALLY INFORMED NARRATIVE REVIEW

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ABSTRACT

Background: Access to psychotherapy among adolescents in public health systems remains a significant challenge despite the growing burden of youth mental health disorders. Individual, family, service, and system-level factors influence whether adolescents initiate and sustain engagement with treatment.
Objectives: To synthesize evidence on barriers and facilitators to accessing psychotherapy among adolescents within publicly funded or subsidized health systems and to identify multilevel determinants relevant to equitable service delivery.
Methods: A systematically informed narrative review was conducted following PRISMA 2020 conventions. PubMed, Scopus, and the Cochrane Library were searched for studies published between 2015 and December 2025 on psychotherapy access among children and adolescents within public health systems. Qualitative, quantitative, and mixed-methods studies reporting barriers or facilitators to access or engagement were included and synthesized narratively using a four-level individual, family, service, and system framework.
Results: Twenty studies met the inclusion criteria. Structural barriers, including long waiting times, limited specialist availability, geographic distance, and fragmented service coordination, were the most consistently reported obstacles. Stigma and cultural or linguistic mismatch further hindered engagement, particularly among migrant and minority populations, while limited mental health literacy and parental non-acceptance were key family-related barriers. Key facilitators included strong therapeutic relationships, active family support, school-based delivery, telehealth, and culturally adapted care models.
Conclusions: Access to adolescent psychotherapy is shaped by interacting multilevel determinants. Reducing inequities requires coordinated strategies addressing structural barriers and psychosocial factors. Future research should adopt standardized definitions of access and prioritize underserved populations and low-resource settings.

KEYWORDS

Adolescent Mental Health; Psychotherapy Access; Barriers to Care; Facilitators of Care; Public Health Systems; Mental Health Services

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1. Introduction

Mental well-being in adolescence has emerged as a public health priority [1]. Globally, one in seven adolescents, between ages 10 and 19, has a mental disorder. Disorders like depression, anxiety, and behavioral disorders are significant contributors to ill health and disability among adolescents [2]. Mental health problems developing during adolescent years may have adverse consequences on academic performance, social interactions, physiological well-being, and future prospects in adulthood [1]. Early identification and treatment, therefore, have great significance, not only from a personal standpoint but also from a public health perspective [3]. While there are effective psychological interventions available for adolescents, availability of these interventions does not necessarily imply accessibility of therapy [4]. Accessing psychotherapy must be considered a process involving several steps and not just being referred to or having access to therapy [5]. It is particularly relevant for adolescent psychotherapy, which depends on many other things that influence the process of getting therapy. Such factors can involve adolescent development, parental involvement, confidentiality concerns, stigma, and professional trust issues [6, 7]. Studies have revealed both internal and external barriers preventing youth from seeking professional assistance regarding their mental well-being [6]. For instance, previous literature reviews have identified several barriers among young individuals such as stigma, shame, inadequate knowledge of mental illnesses, desire to solve problems on their own, as well as concerns related to confidentiality [8]. The role of parents and guardians cannot be ignored in regard to the access to mental health services in the case of children and teenagers [9]. Parents' attitudes towards psychotherapy, their family-related factors, and perception of mental health services could contribute to a teenager receiving professional assistance or not. Thus, access to psychotherapy is affected not by one particular barrier but multiple barriers that interact. [9, 10]. Health systems supported by government funding become particularly relevant in this context since they are meant to ensure equal opportunities for treatment regardless of any patient's socioeconomic status [11]. Yet despite efforts to minimize the negative impact of socioeconomic disparities, access to healthcare may still be limited due to long waitlists, shortages of specialists, inadequate referrals, long distances from facilities, and culturally inappropriate care [5, 12, 13, 14]. These factors might have an even more powerful effect on adolescents from marginalized groups such as ethnic minorities, migrants, rural residents, or members of disadvantaged social groups [15]. Moreover, access to psychological help is not merely about attending one visit. In addition to regular therapy sessions, adolescents might find themselves motivated to receive assistance depending on their interactions with the psychologist, family involvement, cultural compatibility, and convenience of care delivery. [16, 17]. Despite an increase in research in relation to help-seeking among youth with psychological concerns, empirical evidence pertaining specifically to the accessibility of psychological therapy among adolescents within publicly funded or supported services remains fragmented [18]. The definitions used for measuring access vary in the literature, where some concentrate on aspects of referral while others concentrate on initiation of therapy, attendance, engagement, or completion of therapy [19]. Additionally, these studies also vary in terms of the perspective taken, whether from the adolescent themselves, their caregivers, clinicians, or even the health service systems [20]. As a result of such diversity, generalizability and comparison becomes challenging [8]. The current systematic narrative review is an attempt to fill this research gap by synthesizing the current literature on barriers and facilitators of access to psychotherapy for adolescents in health care settings that are either funded or subsidized by the government. Through the inclusion of both qualitative and quantitative research as well as mixed-method research, the current review hopes to highlight the main determinants affecting access to psychotherapy. The review also aims to promote equitable youth-centered mental health programs and mental health policies.

2. Methodology

2.1. Study Design

This study was designed as a systematically informed narrative review. The approach combined a structured, reproducible search strategy with narrative synthesis, which was considered most appropriate given the heterogeneity of the included literature, spanning qualitative, quantitative, and mixed-methods studies across diverse healthcare settings. To enhance methodological transparency, predefined eligibility criteria, duplicate screening, and structured data extraction were applied throughout the review process. However, the review was not prospectively registered and was not intended to meet all criteria of a formal systematic review. The narrative framework was therefore chosen to allow for contextually sensitive interpretation of findings, with direct relevance to clinical practice and public health policy.

2.2. Conceptual Scope of the Review

For the purposes of this review, access to psychotherapy was understood as a multidimensional construct encompassing the initiation, engagement, and continuation of psychological treatment, rather than referral alone. The term psychotherapy was applied broadly to include structured, evidence-informed psychological interventions delivered by trained professionals, regardless of modality.

Adolescence was defined as the period spanning 10 to 18 years of age, in line with the WHO definition and the eligibility criteria applied in this review. A small number of included studies extended recruitment to young people up to the age of 21, reflecting local service boundaries or national definitions of youth mental health care; this variation was noted during data extraction but did not alter the analytical scope of the review.

Public health systems were understood to include publicly funded or publicly subsidised mental health services, NHS-based care pathways, Medicaid programmes, and equivalent national health structures, as well as school-based and community-based services operating within such frameworks.

2.3. Eligibility criteria

Eligibility criteria were defined a priori to ensure consistency across the screening process. Studies were considered eligible for inclusion if they focused on children and adolescents aged 18 years or younger, or on samples in which the majority of participants were under the age of 18, recognising that several studies extended eligibility to young people up to the age of 21 in line with national service definitions or local institutional practice.

Eligible studies were required to examine access to psychotherapy within publicly funded or publicly subsidised health systems, including NHS-based care pathways, Medicaid programmes, community mental health services, school-based programmes, and equivalent national structures; studies conducted in mixed public-private contexts were considered eligible provided the public system component was substantially represented.

Eligible outcomes included barriers to access or engagement, facilitators of access or engagement, service utilization, and waiting times. Studies were eligible regardless of whether adolescents, caregivers, or mental health professionals served as the primary study population, as clinician and stakeholder perspectives were considered informative proxies for access-related experiences.

Given the nature of the research question, qualitative, observational, mixed-methods, and secondary analyses of experimental studies were considered eligible, provided that barriers or facilitators to access constituted a primary or substantive secondary aim.

Studies were excluded if they took the form of narrative or systematic reviews, commentaries, or editorials, or if they were conducted exclusively within private healthcare settings without any public system component. No language or geographic restrictions were applied during the initial screening phase; however, studies not available in English or Polish were subsequently excluded on practical grounds.

2.4. Information Sources and Search Strategy

A systematic literature search was conducted across three electronic databases: PubMed, Scopus, and the Cochrane Library. The search covered studies published between 2015 and 2025, with the final search executed on 7 December 2025.

Database-specific search strategies were applied to maximise sensitivity and account for differences in indexing architecture. In PubMed, Medical Subject Headings (MeSH) were combined with free-text terms searched in titles and abstracts. In Scopus, searches were performed using TITLE-ABS-KEY fields, given the absence of a controlled vocabulary equivalent to MeSH. In the Cochrane Library, exploded MeSH descriptors were combined with keyword-based title, abstract, and keyword searches. Search strategies integrated terms across four conceptual domains: pediatric and adolescent populations, psychotherapy, healthcare access, and

barriers or facilitators to care. Complete search strings for each database are available from the corresponding author upon request.

The initial search yielded 476 records in total, comprising 181 records from PubMed, 167 from Scopus, and 128 from the Cochrane Library. Following deduplication, 113 duplicate records were identified and removed, leaving 363 unique studies for title and abstract screening. Of these, 252 were excluded at the abstract screening stage for failure to meet the predefined eligibility criteria. The remaining 111 records underwent full-text evaluation, of which a further 91 were excluded, yielding a final corpus of 20 studies for inclusion in the review. The study selection process is illustrated in Figure 1 following the PRISMA flow diagram convention.

2.5. Study selection

Title and abstract screening, followed by full-text evaluation of potentially eligible records, was carried out by two independent reviewers (Z.W. and D.G.) using the Rayyan web-based platform, which facilitated blinded and parallel assessment. The predefined eligibility criteria outlined in Section 2.3 were applied as the primary framework for decision-making at both screening stages, with a degree of contextual judgement exercised in borderline cases — particularly with respect to upper age boundaries, studies in which mental health professionals or other stakeholders constituted the primary study population, and studies conducted in mixed public–private or research-funded settings where a substantive public system component was nonetheless identifiable. Where disagreement arose between the two reviewers, consensus was sought through discussion; cases that could not be resolved bilaterally were referred to a third reviewer (M.Ś.) for adjudication.

2.6. Data extraction

Data were extracted using a structured standardised form developed a priori. For each included study, the following variables were recorded: bibliographic and contextual data (author, year, country, health system context, and data collection period), population characteristics (sample size, age range, and clinical or demographic profile), methodological features (study design, psychotherapy modality, and delivery setting), and primary outcomes of interest, comprising barriers and facilitators to psychotherapy access or engagement categorised across four levels: individual, family, service, and system. Outcomes related to service utilisation, treatment engagement, and waiting times were extracted where reported.

Each study was additionally summarised through a synthetic key findings statement to facilitate narrative integration. Quality-related data, including the appraisal tool applied, reviewer-assessed risk of bias, statistical adjustments, and author-reported limitations, were recorded alongside supplementary reviewer notes. In studies where clinicians or other stakeholders served as the primary study population, extracted data were attributed accordingly, with the proxy nature of the perspective noted in the reviewer comments field.

2.7. Data synthesis

The synthesis of results was conducted using a structured narrative approach, reflecting the substantial heterogeneity of the included studies with respect to design, population characteristics, health system contexts, and outcome reporting formats. Quantitative meta-analysis was not considered appropriate given the diversity of study methodologies and the predominantly qualitative nature of the included evidence base.

Findings were organised thematically according to the four-level barrier and facilitator framework applied during data extraction: individual, family, service, and system. Within each level, patterns were identified across studies and interpreted in the context of differences in study design, participant perspective, and clinical or cultural setting. Qualitative and quantitative findings were synthesised separately to preserve conceptual clarity, with qualitative evidence forming the primary analytical layer and quantitative data used to contextualise or corroborate identified themes where available.

The synthesis prioritised consistency and transparency of interpretation, with particular attention paid to differences in reporting practices and the proxy nature of clinician-derived data in a subset of included studies. Visual representations, including summary tables, were used to support interpretation and to illustrate key patterns across the evidence base.

2.8. Quality Assessment

Formal risk of bias assessment using a standardised appraisal instrument was not conducted as a prerequisite for inclusion or exclusion of individual studies. This decision was consistent with the narrative synthesis design of the review and with the heterogeneity of included study designs, which precluded the application of a single appraisal framework across all evidence types. Nonetheless, methodological quality was considered throughout the synthesis process: quality-related information, including author-reported limitations, study design characteristics, and reviewer-assessed concerns regarding bias, was recorded during data extraction and informed the interpretation of findings. A descriptive overview of the methodological strengths and limitations of included studies is presented in Section 3.5.

3. Results

3.1. Study selection

The initial search yielded 476 records (181 from PubMed, 128 from the Cochrane Library, and 167 from Scopus). Following the removal of duplicates, 363 studies remained for screening. Based on abstract analysis 252 articles were rejected for not satisfying the inclusion criteria. A rigorous full-text evaluation of remaining 111 studies resulted in the exclusion of a further 91 reports, leaving a final total of 20 studies for inclusion in this systematic review.

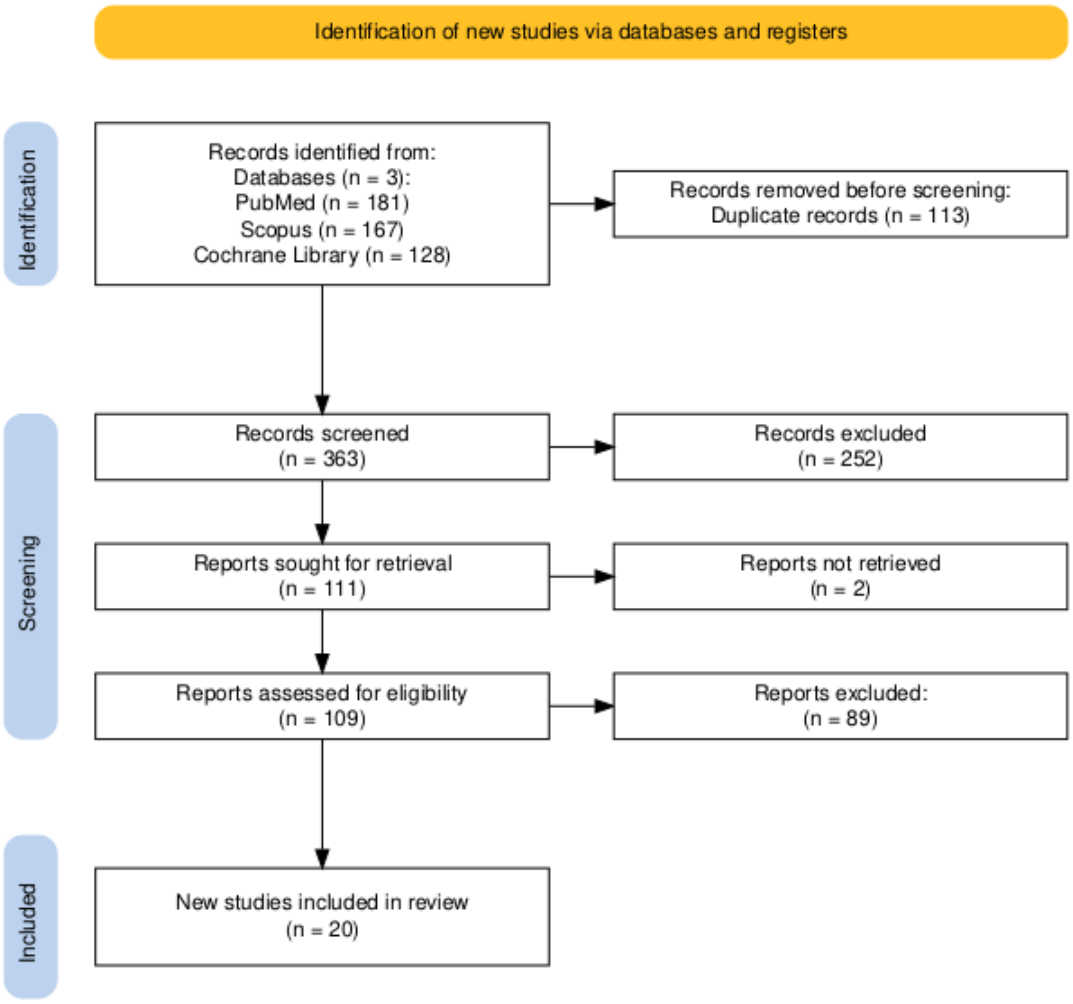

Fig. 1. *Study selection flow diagram [21].*

3.2. Study Characteristics

The 20 included studies were published between 2016 and 2025 and were conducted across multiple countries. The United States contributed the largest number of studies (n = 9), followed by the United Kingdom (n = 3) and Germany (n = 3). Individual studies were conducted in Greece, France, Jordan, and South Africa [Tsamadou et al.; Carretier et al.; Dardas et al.; van de Water et al.], and one multinational study recruited clinician participants across six countries, namely Australia, Canada, New Zealand, Singapore, the United Kingdom, and the United States [Sauerwein et al.]. Data collection periods spanned from 2012 to 2024.

Study designs were heterogeneous across the included evidence base. Qualitative studies constituted the largest methodological group (n = 11), employing semi-structured interviews analysed through thematic or content analysis, interpretive phenomenological analysis, or grounded theory-informed frameworks [Tsamadou et al.; Stafford and Draucker; Kitchen et al.; Schapiro et al.; Isiwele et al.; Carretier et al.; Keiller et al.; Dietlinger et al.; van de Water et al.; Delgado et al.; Sauerwein et al.]. Mixed-methods studies (n = 3) integrated qualitative interview data with quantitative survey or observational components [Sibley et al.; Wecht et al.; Namer et al.]. The remaining six studies adopted quantitative designs: a retrospective cohort study based

on administrative claims data [Upadhyay et al.], a cross-sectional nationally representative school-based survey [Dardas et al.], a cross-sectional observational study using standardized psychometric instruments [Simon et al.], a randomized controlled trial incorporating a secondary analysis of participation barriers [Salloum et al.], an observational service-evaluation survey with closed chart review [Villalobos et al.], and a pre-post pilot study without a control group [Szota et al.].

Participant populations were diverse. Eleven studies recruited adolescents directly, with age ranges predominantly spanning 11 to 18 years, though several studies extended eligibility to young people up to the age of 21 years. The majority of studies additionally recruited caregivers, mental health professionals, or other key stakeholders either as a co-participant group alongside adolescents or as the primary study population [Salloum et al.; Sibley et al.; Kitchen et al.; Wecht et al.; Simon et al.; Schapiro et al.; Isiwele et al.; Carretier et al.; Namer et al.; Sauerwein et al.; Keiller et al.; van de Water et al.; Dietlinger et al.; Delgado et al.]. Clinical populations included adolescents with anxiety disorders, attention-deficit/hyperactivity disorder, major depressive disorder, post-traumatic stress disorder, eating disorders, and mixed or unspecified psychiatric diagnoses. Several studies focused specifically on marginalized or underserved populations, including Latina adolescents with depressive symptoms [Stafford and Draucker], Ghanaian and Nigerian youth attending NHS services in London [Isiwele et al.], Central American unaccompanied immigrant youth [Schapiro et al.], asylum-seeking and refugee adolescents in Germany [Namer et al.; Dietlinger et al.], and migrant families receiving transcultural psychotherapy in France [Carretier et al.].

Health system contexts varied considerably across studies. The majority were situated within publicly funded outpatient mental health services, NHS-based care pathways, Medicaid managed care programmes, tertiary referral centres, or school-based service settings. One study was conducted within a university clinic in which treatment was provided free of charge as part of two randomized controlled trials [Sibley et al.]. One additional study delivered treatment at no cost to participants within community-based outpatient clinics operating under a research-funded programme [Salloum et al.]. Psychotherapy modalities reported across studies included cognitive behavioural therapy and its trauma-focused and school-based variants, behavioural activation, family-based treatment, prolonged exposure therapy, dramatherapy, transcultural group psychotherapy, and motivational interviewing combined with behavioural contracting. Several studies did not specify a single manualized therapeutic modality.

3.3. Results - Qualitative Studies

Table 2 presents the characteristics and key findings of the 11 qualitative studies included in the synthesis.

Reference	Year	Country	Population & Sample	Setting & Therapy	Barriers	Facilitators	Key Findings
Tsamadou et al. [22]	2021	Greece	**N** = 50 adolescents Mixed psychiatric diagnoses (depression, OCD, dysthymia, behavioural disorders)	**Setting:** Tertiary outpatient psychiatric clinic **Therapy:** Mixed/unspecified psychotherapy	**Individual:** Negative therapeutic relationship; perceived ineffectiveness; early symptom remission; stigma **Family:** Non-acceptance of the problem; lack of support **Service:** Poor therapist relationship; boundary violations; paternalism	Trusting, warm, non-paternalistic therapeutic relationship Shared decision-making Confidentiality guarantee Active family support	Adolescent–therapist relationship was the most critical determinant of engagement. Early symptom remission identified as an underappreciated barrier to treatment continuation.

Reference	Year	Country	Population & Sample	Setting & Therapy	Barriers	Facilitators	Key Findings
Stafford & Draucker [23]	2019	United States	**N** = 25 Latina young women Self-reported history of depressive symptoms during adolescence	**Setting:** Primary care and community **Therapy:** Psychotherapy and/or antidepressant medication	**Individual:** Cultural beliefs framing depression as weakness; self-stigma; distrust of providers **Family:** Family dismissal; fear of judgment; punishment for help-seeking **Service:** Confidentiality concerns; mandatory parental disclosure perceived as betrayal	Meaningful, trusting therapist connection Warmth; non-judgmental stance Parental support (especially when caregiver had personal mental health experience)	Latina adolescents experienced more barriers than facilitators. Culturally specific beliefs and family-level stigma were the most prominent barriers to help-seeking.
Kitchen et al. [24]	2023	United Kingdom	**N** = 16 6 young people, 5 parents, 5 therapists — UK RCT of behavioural activation for adolescent depression	**Setting:** NHS-affiliated community **Therapy:** Behavioural Activation (BA)	**Individual:** Low motivation; ambivalence; co-occurring ASD and anxiety **Family:** Divergent expectations; limited parental knowledge; uneven involvement **Service:** Limited sessions; insufficient flexibility to extend treatment	Regular weekly sessions supporting continuity Strong therapeutic alliance Parental involvement aligned with young person's goals	Effective BA delivery depends on maintaining motivation and aligning parental expectations with therapeutic goals.
Schapiro et al. [25]	2024	United States	**N** = 26 10 stakeholders, 16 youth — Central American unaccompanied immigrant youth	**Setting:** School-based group **Therapy:** CBITS	**Individual:** Silence around trauma; fear of disclosure; denial/minimization **Family:** Limited caregiver support; living with non-parental relatives **Service:** Curriculum not fully culturally adapted; language barriers including indigenous languages	School-based format increasing accessibility Group format providing peer support Safe and familiar environment	CBITS was helpful via coping skills and peer support, but acceptability was limited by cultural/linguistic mismatch and disclosure fears.

Reference	Year	Country	Population & Sample	Setting & Therapy	Barriers	Facilitators	Key Findings
Isiwele et al. [26]	2025	United Kingdom	**N** = 12 5 Ghanaian/Nigerian youth, 2 parents, 5 NHS mental health practitioners — London	**Setting:** NHS community/outpatient **Therapy:** Primarily standardized CBT-based approaches	**Individual:** Feeling misunderstood; difficulty relating to therapy models; reduced trust **Family:** Stigma; limited understanding of NHS system **System:** Structural inequalities; rigid standardized care models; lack of cultural competence	Cultural humility in clinicians Adaptation of therapeutic models to cultural identity Improved service inclusivity	Standardized NHS models (e.g., CBT) were often culturally misaligned with Ghanaian and Nigerian youth, leading to disengagement and suboptimal access.
Carretier et al. [27]	2020	France	**N** = 44 migrant adolescents Receiving transcultural group psychotherapy	**Setting:** Specialist transcultural outpatient service **Therapy:** Transcultural group psychotherapy	**Individual:** Cultural mismatch with standard care; language barriers **Family:** Competing demands; limited parental engagement with services	Integration of cultural narratives into therapy Active family participation Bilingual therapists Culturally adapted therapeutic model	A specialized transcultural group psychotherapy model integrating cultural narratives improved both engagement and perceived effectiveness among migrant adolescents.
Sauerwein et al. [28]	2025	Multinational (AU, CA, NZ, SG, UK, US)	**N** = 41 FBT clinicians Formal training in Lock and Le Grange model; treating adolescents with eating disorders	**Setting:** Community, private practice, and tertiary/specialist **Therapy:** Family-Based Treatment (FBT)	**Individual:** Lack of FBT awareness; misconception of not fitting 'typical' eating disorder stereotype **Family:** Competing demands; employment obligations; financial constraints **System:** Racism; classism; immigration/legal status; shortage of trained FBT clinicians in rural areas	Telehealth delivery Sliding scale fees Flexible scheduling Community collaboration and resource navigation	Social determinants restrict access to FBT. Equitable delivery requires flexible, culturally responsive, and structurally sensitive adaptations.

Reference	Year	Country	Population & Sample	Setting & Therapy	Barriers	Facilitators	Key Findings
Keiller et al. [29]	2024	United Kingdom	**N** = 12 school-based dramatherapists Working with young people aged 8–18 years in UK schools	**Setting:** School-based (primary, secondary, sixth form) **Therapy:** Dramatherapy	**Service:** Unsuitable physical spaces; pressure to demonstrate clinical efficacy; waiting times; inadequate remuneration **System:** Funding insecurity; number of sessions determined by available funding rather than clinical need	School as safe and accessible space Integration into school daily timetable Collaboration with school-based professionals Broader organizational support	School-based dramatherapy was perceived as useful and safe, but limited by funding insecurity, unsuitable physical environments, and organizational constraints.
Delgado et al. [30]	2024	United States	**N** = 49 15 autistic youth with co-occurring anxiety, 15 caregivers, 11 CMH clinicians, 8 CMH clinic leaders	**Setting:** Community mental health **Therapy:** Type not specified	**Individual:** Processing-speed differences; communication differences; comprehension issues **Family:** Limited psychoeducation about autism/anxiety; lack of parental buy-in **Service:** Scheduling difficulties; lack of modified clinical settings **System:** Geographic location; limited clinician awareness of autism + anxiety presentations	Rapport-building between providers, youth, and caregivers Matching providers to youth needs Caregiver psychoeducation	Autistic youth with co-occurring anxiety face multi-level barriers spanning individual, caregiver, provider, and system levels.
Dietlinger et al. [31]	2025	Germany	**N** = 20 psychotherapists Treating 33 unaccompanied young refugees (UYRs) with PTSD — BETTER CARE trial	**Setting:** Outpatient psychotherapy linked to CYWS facilities **Therapy:** TF-CBT	**System:** Legal/asylum status complications; unclear funding between Youth Welfare Offices and health insurance; lack of suitable interpreters; absence of country-wide interpreter standards; long travel distances	Specialized training Case consultation Structured project support Skilled interpreter collaboration Caregiver involvement	System-level barriers — interpreter access, legal status, and funding ambiguity — were most prominent. Structured support and specialized training facilitated TF-CBT delivery.

Reference	Year	Country	Population & Sample	Setting & Therapy	Barriers	Facilitators	Key Findings
van de Water et al. [32]	2017	South Africa	**N** = 6 3 nurse counsellors, 3 school liaisons — qualitative evaluation nested within an RCT	**Setting:** School-based **Therapy:** Task-shifted psychotherapy for adolescents with PTSD	**Service:** Transport difficulties; lack of suitable private venues; communication gaps; scheduling problems **System:** Limited access to trained mental health professionals	School-based delivery Face-to-face clinical supervision Peer support among nurse counsellors School liaison coordination Networking between health and education departments	School-based task-shifted psychotherapy was feasible and valued. Conducting therapy within schools was identified as a key structural facilitator of access.

Note. CBT = cognitive behavioural therapy; NHS = National Health Service; PTSD = post-traumatic stress disorder; ASD = autism spectrum disorder; FBT = family-based treatment; CBITS = Cognitive Behavioral Intervention for Trauma in Schools; TF-CBT = trauma-focused cognitive behavioural therapy; BA = behavioural activation; CMH = community mental health; CYWS = child and youth welfare services; RCT = randomized controlled trial.

Therapeutic relationship. The quality of the adolescent-therapist relationship was identified as a central determinant of engagement across multiple qualitative studies. Tsamadou et al. (2021) reported, on the basis of semi-structured interviews with 50 adolescents attending a tertiary outpatient psychiatric clinic in Greece, that a trusting, warm, and non-paternalistic therapeutic relationship was the most frequently cited facilitator of engagement, while a poor or boundary-violating relationship constituted the most prominent individual barrier. These findings were consistent with those of Stafford and Draucker (2019), who reported that a meaningful and trusting therapeutic connection was a key facilitator among 25 Latina young women with a history of depressive symptoms in the United States, whereas provider distrust and unhelpful therapeutic styles were major deterrents to accessing care. Isiwele et al. (2025) similarly documented, in a qualitative IPA study of five Ghanaian and Nigerian youth attending NHS services in London, that difficulty building therapeutic rapport and a perceived cultural mismatch with clinicians were prominent barriers to engagement.

Stigma and help-seeking attitudes. Stigma - encompassing both anticipated social stigma and internalized self-stigma - was identified as an individual-level barrier in several qualitative studies, though its salience varied across clinical and cultural contexts. Tsamadou et al. (2021) identified fear that others would discover an adolescent was receiving psychiatric treatment as a recurrent deterrent to engagement among young people attending a tertiary outpatient clinic in Greece. Stafford and Draucker (2019) similarly documented that among Latina adolescents in the United States, fear of family judgment following disclosure of depressive symptoms, alongside deep-seated distrust of mental health providers, functioned as significant barriers to both initiating and sustaining help-seeking.

Cultural and linguistic factors. Studies involving migrant, refugee, or ethnic minority populations documented cultural mismatch as a prominent multi-level barrier to engagement. Stafford and Draucker (2019) identified culturally specific beliefs among Latina adolescents - including narratives framing depression as a sign of weakness, immaturity, or not a real problem - as prominent individual-level barriers to help-seeking. Schapiro et al. (2024), examining a school-based CBT intervention for Central American unaccompanied immigrant youth, identified silence around trauma, fear of disclosure, and the linguistic marginalization of indigenous languages as barriers to engagement. Isiwele et al. (2025) found that standardized NHS care models were perceived as failing to reflect the cultural identities and lived experiences of Ghanaian and Nigerian youth, leading to reduced engagement and suboptimal service utilization. In contrast, Carretier et al. (2020) found that a specialized transcultural group psychotherapy model in France - which explicitly integrated cultural narratives and involved family participation across 44 participants - improved both engagement and perceived effectiveness among migrant adolescents.

Motivation and adolescent-specific factors. Adolescent-specific factors were identified as barriers to sustained treatment engagement across qualitative studies. Tsamadou et al. (2021) reported that early symptom remission was a clinically underappreciated barrier, as adolescents who perceived improvement frequently discontinued treatment prematurely. Kitchen et al. (2023), in a qualitative evaluation nested within a UK RCT of behavioural activation for adolescent depression - comprising interviews with six young people, five parents, and five therapists - similarly identified low motivation and ambivalence toward change as prominent barriers, alongside co-occurring conditions such as autism spectrum disorder and anxiety that complicated engagement with manualized protocols.

Family-level factors. Parental non-acceptance of a mental health problem and family dismissal of symptoms were identified as prominent barriers across multiple qualitative studies. Stafford and Draucker (2019) reported that family dismissal of depression as not real or culturally irrelevant, alongside fear of family judgment, constituted significant deterrents to help-seeking among Latina adolescents. Kitchen et al. (2023) similarly documented that differences between young people and parents regarding expectations of therapeutic success, limited parental knowledge about therapy, and uneven levels of parental involvement complicated engagement with treatment. Conversely, active family support was reported as a key facilitator to initiating and sustaining treatment engagement across several qualitative studies [Tsamadou et al.; Kitchen et al.; Stafford and Draucker]. Stafford and Draucker (2019) additionally noted that parental support was particularly salient when a caregiver had personal experience of mental health difficulties. The role of parental involvement was described as ambivalent, with over-involvement or uneven parental engagement constituting additional barriers in some clinical contexts [Kitchen et al.].

Structural service- and system-level barriers. Keiller et al. (2024), in a qualitative study of 12 school-based dramatherapists in the United Kingdom, found that funding insecurity, unsuitable physical spaces, pressure to demonstrate clinical efficacy, and waiting times dependent on therapist availability constrained access to school-based psychotherapy, with the number of sessions offered frequently determined by available funding rather than clinical need. Dietlinger et al. (2025), in a qualitative study nested within the BETTER CARE dissemination trial in Germany involving 20 psychotherapists treating 33 unaccompanied young refugees with PTSD, documented system-level barriers including legal and asylum status complications, unclear funding responsibilities between Youth Welfare Offices and health insurance providers, lack of available and suitable interpreters, absence of country-wide interpreter standards for psychotherapy, and long travel distances between residential facilities and treating psychotherapists. Van de Water et al. (2017), in a qualitative study nested within an RCT in South Africa involving nurse counsellors and school liaisons, reported transport difficulties, lack of suitable and private venues, communication gaps between school and health system personnel, scheduling problems, and limited access to trained mental health professionals as implementation barriers to a task-shifted school-based psychotherapy programme for adolescents with PTSD.

School-based delivery as a facilitator. School-based service delivery was highlighted as a structural facilitator across several studies, particularly those conducted in lower-resource or marginalized settings. Schapiro et al. (2024) found that the school-based format increased accessibility and was perceived as a safe and familiar environment reducing practical barriers to engagement among Central American unaccompanied immigrant youth; however, full acceptability remained contingent on adequate cultural and linguistic adaptation, as disclosure fears and cultural mismatch continued to limit uptake among some participants. Van de Water et al. (2017) similarly identified school-based delivery as a pragmatic facilitator of access to task-shifted psychotherapy for adolescents with PTSD in South Africa, with additional facilitators including face-to-face clinical supervision, school liaison coordination, and active networking between health and education departments. Keiller et al. (2024) reported that school settings were perceived as both accessible and safe spaces for therapeutic work, with integration into the school's daily and termly timetable and collaboration with other school-based professionals identified as key enabling conditions.

3.4. Results – Quantitative and Mixed-Methods Studies

Table 3 presents the characteristics and key findings of the nine quantitative and mixed-methods studies included in the synthesis.

Reference	Year	Country	Study Design	Population & Sample	Main Outcome / Access Measure	Key Findings
Sibley et al. [33]	2022	United States	Mixed-methods; qualitative grounded theory coding of 822 audio-recorded sessions + quantitative generalized linear models; secondary analysis of two RCTs	**N** = 121 adolescents with DSM-diagnosed ADHD and their parents (77.7% Latinx)	**Low motivation:** 75.2% of sessions **Belief no change needed:** 56.2% **Forgetfulness:** 60.3% **Parental failure to monitor practice:** 69.4% **Schedule conflicts:** 31.4%	Teen motivational and attitudinal barriers were the most prevalent engagement barriers to ADHD behaviour therapy, present in the majority of recorded sessions.
Wecht et al. [34]	2024	United States	Mixed-methods; online survey followed by semi-structured interviews with adolescents and parents	**N** = 40 20 adolescents aged 12–19 years + 20 parents/guardians	Adolescents reported significantly higher barriers than parents; psychotherapy improved parent-adolescent communication and increased mutual empathy	Parent-adolescent communication plays a central role in access to mental health care. Adolescents consistently perceive significantly more barriers than their parents.
Namer et al. [35]	2022	Germany	Mixed-methods; cross-sectional quantitative survey combined with insights from mental health professionals	**N** = 216 asylum-seeking and refugee (ASR) adolescents	**Psychotherapy use:** Only 6.9% **Intent to use:** 4.3% High level of unmet mental health need despite significant emotional difficulties	Mental health services are severely underutilized among ASR adolescents. Help-seeking is shaped by stigma, unfamiliarity with services, and structural system-level barriers.
Upadhyay et al. [36]	2019	United States	Retrospective cohort study; Medicaid administrative claims data	**N** = 4,022 children and adolescents Newly diagnosed major depressive disorder (MDD) across 20 counties in Texas	**Treatment engagement:** 70.1% **Minimum adequate treatment:** 13.6% **Distance ≥15 miles:** OR = 0.78 for completion **Specialist-initiated treatment:** OR = 3.04 **Specialist density:** OR = 1.63–2.28 for Black adolescents	Geographic access barriers and low specialist density were significantly associated with lower treatment quality. Specialist-initiated care strongly predicted treatment completion across all groups.

Reference	Year	Country	Study Design	Population & Sample	Main Outcome / Access Measure	Key Findings
Simon et al. [37]	2017	United States	Cross-sectional observational study using standardized psychometric instruments	**N** = 52 child-caregiver dyads Youth aged 6–15 with trauma history and non-offending caregivers	Caregiver stigmatization and youth PTSD symptoms jointly predicted caregiver treatment motivation; motivation not significantly predicted by child internalizing/externalizing symptoms alone	Caregiver stigmatization and youth PTSD symptom severity jointly shape treatment engagement, with higher levels of both increasing caregiver motivation to seek care.
Villalobos et al. [38]	2023	United States	Observational service-evaluation survey with closed chart review	**N** = 60 youth receiving TF-CBT via telehealth Caregiver satisfaction data: n = 51; youth data: n = 44	**Attendance only possible via telehealth:** 84.3% of caregivers **Distance to nearest clinic as barrier:** 55.8% **Nearest service:** 5–89 miles away **Lack of transportation:** 44.2% **Preferred telehealth:** 96.1% caregivers; 95.5% youth	Telehealth delivery overcame major geographic and logistical barriers in an underserved community setting. High satisfaction was reported by both youth and caregivers.
Dardas et al. [39]	2017	Jordan	Cross-sectional, nationally representative, school-based survey; stratified random sampling	**N** = 2,349 Jordanian adolescents Attending public and private schools	**Would not seek professional help for depression:** 25% Preferred help sources: family members (57%), school counselors (46%), psychiatrists (43%) Stigma and depression severity: negatively associated with willingness to seek psychotherapy Female sex: positively associated with willingness to seek help	Substantial barriers to professional depression help-seeking exist among Jordanian adolescents. School counselors and school-based approaches emerged as the most feasible access points.
Salloum et al. [40]	2016	United States	Randomized controlled trial — secondary analysis of access and participation barriers	**N** = 100 children with primary anxiety disorders and their parents 3 community outpatient clinics in Florida	**Not knowing where/whom to seek help:** 66% **Insurance not covering services:** 37% **Financial concerns:** 35% **Child stigma:** 42% **Parental stress:** 32.4% **Child shame — completers vs. non-completers:** 17.1% vs. 40.0% ($p < .05$) **Discomfort discussing problems:** 32.9% vs. 60.0% ($p < .05$) **Parental dissatisfaction:** 8.6% vs. 26.7% ($p < .05$)	Limited knowledge of available services, child stigma, and parental stress were dominant barriers. Higher perceived barriers were significantly associated with lower treatment completion.

Reference	Year	Country	Study Design	Population & Sample	Main Outcome / Access Measure	Key Findings
Szota et al. [41]	2025	Germany	Pre-post pilot study without a control group; repeated-measures online survey	**N** = 133 adolescents School-based Living Library mental health literacy interventions; N = 80 completed post-assessment	**Mental health literacy:** Increased significantly (mean 41.75 → 59.11; Cohen's d = 0.62) **Help-seeking stigma:** Reduced modestly (mean 2.87 → 2.75; d = −0.23) No significant changes in fear of public stigma, problem denial, or psychotherapy-setting fears	A brief school-based Living Library intervention improved adolescents' self-rated mental health literacy and modestly reduced help-seeking stigma, but did not address more entrenched attitudinal barriers.

Note. MDD = major depressive disorder; PTSD = post-traumatic stress disorder; TF-CBT = trauma-focused cognitive behavioural therapy; ADHD = attention-deficit/hyperactivity disorder; OR = odds ratio; MHL = mental health literacy; ASR = asylum-seeking and refugee; RCT = randomized controlled trial; TSQ = Telehealth Satisfaction Questionnaire.

Geographic access and specialist density. Upadhyay et al. (2019) conducted a retrospective cohort study using Medicaid administrative claims data from 4,022 children and adolescents with newly diagnosed major depressive disorder across 20 counties in Texas. Travel distance to the treating provider was negatively associated with treatment engagement among Hispanic adolescents (5-14.9 miles versus fewer than 5 miles: OR = 0.74; ≥15 miles versus fewer than 5 miles: OR = 0.82) and with guideline-concordant treatment completion across all racial and ethnic groups (≥15 miles: OR = 0.78). Higher mental health specialist density was positively associated with treatment engagement among Black adolescents (OR = 1.63-2.28), and specialist-initiated treatment was associated with substantially higher completion rates than treatment initiated by a primary care physician (OR = 3.04); notably, none of the 20 counties met the recommended benchmark of one psychiatrist per 4,000 population, and only 13.6% of the sample achieved minimum adequate treatment duration.

Telehealth as a facilitator. Villalobos et al. (2023) conducted an observational service-evaluation study among 60 youth receiving trauma-focused CBT via telehealth in an underserved community setting in the United States. Distance to the nearest mental health clinic was identified as a barrier by 55.8% of caregivers, with the nearest available service located between 5 and 89 miles away, and lack of transportation was reported by 44.2%. A total of 84.3% of caregivers indicated that their child could only attend treatment because sessions were delivered remotely, and 96.1% of caregivers and 95.5% of youth reported preferring telehealth over clinic-based attendance. Initial discomfort with telehealth equipment was reported by a minority of participants, with the majority of youth and caregivers reporting comfort with the technology from the outset.

Stigma, access barriers, and treatment participation. Salloum et al. (2016), in a secondary analysis of an RCT of computer-assisted CBT involving 100 children with anxiety disorders across three community clinics in Florida, reported that not knowing where or whom to seek help was the most commonly identified access barrier (66%), followed by health insurance not covering services (37%) and financial concerns (35%). Child stigma - fear that others would learn about treatment - was reported by 42% of participants, and parental stress was the most frequently endorsed participation barrier (32.4%). Statistically significant differences were observed between treatment completers and non-completers, with higher rates of shame about needing help (17.1% versus 40.0%, $p < .05$), discomfort discussing problems (32.9% versus 60.0%, $p < .05$), and parental dissatisfaction with services (8.6% versus 26.7%, $p < .05$) among those who did not complete treatment.

Help-seeking intentions. Dardas et al. (2017) administered a nationally representative cross-sectional school-based survey to 2,349 Jordanian adolescents. Among respondents, 25% indicated they would not seek professional help for depression. Of those willing to seek help, the most frequently endorsed sources were family members (57%), school counselors (46%), and psychiatrists (43%). Higher depression severity and greater stigma were negatively associated with willingness to seek psychotherapy, while female sex was positively associated with willingness to seek some forms of professional support.

3.5. Methodological Quality of Included Studies

Formal quality scoring was not performed, in line with the narrative synthesis design of this review. The methodological limitations of individual studies were considered during synthesis and are summarized below.

Most qualitative studies employed purposive or convenience sampling strategies and were conducted at single sites or within single regions, limiting generalizability [Tsamadou et al.; Stafford and Draucker; Schapiro et al.; Keiller et al.; Kitchen et al.]. Several relied exclusively on clinician or therapist perspectives, without direct adolescent or caregiver input, introducing a risk of proxy bias [Sauerwein et al.; Keiller et al.; van de Water et al.; Dietlinger et al.]. Studies recruiting treatment-engaged samples may have systematically underrepresented adolescents who never initiated contact with services, potentially attenuating the magnitude of reported access barriers [Tsamadou et al.; Sibley et al.].

Among quantitative studies, the retrospective claims-based design employed by Upadhyay et al. (2019) allowed large-scale geographic analysis but relied on zip code-level geolocation and lacked data on transportation access and patient-reported outcomes. The service-evaluation study by Villalobos et al. (2023) was limited by its small completer-only sample, absence of a comparison group, and potential social desirability bias arising from post-discharge interview administration. The pilot study by Szota et al. (2025) lacked a control group and used a non-validated mental health literacy instrument, limiting the interpretability of observed changes. Cross-sectional designs precluded causal inference across most included studies. The RCT secondary analysis by Salloum et al. (2016) and the dissemination trial component by Dietlinger et al. (2025) were the only studies employing experimental or quasi-experimental frameworks, both focused on participation-related rather than primary access outcomes.

4. Discussion

4.1. Principal Findings

This systematically informed narrative review synthesized evidence from 20 studies conducted across multiple countries to examine barriers and facilitators to accessing psychotherapy among adolescents within public health systems. The findings demonstrate that access is determined by a complex and interacting set of factors operating at four distinct levels: individual, family, service, and system. Structural barriers - most prominently long waiting times, insufficient mental health specialist density, and fragmented inter-agency coordination - emerged as among the most pervasive impediments to care and were identified consistently across health system contexts. Stigma, including both anticipated social stigma and internalized self-stigma, and negative or distrustful attitudes toward mental health services constituted equally consistent individual-level barriers, particularly among ethnic minority, migrant, and socioeconomically disadvantaged adolescents. At the family level, parental non-acceptance of a mental health problem and poor parental knowledge about psychotherapy were recurrent deterrents, while active family support functioned as a key facilitator of both initiation and sustained engagement. School-based service delivery, youth-friendly therapeutic relationships, and culturally adapted models were identified as among the most consistently reported facilitators, though their implementation across public systems remained uneven. These findings, taken together, indicate that no single intervention is sufficient to address access inequities; rather, coordinated, multilevel strategies targeting both structural and psychosocial determinants are required.

4.2. Interpretation of Barriers and Facilitators

The primacy of structural barriers identified in this review is consistent with broader evidence on access to mental health services in publicly funded systems. Long waiting times and limited availability of trained therapists have been documented across high-income healthcare systems as among the most consistently reported systemic impediments to timely care [references]. The evidence synthesized here extends these observations specifically to adolescent psychotherapy, demonstrating that geographic distance to services exerts a measurable and independent negative effect on treatment engagement - particularly among Hispanic and other ethnic minority adolescents covered by Medicaid-based care pathways [Upadhyay et al.]. Notably, none of the twenty counties included in the Texan administrative cohort met the recommended benchmark of one psychiatrist per 4,000 population, and only 13.6% of the sample achieved minimum adequate treatment duration - figures that underscore a systemic, rather than individual, failure of access.

The role of stigma as a barrier to help-seeking warrants careful contextualisation. Across qualitative and quantitative studies, both social and internalized stigma were identified as deterrents to initiating and sustaining engagement with psychotherapy, with particular salience among adolescents from cultural contexts in which mental illness may be framed as a sign of weakness, immaturity, or a spiritual failing [Stafford and Draucker; Tsamadou et al.; Dardas et al.]. In the Jordanian nationally representative survey, 25% of adolescents indicated

they would not seek professional help for depression, and higher stigma was independently associated with reduced willingness to engage with mental health services. These findings align with a substantial body of literature identifying stigma as a primary barrier across age groups and cultural settings, and suggest that public mental health literacy campaigns and school-based psychoeducation may be particularly important interventions in this population.

Cultural and linguistic mismatch between adolescents - particularly those from ethnic minority, migrant, or refugee backgrounds - and standardized therapeutic service models emerged as a prominent and clinically underappreciated barrier in this review. Studies involving Ghanaian and Nigerian youth in the NHS [Isiwele et al.], unaccompanied Central American immigrant youth in school-based settings [Schapiro et al.], asylum-seeking adolescents in Germany [Namer et al.; Dietlinger et al.], and Latina adolescents in the United States [Stafford and Draucker] consistently documented that mainstream care pathways failed to reflect the cultural identities, linguistic needs, and lived experiences of these young people. Conversely, the transcultural group psychotherapy model evaluated by Carretier et al. in France - which explicitly integrated cultural narratives and family participation - demonstrated meaningful improvements in both engagement and perceived effectiveness. This contrast underscores the potential of culturally adapted service models to reduce access inequities, and highlights the inadequacy of assuming that evidence-based manualized treatments are universally applicable across cultural and linguistic contexts.

The therapeutic relationship emerged as a cross-cutting facilitator in the qualitative evidence base, identified consistently as the most important individual-level determinant of both initiating and sustaining engagement. A trusting, non-paternalistic, and culturally sensitive relationship with the therapist was described as a primary facilitator in studies from Greece [Tsamadou et al.], the United States [Stafford and Draucker], and the United Kingdom [Isiwele et al.], irrespective of clinical population or service setting. Provider distrust, perceived cultural mismatch, and unhelpful therapeutic styles, conversely, were among the most frequently cited deterrents. These findings are consistent with psychotherapy outcome research more broadly, in which therapeutic alliance has been identified as one of the most robust predictors of treatment response across diagnoses and modalities. They suggest that investment in relational competencies, cultural humility training, and therapist–client matching may yield meaningful dividends in terms of both access and engagement.

Family-level factors constitute a distinctive dimension of adolescent access that has no direct equivalent in adult mental health research. This review found that parental attitudes - including non-acceptance of a mental health diagnosis, dismissal of symptoms as culturally irrelevant or not real, and limited knowledge about the nature or content of psychotherapy - functioned as significant barriers across multiple qualitative studies [Stafford and Draucker; Kitchen et al.]. These findings suggest that effective engagement of adolescents with psychotherapy is contingent, to a substantial degree, on the ability to simultaneously engage their caregivers. Active family support was correspondingly identified as a key facilitator, particularly when parents had personal experience with mental health difficulties or were provided with adequate psychoeducation. The ambivalence of parental involvement - recognized in several studies as both a potential facilitator and, when excessive or uneven, a barrier - highlights the need for nuanced, family-sensitive approaches that neither exclude parents from the therapeutic process nor allow their involvement to impede adolescent autonomy.

4.3. Why Evidence in This Field Is Limited

The available evidence on barriers and facilitators to adolescent psychotherapy access in public systems is constrained by several important structural and methodological limitations. The most fundamental is the absence of a consistent, multidimensional operational definition of "access" across the included literature. Studies variously operationalized access as referral receipt, first appointment attendance, treatment initiation, session completion, or minimum adequate treatment duration, with many studies addressing only one of these dimensions. This definitional heterogeneity substantially impedes cross-study synthesis and prevents reliable estimation of the cumulative burden of access failure across the care pathway.

A second major limitation concerns the representativeness of existing samples. The majority of qualitative studies recruited from treatment-engaged populations - adolescents who had already initiated contact with services - which may have systematically underrepresented those facing the most severe access barriers, including adolescents who never sought or reached services at all. This sampling paradox is particularly consequential in the context of this review, as the experiences of adolescents who never access care are arguably most relevant to informing structural and system-level interventions. Quantitative studies, by contrast, were predominantly retrospective and relied on administrative or claims-based data, limiting the availability of patient-reported access barriers and engagement experiences.

Methodological heterogeneity across study designs further constrained the depth of synthesis achievable in this review. The predominance of qualitative evidence - while appropriate given the experiential nature of the research question - means that the magnitude of effects associated with specific barriers or facilitators cannot be reliably estimated. Among quantitative studies, cross-sectional designs precluded causal inference, completer-only samples introduced systematic attrition bias, and single-site recruitment limited external generalizability. Only two studies employed experimental or quasi-experimental frameworks [Salloum et al.; Dietlinger et al.], and neither was designed with access as its primary outcome. Together, these constraints reflect the broader immaturity of the evidence base in this area and highlight the methodological investment required to generate actionable knowledge for service design and policy.

4.4. Comparison with Broader Mental Health Access Literature

The findings of this review converge with patterns documented in prior syntheses on adolescent mental health help-seeking. Radez et al. (2021), in a systematic review of 53 quantitative and qualitative studies, identified individual-level barriers - including limited mental health literacy and stigma - in 96% of included studies, and social barriers such as fear of judgment in 92% [6]. Aguirre Velasco et al. (2020), reviewing 90 studies across adolescents aged 10-19, similarly found stigma and negative beliefs about mental health professionals to be the most consistently cited barriers, and noted that effective interventions were predominantly school-based [8]. Both reviews also identified the absence of a consistent operational definition of help-seeking across studies - a methodological limitation that directly mirrors the definitional heterogeneity of access documented in Section 4.3 of the present review.

The structural barriers identified here - specialist shortages, long waiting times, and fragmented inter-agency coordination - are consistent with findings from broader child and adolescent mental healthcare research. Fernández-Sánchez et al. (2023), synthesizing 51 studies from 2018-2022, documented that inadequate public policies, overburdened services, stigma, and absent community resources constitute globally recurring impediments to youth mental healthcare, and argued that these patterns reflect systemic underinvestment rather than individual-level failures [41]. The present review extends these observations by demonstrating their operation specifically within the psychotherapy access pathway and within a defined public system context - a scope that prior syntheses have not applied explicitly.

A distinctive feature of adolescent access not fully captured in the adult mental health literature is the dual role of the school system as both a referral pathway and a service delivery context. The school-based facilitators identified across multiple studies in this review are consistent with evidence that co-location of services within normative youth environments reduces stigma and logistical barriers. However, as this and prior reviews document, the sustainability of school-based models is frequently undermined by funding insecurity and inconsistent institutional support - conditions that limit their scalability across public systems. Similarly, the therapeutic alliance findings reported here align with meta-analytic evidence identifying alliance quality as a robust predictor of treatment outcomes in child and adolescent psychotherapy, with effect sizes ranging from small to moderate across informants and modalities [42, 43].

4.5. Clinical Implications

The findings of this review carry several implications for clinical practice and service design. First, the consistent identification of the therapeutic relationship as the most important individual-level facilitator of engagement underscores the importance of relational and culturally sensitive competencies in the training and continuing professional development of therapists working with adolescent populations. Therapeutic approaches that are exclusively focused on the delivery of manualized protocols, without attending to the quality of the alliance and the cultural fit between therapist and young person, are unlikely to achieve adequate engagement in ethnically diverse or marginalized populations.

Second, the evidence on family-level barriers suggests that access interventions targeting only the adolescent are likely to be insufficient. Pre-treatment psychoeducation for caregivers, inclusion of parents in goal-setting and progress discussions where appropriate, and the availability of parallel support for parents experiencing their own mental health difficulties may all contribute to reducing family-mediated impediments to adolescent engagement. Clinicians working in public systems should receive training in family-sensitive engagement strategies, particularly when working with families from cultural backgrounds in which mental illness carries significant stigma or in which collective decision-making norms may affect adolescent autonomy in help-seeking.

Third, service planners and commissioners should recognize that structural barriers - particularly waiting time, geographic access, and specialist availability - are not merely background conditions against which clinical work occurs, but are themselves primary determinants of whether adolescents ever reach the point of

clinical contact. The evidence reviewed here suggests that telehealth delivery, school-based provision, and integrated care models represent practical and evidence-informed approaches to reducing structural barriers, and should be prioritized in public system investment decisions. The finding that specialist-initiated treatment is associated with substantially higher completion rates than primary care-initiated treatment [Upadhyay et al.] further suggests that triage and referral processes, including criteria for expedited specialist involvement, warrant critical re-examination.

4.6. Research Recommendations

The evidence reviewed here, despite its limitations, points to several priorities for future research. Most fundamentally, the field requires methodological standardization in the operationalization and measurement of access. Future studies should adopt a multidimensional access framework that distinguishes between availability, accessibility, acceptability, affordability, and appropriateness of services, and that captures the full care pathway from initial help-seeking through to treatment completion or appropriate discharge. Consistent use of validated, adolescent-specific instruments for measuring perceived barriers, treatment engagement, and therapeutic alliance would substantially enhance the comparability of evidence across studies and settings.

A second research priority is the systematic inclusion of populations who never access services, rather than restricting recruitment to treatment-engaged samples. Population-based designs, including longitudinal cohort studies nested within school or community settings, and administrative linkage studies connecting mental health need assessments with service utilization data, would provide a more complete and less biased picture of the access gap and its determinants. Such designs are particularly important for identifying the structural and individual-level factors that predict non-initiation of care, which is arguably the most consequential form of access failure.

Third, there is an urgent need for more rigorous evaluation of interventions specifically designed to improve access rather than treatment outcomes per se. Randomized and quasi-experimental designs testing access-focused interventions - including structured waiting-list support, active outreach to non-initiating families, culturally adapted engagement protocols, and telehealth delivery models - are rare in the existing literature and represent an important methodological gap. Such studies should be accompanied by economic evaluations to enable comparisons of cost-effectiveness across intervention types and settings.

Finally, future research should give systematic attention to underrepresented populations, including adolescents from ethnic minority and migrant backgrounds, those with co-occurring neurodevelopmental or physical health conditions, and young people in low-resource or conflict-affected settings. These groups face the highest barriers to access and are the most consistently underrepresented in the existing evidence base, including the studies reviewed here. Cross-national comparative studies, leveraging differences in public system design, funding models, and cultural context, would also be of considerable value in identifying the system-level features most strongly associated with equitable access.

5. Strengths and Limitations

This review has several strengths. It addresses an important and policy-relevant concern regarding access to psychotherapy among adolescents within public health systems, with a focus not only on treatment initiation but also on engagement and continuation of care. By conceptualising access as a multidimensional process, this study captures a broader and more clinically relevant range of barriers and facilitators. Additionally, the inclusion of qualitative, quantitative and mixed-methods studies allowed for an extensive synthesis of evidence across different health system contexts and study populations, as well as an exploration of the perspectives of both adolescents and key stakeholders. The four-level analytical framework that extracted data on individual-, family-, service- and system-level factors was particularly valuable, given the complex nature of barriers and facilitators to psychotherapy access, as it helped organise heterogeneous findings in a clear and policy-relevant manner. Furthermore, this review used a structured and reproducible search strategy across three major databases, with predefined eligibility criteria, screening performed by two independent researchers and standardised data extraction. This strengthens the transparency and consistency of the review process, despite the study being designed as a systematically informed narrative review rather than a formal systematic review.

Several limitations should also be acknowledged. This study was not prospectively registered and did not include a formal risk-of-bias assessment using a standardised appraisal tool. Although methodological limitations were considered during data extraction and synthesis, the absence of formal quality scoring limits the ability to compare the strength of evidence across included studies. Moreover, the identified studies were

highly heterogeneous in terms of study design, participant populations, health system context, types of psychotherapy and outcome definitions. As a result, quantitative pooling was not appropriate and the findings were synthesised narratively.

Additional limitations arise from the characteristics of the included literature. Many studies were qualitative, single-site, or based on purposive or convenience samples, which may limit generalisability. Several studies included adolescents who were already engaged with services, potentially underrepresenting young people who never received psychotherapy despite experiencing a need. In addition, some studies centred on the perspectives of clinicians, therapists or other stakeholders, which may not adequately reflect adolescents' own experiences of access barriers and facilitators. The geographic distribution of studies was also uneven, with a predominance of evidence from high-income countries, particularly the United States, the United Kingdom and Germany, whereas low-resource settings were less represented. A further limitation concerns the heterogeneity of access-related outcomes. The included studies did not use uniform outcome measures. Rather, they addressed different aspects of access, ranging from initial help-seeking and referral to treatment engagement, completion and service utilisation. This limited direct comparability across studies and reduced the ability to draw firm conclusions about which barriers and facilitators were most consistently reported across the evidence base. Finally, although no language restrictions were applied during the initial screening phase, studies unavailable in English or Polish were excluded for practical reasons, which may have introduced language bias.

Overall, these limitations suggest that the findings should be interpreted as a structured synthesis of available evidence, rather than as definitive conclusions about the frequency or impact of specific barriers and facilitators. Nevertheless, this review identifies recurring multilevel factors affecting psychotherapy access among adolescents and highlights key gaps for future research, including the need for more standardised definitions of access, stronger comparative study designs, and greater representation of underserved populations and low-resource settings.

6. Conclusions

Access to psychotherapy among adolescents in public health systems is determined by multilevel factors encompassing structural, socioeconomic, cultural, and individual dimensions, which interact in ways that compound disadvantage for the most vulnerable young people. The most frequently reported barriers are structural in nature, including long waiting times, insufficient availability of qualified therapists, and fragmented coordination between health, education, and social care sectors, and disproportionately affect adolescents from low-income families, rural areas, and ethnic minorities. Facilitators such as school-based services, integrated care models, and youth-friendly approaches demonstrate meaningful potential to reduce inequities in access, yet their implementation remains inconsistent across systems. The available evidence is limited in scope and methodologically heterogeneous, with considerable variation in how "access" is defined and operationalized across studies, precluding robust cross-national comparisons. Future research should adopt standardized study designs and outcome measures, apply a consistent, multidimensional definition of access, and give particular attention to underrepresented populations and low-resource settings. Addressing these gaps is essential to inform equitable, evidence-based policy and service design that ensures no adolescent is excluded from mental health care on the basis of structural or social circumstance.

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