Barriers to accessing and using preventive mental health services for psychosocially strained children and families in Germany: Perspectives of professionals from different sectors

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Barriers to accessing and using preventive mental health services for psychosocially strained children and families in Germany: Perspectives of professionals from different sectors☆

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ABSTRACT

Objective: Children, young people, and families (CYF) with psychosocial strains face elevated risks for mental health problems. Preventive mental health services in health, education, and social sectors can reduce this risk, but are often underused or have waiting times. While some data on barriers to use from clients' perspectives exist, the professionals' perspective is also important, particularly for understanding barriers at the side of providers and organizations and identifying solutions. This study examines barriers to accessing and using services from the perspective of professionals in multiple sectors.
Methods: Nineteen semi-structured interviews were conducted with professionals from the health, education, and social sectors in socioeconomically disadvantaged districts of two German cities in 2024. Interviews were audio-recorded, transcribed verbatim and coded using thematic analysis.
Results: Professionals described barriers at the (1) Client level (e.g., feeling ashamed using psychosocial services), (2) Provider level (e.g., insufficient knowledge about services), (3) Organizational level (e.g., responsibility or expertise not fitting families' needs), and (4) System level (e.g., long waiting times). To address barriers, professionals suggested trust-building with families, establishing contact and collaboration with other professionals, and building one-stop-shop models of co-located services to overcome parents' time constraints when children need multiple services.
Conclusions: Professionals are key to identifying barriers to preventive mental health service access and use in psychosocially strained CYF and finding solutions. Intersectoral exchange with other professionals can increase service awareness from other institutions and guide intersectoral collaboration. Barriers must be addressed holistically across levels and sectors to effectively overcome them.

1. Introduction

Children and young people exposed to socio-economic stress, parental mental health problems, family conflicts, bullying, or other psychosocial strains have an increased risk of developing mental health problems, including behavioral disorders and internalizing problems (Lorenz et al., 2020; World Health Organization, 2021). In Germany, the risk for mental health problems in children is estimated to increase fivefold in high-conflict families and threefold with parental mental health problems (Ravens-Sieberer et al., 2007; Klasen et al., 2017). The

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prevalence of mental health problems among children and young people in Germany is around 15 % overall and almost 20 % among families with low socio-economic status comprising about 20 % of the German population (Schmidtke et al., 2021).

Psychosocial support can effectively prevent mental health problems. For instance, parenting programs can foster positive parent-child interactions and school-based resilience promotion can enhance self-esteem while reducing anxiety symptoms in children (Carbone, 2020; Olowokere and Okanlawon, 2018). Additionally, educating teachers about children's psychosocial needs improves their ability to support those with mental health problems (Olowokere and Okanlawon, 2014). To maximize the potential for prevention, children, young people, and families (CYF) in need of psychosocial support should be identified early and supported by appropriate preventive mental health and psychosocial support services (World Health Organization, 2021; Klasen et al., 2017; Kessler et al., 2010; Jeindl et al., 2023; World Health Organization, 2018; Robert Koch-Institut, 2021).

Professionals in schools, early childcare, and other settings interacting with children and young people are uniquely positioned to identify mental health concerns (e.g. changes in mood and behavior) early (Goodwin, 2016). They can connect CYF to health professionals (e.g., pediatricians, psychiatrists) for diagnostics and early interventions or help families access social services for parenting and psychosocial support. The World Health Organization's setting approach (Ottawa) highlights the need for a multisectoral perspective in preventing mental health problems (World Health Organization, 2016). Collaboration across health, education, and social sectors creates a support system by linking institutions, professionals, and services for comprehensive, timely, and needs-based support. Key components include early identification of psychosocial strains, prompt referral to services adjusted to individual needs, and training professionals to recognize psychosocial strains and understand available services (Goodwin, 2016; World Health Organization, 2016).

Preventive mental health and psychosocial support services are widely available in Germany and other high-income countries across health, education, and social sectors, including parent counseling, financial aid, outpatient family assistance, resilience programs, and language support (de Graaf et al., 2008; Webster-Stratton, 2005; Fröhlich-Gildhoff et al., 2012; Eriksen et al., 2025). However, these services are often underused in practice (Robert Koch-Institut, 2021; Franzke and Schultz, 2015; Rickwood et al., 2007; Duong et al., 2021; Simon et al., 2015). In Germany, only around 27 % of children with mental health problems use psychological or psychotherapeutic services (Robert Koch-Institut, 2021).

Studies from the clients' perspective show that access and use of these services can be hindered by limited service awareness (Gulliver et al., 2010; Radez et al., 2021; Boydell et al., 2006), low trust in professionals and service effectiveness (Gulliver et al., 2010; Radez et al., 2021), fear of stigmatization (Gulliver et al., 2010; Radez et al., 2021; Goodcase et al., 2022; Reardon et al., 2017), long waiting times (Platell et al., 2020), geographical barriers (Gulliver et al., 2010; Boydell et al., 2006; Eigenhuis et al., 2021), or lack of services altogether (Klasen et al., 2017; Gulliver et al., 2010; Bevaart et al., 2014).

CYF from low socioeconomic status (SES), migrant backgrounds or ethnic minority groups often face greater challenges accessing preventive mental health and psychosocial support services due to unfamiliarity or communication issues (Bevaart et al., 2014; Bammert et al., 2024). These difficulties in accessing services can sustain psychosocial strains and widen health inequalities (Bevaart et al., 2014; Bammert et al., 2024; Kuntz and Lampert, 2010). For example, 16.2 % of Dutch children with problem behavior used mental health care, compared to only 7.4 % or less of children from ethnic minority groups (Bevaart et al., 2014). To prevent this, it is crucial to understand how barriers to accessing and using preventive mental health and psychosocial support services can be minimized.

While the client perspective gives valuable insight into barriers to service access and use, the professional perspective is essential to comprehensively understand and address the barriers that go.

beyond the clients' experiences, focusing on systemic and institutional issues required for improving service access and other possible solutions.

Barriers to cross-sectoral preventive mental health and psychosocial support services for CYF from the professionals' perspective have received little attention, despite professionals being key to identifying psychosocial needs and connecting CYF to services.

Studies exploring barriers for other services, e.g., mental health care, have identified several barriers from the professionals' perspective (e.g., a lack of service coordination, services not sufficiently considering potential stigmatization and low mental health literacy). Barriers related to services for the prevention of mental health problems or in other sectors than the health sector have not been addressed, yet (Goodcase et al., 2022).

In Germany, fragmentation between the health, education, and social sectors complicates access to services for both clients and professionals, hindering integrated support pathways essential for effective psychosocial prevention. Understanding barriers to a multisectoral approach is therefore key to developing sustainable solutions. Examining such barriers across sectors is complex, given the differing structures and operational logics. A localized analysis allows for an in-depth exploration of sector-specific dynamics and barriers perceived by professionals.

This study, therefore, aims to conduct an in-depth examination of barriers to accessing and using preventive mental health and psychosocial support services by CYF from the perspective of professionals in two city districts. It focuses on professionals in the health, education, and social sectors and answers the question: What are barriers to access and use of preventive mental health and psychosocial support services by CYF from the perspective of professionals in the health, education, and social sectors?

2. Methods

2.1. Study design and setting

This qualitative study, embedded in a German Center for Mental Health project, employed semi-structured interviews with professionals from the health, education, and social sectors. The study was conducted in 2024 in two districts of large cities in western (region 1) and eastern (region 2) Germany. The city districts had a population of approximately 20.000 and 45.000 people, a geographical area of around three and ten square kilometers, respectively, and were both characterized by socioeconomic challenges, high immigration, and poverty. The ethics committee of the Ruhr University Bochum has issued a positive ethics vote (ID Nr: 876, 13/12/2023).

2.2. Study population and selection criteria

Interview participants were professionals from the two city districts working in health, education, or social care institutions providing mental health or psychosocial support services for CYF (e.g., counseling centers, youth welfare institutions) or providing childcare or education (e.g., schools, kindergartens). Larger, nearby regional institutions (e.g., public health departments, hospitals) serving the two districts were also included. Interview participants were the institution's head, deputy or a professional recommended by the head because these professionals likely had an overview of services and collaboration.

For recruitment, eligible institutions were identified through online research and the study team's network. A list was compiled for each district (district east = 94, district west = 114), including kindergartens, schools, pediatricians, therapy practices, counseling centers (e.g., family counseling), and youth welfare facilities (e.g., housing groups). At least two to three institutions of each sector in each region were purposefully

sampled to ensure a diverse mix of disciplines, institutions, and funding authorities. Respective professionals were contacted via e-mail or telephone with a standardized invitation text. Professionals were informed about the study's background, aim and procedure. Selection of interview partners was based on willingness to participate. Main reason for non-participation was a lack of time. Professionals were not incentivized.

2.3. Data collection

Two female researchers coordinating the project (AR, a medical doctor, and SB, a social scientist) conducted the interviews using a semi-structured guide (Supplement 1). To ensure a standardized approach to conducting the interviews, the two researchers collaboratively developed the guide, standardized prompts for missing answers, refined it with the larger research team, and pilot-tested it ($n = 4$) outside the study regions. The guide included open-ended questions on institution type, professional roles, psychosocial services for CYF, accessibility, outreach strategies, and collaboration. Interviews were audio-recorded, transcribed verbatim with identifying information removed. Field notes were taken during the interviews.

2.4. Research team and reflexivity

The research team had diverse backgrounds in (pediatric) medicine, social sciences, public health, psychology, educational science, health economics, and health policy. To reduce bias and ensure rigor, coding, analysis, and data saturation were regularly discussed with the research team allowing for multiple perspectives to be included in data reflection and interpretation.

2.5. Data analysis

The pseudonymized interview transcripts were independently coded by two researchers for both study districts and analyzed through qualitative content analysis based on Kuckartz's approach (like Creswell's method) (Kuckartz, 2012; Creswell, 2012). Deductive coding categories were formed based on the interview guide and supplemented with inductive subcategories. We used Bronfenbrenner's socio-ecological model to guide our analysis of perceived barriers to accessing and using services by professionals at the client (e.g., individuals' limited knowledge about services, potential stigmatization), provider (e.g., professionals' training, capacities), organizational (e.g., financial and human resources, lack of institutional support in delivering services), and system levels (e.g., regulation, fragmented service structures, lack of services) (Bronfenbrenner, 1994). The relevance of barriers was assessed qualitatively depending on how clearly they were described and how frequently they appeared in each interview and across interviews and sectors. "Very often" refers to barriers mentioned at least five times by professionals from at least two different sectors and "often" to barriers mentioned at least three times by professionals from at least two different sectors. Interview transcripts were coded using MAXQDA 2024 (VERBI Software, Version 24.4.1, Berlin). We followed the Consolidated criteria for reporting qualitative studies.

3. Results

Seventeen interviews were conducted with a total of 19 professionals between February and July 2024. Characteristics of the study participants are presented in Table 1. Most interviews involved one interviewer and one professional, except for two instances where two professionals participated in each interview (one to capture both outpatient and inpatient perspectives, the other to provide a comprehensive overview of the same field). No other people were present during the interviews. The interviews lasted 77 min on average, ranging from 48 min to 128 min. The interviews were conducted in person at the institution where the interview participants were employed.

Table 1
Characteristics of the professionals in the interviews from institutions in the health, education, and social sectors from the two study districts in Germany characterized by socioeconomic challenges, high immigration, and poverty in 2024.

	Region 1		Region 2		Total	
Category	Female	Male	Female	Male	Female	Male
Number	$n = 10$ (83 %)	$n = 2$ (17 %)	n = 4 (57 %)	$n = 3$ (43 %)	$n = 14$ (74 %)	$n = 5$ (26 %)
Distribution across sectors						
Health	3	1	0	2	3	3
Education	3	0	2	0	5	0
Social	4	1	2	1	6	2
Position within the institution						
Head of institution	5	2	1	2	6	4
Employee	5	0	3	1	8	1

Notes: Socio-demographic characteristics were derived from a short additional questionnaire completed by interview participants.

3.1. Barriers to accessing and using preventive mental health services for CYF

Our findings on barriers from the professionals' perspective are presented according to the levels on which they occurred ((1) Client, (2) Provider, (3) Organizational, and (4) System level)). The identified barriers could be further divided into categories: (I) Psychological barriers, (II) Information and communication barriers, (III) Collaboration barriers, (IV) Structural and organizational barriers, (V) Practical and logistical barriers, and (VI) Resource-related barriers. Fig. 1 shows which barriers occurred at which level. Some barriers were relevant at multiple levels (e.g., information and communication barriers) and interacted with other levels (see: white arrows in Fig. 1). Barriers were dynamic and subject to change (e.g., change in professionals or funding). Changes at one level could lead to changes at other levels (e.g., time-limited regional projects may temporarily reduce geographical barriers in this region; new services could face initial informational barriers) (see: gearwheel structure of the levels). Table 2 provides example quotes for the barriers at the four levels from client to system.

(A) Barriers at the client level

At the client level, professionals identified psychological, information and communication, practical and logistical (e.g., lack of time for families with multiple children), and resource-related barriers (e.g., service fees). Psychological, information, and communication barriers were mentioned most frequently by professionals.

3.1.1. Psychological barriers

These included parents feeling ashamed of psychosocial problems (quote #1), having prejudices against institutions (e.g., youth welfare office), and being deterred by service names like "mentally ill parents" (quote #2). These barriers were mentioned very often by professionals and resulted in poor communication between clients and professionals making it difficult for professionals to provide adequate support (e.g., through assessment of support needs). The psychological impact of service names communicated to clients by organizations highlighted an interaction between the client level and organizational level.

3.1.2. Information and communication barriers

These were mentioned very often and included parents not sharing psychosocial problems with professionals (quote #3), language difficulties, parents misunderstanding medical recommendations, and lacking awareness of services (quote #4). Language difficulties or illiteracy

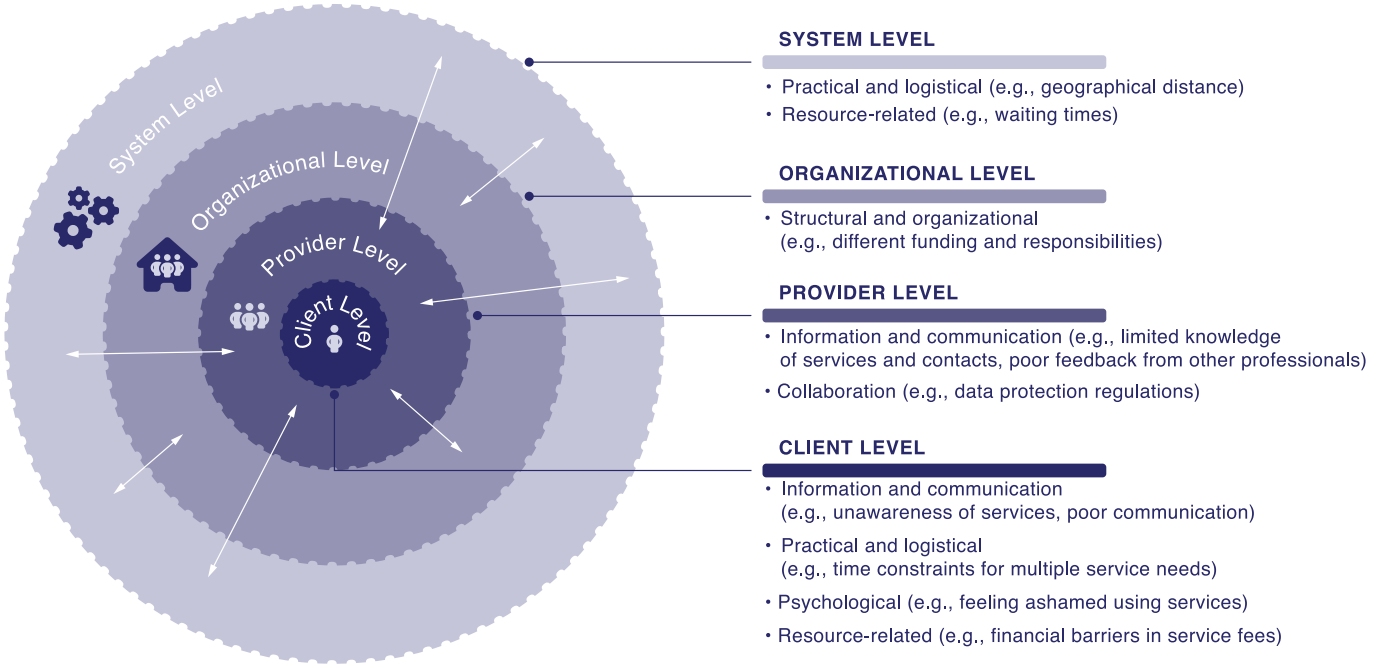

Fig. 1. Barriers identified by the professionals in the interviews from institutions in the health, education and social sectors in the two study districts in Germany characterized by socioeconomic challenges, high immigration, and poverty in 2024 presented by operational levels at which they occur.

made contacting professionals, booking appointments, or completing forms difficult (quote #5). Psychological barriers, distrust, and language difficulties also hindered communication. Professionals aimed to use simple language to improve understanding. Trust – necessary for parents to discuss psychosocial problems – often took time to build. Social sector professionals helped parents connect with services, book appointments, and complete forms (quote #5–6).

(B) Barriers at the provider level

At the provider level, professionals identified information, communication, and collaboration barriers.

3.1.3. Information and communication barriers

Professionals across sectors often reported that they lacked knowledge about regional services to refer CYF (quote #7). The dynamic service landscape made it harder to keep track of existing services (quote #5). Poor communication within and across sectors was common with a pediatrician noting difficulties in receiving feedback from other institutions due to data protection regulations (quote #8). These regulations were seen as a barrier to information exchange (quote #8). Even without legal issues, communication and feedback – such as on diagnostics – between professionals were often poor or missing.

3.1.4. Collaboration barriers

Unstructured collaboration (e.g., irregular meetings), lack of knowledge about regional services, and poor cross-sector communication (e.g., data protection hurdles) were very often reported barriers to collaboration. Lacking knowledge of services and professionals hindered CYF referrals, highlighting an interaction with information barriers. Effective communication and service knowledge were essential for professionals to refer CYF to suitable services. Professionals reached out to other professionals for background information about CYF to provide needs-based support (quote #9). However, the reported lack of communication and feedback hindered collaboration and showed that communication barriers interacted with collaboration barriers.

(C) Barriers at the organizational level

Structural and organizational barriers arising from different funding of institutions and services could complicate continuous service provision throughout different phases of life as mentioned by one professional (e.g., children's transition from kindergarten to school required new formal applications for certain services like integration assistants due to different responsibilities and associated funding models) (quote #10). Some institutions (e.g., school psychological counseling center) had specific areas of responsibility and referred CYF to other services when topics did not fall within their area of responsibility (quote #11). Both barriers could complicate access (e.g., by delaying or interrupting service use).

(D) Barriers at the system level

At the system level, professionals identified practical and logistical (e.g., long distances to services, especially for families facing financial difficulties in meeting transportation costs or time constraints with multiple children needing support), and resource-related barriers (e.g., long waiting times mentioned by several professionals, lacking availability or low-threshold accessibility of services, areas being underserved with specific services, and lacking human and financial resources to deliver or scale services) (quotes #12–14).

3.2. Intersectoral perspective on barriers

The intersectoral perspective of professionals from the health, education, and social sectors illustrated the complexity of barriers to accessing and using psychosocial services for CYF. Some barriers were commonly perceived by professionals from all sectors, such as insufficient knowledge about services, lacking communication, data protection regulations, language barriers, and long waiting times. However, other barriers were primarily recognized by professionals from certain sectors. For example, professionals from the health sector often reported limited time and a lack of feedback from other diagnostics hindering their ability to adequately support CYF. In the education sector, professionals highlighted families' struggle to talk openly about psychosocial problems, emphasizing the need to build trusting relationships with CYF and assist them in understanding medical reports. Meanwhile, professionals

Table 2
Quotes of the professionals in the interviews from institutions in the health, education, and social sectors from the two study districts in Germany characterized by socioeconomic challenges, high immigration, and poverty in 2024 [translation by authors].

#	Level	Category of barriers	Quote
1	Client	Psychological	'And I think the same applies to parents. I'm sure there are also parents who perhaps don't know much about us or don't have a clear idea of what we do here or are ashamed. So, whenever it's about money, that's a big shameful topic. Or also under conditions of separation. There are some parents who are so worried that they just want support and then talk openly about all their problems. But there are also other parents who feel sorry and so uncomfortable that they don't want to tell anyone about it out of shame and would rather try to fight through it themselves.' (school social worker 1, elementary school, region 2, social sector)
2	Client	Psychological	'This is a group for children of parents with mental stress. We consciously called it that because it used to be called a group for mentally ill parents. On the one hand, however, this often discouraged and deterred parents from getting their children involved. Because it's just not nice to come out like that sometimes. And on the other hand, the new wording somehow no longer means that you definitely need a diagnosis beforehand, right? Which, as we have just reported, is sometimes not so easy to find an insight into the illness or problem and then have a diagnosis made. That's why parents with mental stress.' (social pedagogue, outpatient youth welfare center, region 1, social sector)
3	Client	Information and communication	'And the more contact we have with the parents, the more they talk to us about it and tell us what their problems are. And where they might also have something, so that we're now in the process of dealing with it openly. To see what the families need, what is going on and that they tell us about it. Because I believe that, first and foremost, it has to come from the parents, that they are willing to talk to us about it and create trust that we can support them.' (early childhood educator 1, kindergarten, region 1, education sector)
4	Client	Information and communication	'It's often the case that parents come with referrals, for example. And they don't even know where to go with them. So, if a family has a referral to pediatric audiology, some of them don't even know what it is. They don't know where to call. (…) and the parents don't get that/ so somehow, it's not communicated that they know who to contact and where they can make an appointment. And that's why they often just don't go there because they don't know where to go.' (early childhood educator 1, kindergarten, region 1, education sector)
5	Client	Information and communication	'That's where I provide support. Because many of my parents aren't literate either, or can't read what it says or fill it in to the best of their knowledge and belief. But we've often had applications sent back because something was missing or filled in incorrectly. And if they were to go to the collection point where it could be filled in, it's in the center of [city], that's a long way. And it was closed for a very, very long time. It's only now opening again. Or it's best to make an appointment by phone in advance, as many parents have already reached their limits. And even if I don't like doing it, because I think there's nothing more boring than always filling out the same forms, it's important work.' (school social worker 1, elementary school, region 1, social sector)
6	Client	Information and communication	'Sometimes the parents are already well connected to other services, but not always. So, some parents, in the course of the support, we first realise that there is probably a mental illness, but it has not yet been diagnosed, so we first have to find out what it actually is that we have encountered. And then to find this contact with the various providers in this psychiatric system, to find the best possible connection and to motivate the parents to make regular use of these services. So that's a very important focus.' (pedagogue and systemic counsellor, meeting center, region 2, social sector)
7	Provider	Information and communication	'There are so many different sites and not everyone has every other site on their screen. So yes, no, more overview for everyone, who does what when and why. Like this. And I don't think some clients can see through it at all.' (psychologist 1, school psychological counseling center, region 1, social sector)
8	Provider	Collaboration	"Yes, of course, data protection is an issue. Then you either have to make a release from the duty of confidentiality or, if it is a medical institution, then the referral is actually sufficient for the exchange of information, right? […] we always write on it: 'Please report'. So that you simply get this feedback on what has been found, what is planned, what recommendation. And sometimes it's a bit tough and, yes, like chewing gum, isn't it?" (pediatrician, outpatient practice, region 1, health sector)
9	Provider	Collaboration	"Sometimes kindergartens don't know us, they don't know we exist. But sometimes / so I often approach the kindergartens when there are any problems with the children and say: 'Oh dear, let's go to the kindergartens and ask the nursery teachers how things are going

(*continued on next page*)

Table 2 (*continued*)

#	Level	Category of barriers	Quote
			there.' And then we have a joint discussion with the parents at the kindergarten. I really like doing that. Because the teachers are the professionals, and I rely on them a lot." (couple and family therapist, family counseling center, region 2, social sector)
10	Organizational	Structural and organizational	'Ultimately, it's always about money in terms of funding. (…) if I have a child who has integration support in kindergarten and then the transition to school, yes? Most people would somehow assume that this is a difficult situation for the child and the family. And that if the child was already so conspicuous in kindergarten, it might need integration support, that it might be the same when they start school. But in kindergarten this is funded at national level and in school at municipal level. This means that a new application has to be made. […] it's just these different sponsors.' (child and adolescent psychiatrist, outpatient practice, region 1, health sector)
11	Organizational	Structural and organizational	'The other criterion that differentiates us is if the problem that is brought to us mainly becomes visible at school or arises at school. There are of course problems that are also present at school, but also elsewhere. Then we might refer them to the family counseling Centre, for example. So, if a child, (…) I'm just thinking about it. Let's say a child has eating problems and they also show up at school, but they also show up at home and in the club and everywhere. In that case, we wouldn't feel responsible for counseling the family.' (psychologist 1, school psychological counseling center, region 1, social sector)
12	System	Practical and logistical	'Because I simply realised that it's within walking distance from here, that's two minutes, so I know that the parents will definitely arrive. It's not a complicated route. Many people walk past it. And then an afternoon programme can also take place there.' (school social worker 1, elementary school, region 1, social sector)
13	System	Resource-related	'So, the waiting times just for diagnostics by a child and adolescent psychiatrist, which is always a prerequisite for some other options, are easily six months or more.' (occupational therapist, occupational therapy practice, region 1, health sector)
14	System	Resource-related	'But the staff aren't even there to look after the group. They can't realise such services on top of that. I think that's real / staff shortages make a huge difference to mental health development.' (social worker, family counseling Centre, region 1, social sector)

in the social sector frequently pointed to challenges regarding funding complicating both access to services and the continuity of care for CYF.

4. Discussion

This study examined barriers to access and use of preventive mental health and psychosocial support services by CYF with psychosocial strains from the perspective of professionals from the health, education, and social sectors. Identified barriers were assigned to operational levels at which they occurred. While client-level barriers are well-reported in studies analyzing the client perspective, this study provides valuable insights into barriers at the provider, institutional, and system level. From a professional perspective, new findings on barriers at the client level are the clients' reluctance to communicate psychosocial challenges and problems and the potentially deterrent effect of service names.

Psychological barriers at the **client level** align with previous studies from the clients' perspective (Radez et al., 2021; Boydell et al., 2006; Reardon et al., 2017). Their interactions with information and communication barriers hinder client-professional communication and adequate support, also described in previous studies (Reardon et al., 2017; Roberts et al., 2013; Gondek et al., 2017; Ekornes, 2015). Clients' prejudices toward institutions reflect Levesque et al.'s (2013) framework, where service acceptance affects use (Levesque et al., 2013). Professionals emphasized trust-building to foster communication and reduce prejudices (Reardon et al., 2017). Limited service knowledge among clients and professionals restricted access to services (at the client level) and referrals (at the provider level), aligning with prior research (Gulliver et al., 2010; Radez et al., 2021; Boydell et al., 2006; Reardon et al., 2017; Roberts et al., 2013; Ekornes, 2015; Hall et al., 2021). This highlights the importance of service information in overcoming access barriers (Levesque et al., 2013).

At the **provider level**, collaboration barriers like reduced collaboration, limited service-knowledge, and poor communication hinder access and use of services, consistent with previous studies (Hall et al., 2021; Viklund et al., 2023; Richter Sundberg et al., 2024; Rawlinson et al., 2021; Fraser et al., 2022). Regular, intersectoral meetings can help overcome collaboration barriers by fostering information exchange, structured collaboration, mutual familiarization and trust (Viklund et al., 2023; Richter Sundberg et al., 2024; van Dale et al., 2020). To allow sufficient time for regular meetings, communication and the development of a professional network, measures for time management and integrating networking into daily work are needed (van der Vliet et al., 2022).

At the **organizational level**, barriers to service use due to different funding and responsibilities across sectors align with previous studies (Rawlinson et al., 2021; Shoesmith et al., 2021). Not many barriers at organizational level were mentioned in the interviews. This could be related to the selection of interview participants (e.g., head of institution) as they would have criticized themselves if organizational barriers, such as the management's lack of support or not allowing time for collaboration, had been raised.

At the **system level**, barriers identified by professionals and those identified by parents and young people aligned (Gulliver et al., 2010; Reardon et al., 2017). When looking at the practical and logistical barriers (e.g., long distances, lack of transportation, high travel costs), accessibility is an important factor influencing service use (Gulliver et al., 2010; Boydell et al., 2006; Reardon et al., 2017; Eigenhuis et al., 2021; Owens et al., 2002). As geographic location can limit service access, it is important to offer services close to families or transport options (Levesque et al., 2013). Resource-related barriers, like the complete lack of services or long waiting lists, were also described by both professionals and parents (Gulliver et al., 2010; Boydell et al., 2006; Goodcase et al., 2022; Reardon et al., 2017; Platell et al., 2020).

The results of this study emphasize the multidimensional perspective on access of psychosocial services as shown in Levesque et al.'s (2013) framework. Information on services (necessary for CYF to access services

and for professionals to make referrals), values and beliefs (CYF need to accept institutions and their services) and geographical location (services need to be available within reach) play an important role in service access as also seen in our study (Levesque et al., 2013). From a process perspective, some barriers primarily affected access (e.g., fear of stigmatization, feeling ashamed using services), while others primarily influenced (continuous) service use (e.g., financial barriers or geographical distance) (Levesque et al., 2013).

4.1. Recommendations for public health practice

Our findings show that barriers to accessing and using psychosocial services interact across the client, provider, organizational, and system levels. Barriers should be addressed at several levels to promote psychosocial prevention in CYF. For instance, psychological barriers from service names could be overcome at the **organizational level** by using target-group-oriented names internally (i.e., within an institution) and externally (i.e., to clients). **System level** barriers (e.g., distance to services) and client level barriers (e.g., time constraints) could be addressed at the **provider level** through one-stop-shop models of co-located services facilitating access to services across sectors (e.g., offering youth welfare services in schools).

With barriers existing across sectors, integrated approaches could address them collectively. Social prescribing is one such model bridging sector gaps by facilitating referrals of CYF from the health sector to community-based services in education or social sectors like parenting programs or leisure activities (Muhl et al., 2023). This promotes cross-sector collaboration and addresses social determinants of health (e.g., social isolation) fostering a holistic health approach (Muhl et al., 2023).

Another intersectoral solution is fostering collaboration between professionals to improve referrals and enable one-stop-shop service models. This includes building intersectoral networks, holding regular meetings, offering joint training (e.g., on regional services), and clarifying legal frameworks for collaboration. A local networking centre – integrated into or separate from municipal or communal welfare services – could coordinate care, financing, and networking based on local needs.

Professionals must know about local services and contacts to refer CYF appropriately. Furthermore, clients need information about available services to access them. A regularly updated regional service map could be useful in this process (Romero-Lopez-Alberca et al., 2019). Making this overview available to both groups may reduce knowledge-related barriers.

4.2. Strengths and limitations

Integrating professionals' perspectives from the health, education, and social sectors provides a comprehensive view of barriers to service access and use, complementing existing research, which primarily focused on the client's perspective.

Limitations include a small sample size due to the study's regional scope, potentially limiting the generalizability of findings, particularly to broader contexts. The focus on two districts allows an in-depth, context-sensitive analysis, but the results cannot be easily transferred to other districts or countries. Lack of incentives may have reduced participation and led to selective responses, particularly among professionals with high workloads. Few operational-level professionals were included, further limiting representativeness. Oftentimes, more women than men work in areas for children and young people, thus female interviewees are probably overrepresented in our study. As the study focused on professionals, the client perspective is missing, but we compared our findings with client-focused studies to address this.

5. Conclusion

This study analyzes barriers to accessing and using preventive mental health and psychosocial support services for psychosocially strained CYF from the perspective of professionals from the health, education, and social sectors. As the identified barriers interact across the four operational levels specified, they need to be tackled in combination through integrated and holistic approaches (e.g., informing professionals about regional services so that they can inform CYF and make referrals across sectors). Particularly noteworthy are barriers identified at the **provider level** (e.g., barriers to collaboration). Intensive collaboration and communication have the potential to increase service access and use for CYF, as professionals can refer to other services when well-informed.

CRediT authorship contribution statement

A. Reinhart: Writing – original draft, Visualization, Project administration, Investigation, Formal analysis, Conceptualization. **A. Alayli:** Writing – review & editing, Visualization, Supervision, Conceptualization. **S. Beierle:** Writing – review & editing, Project administration, Investigation, Formal analysis. **A. Löffler:** Writing – review & editing, Formal analysis. **B. Reißig:** Writing – review & editing, Conceptualization. **S. Walper:** Writing – review & editing, Funding acquisition, Conceptualization. **S. Kuger:** Writing – review & editing, Funding acquisition, Conceptualization. **F. De Bock:** Writing – review & editing, Supervision, Resources, Methodology, Funding acquisition, Conceptualization.

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Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ypmed.2025.108392.

Data availability

The authors do not have permission to share data.

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