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RESEARCH ARTICLE

Predictors of barriers to accessing youth mental health and/or addiction care

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Abstract

Background: It is estimated that 1.2 million Canadian youth are affected by mental health and/or addiction issues; yet only a small proportion of young people receive appropriate and specialized treatment. Given caregivers are often tasked with navigating the complex mental health and/or addiction care systems for their youth, it is important to identify and understand the characteristics, such as those related to youth and their families, that are associated with caregivers' perceived barriers to accessing youth mental health and/or addiction services. **Objective:** The objective of this cross-sectional survey study was to examine the unique predictors of caregivers' perceived barriers to accessing youth mental health and/or addiction services. **Method:** Participants were 259 caregivers of at least one youth, aged 4 to 29 years (M_{age} = 16.7, *SD* = 5.3) with mental health and/or addiction issues in Ontario, Canada identified from a community-based online survey. **Results:** Regression results showed that caregivers' demographics (i.e., living in a rural area, having an education level of college/university degree or higher), youth having concurrent issues, and service use patterns (i.e., currently accessing and/or seeking services) significantly predicted a higher level of barriers to accessing mental health and/or addiction services. **Conclusion:** In order to improve access to care for youth with mental health and/or addiction issues, understanding the predictors of barriers to accessing appropriate services is an important step in making services more accessible for youth and families.

Key Words: *mental health, help-seeking, youth, caregivers, barriers*

Résumé

Contexte: On estime à 1,2 million le nombre de jeunes canadiens qui sont affectés par des problèmes de santé mentale et/ou de dépendance; et pourtant, seule une petite proportion de jeunes gens reçoit un traitement approprié et spécialisé. Étant donné que les soignants sont souvent chargés de naviguer dans les systèmes de soins complexes de santé mentale et/ou de dépendance pour leurs jeunes, il est important d'identifier et de comprendre les caractéristiques, comme celles qui sont liées aux jeunes et à leur famille, qui sont associées aux obstacles perçus par les soignants à l'accès aux services des jeunes en santé mentale et/ou dépendance. **Objectif:** L'objectif de la présente étude par sondage transversal était d'examiner les prédicteurs uniques des obstacles perçus par les soignants à l'accès aux services des jeunes en santé mentale et/ou dépendance. **Méthode:** Les participants étaient 259 soignants d'au moins un jeune âgé de 4 à 29

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ans ($M_{âge}$ = 16,7, *ET* = 5,3) avec au moins des problèmes de santé mentale et/ou de dépendance en Ontario, Canada, identifiés depuis un sondage en ligne communautaire. **Résultats:** Les résultats de la régression ont montré que les données démographiques des soignants (c.-à-d., vivre en milieu rural, avoir un niveau d'instruction de diplôme collégial/universitaire ou mieux) des jeunes ayant des problèmes concurrents, et des modèles d'utilisation des services (c.-à-d., accéder et ou rechercher des services présentement prédisait significativement un niveau plus élevé d'obstacles à l'accès aux services de santé mentale et/ou de dépendance. **Conclusion:** Afin d'améliorer l'accès aux soins pour les jeunes ayant des problèmes de santé mentale et/ou de dépendance, comprendre les prédicteurs des obstacles à l'accès aux services appropriés est une étape importante pour rendre les services plus accessibles aux jeunes et aux familles

Mots clés: *santé mentale, recherche d'aide, jeunes, soignants, obstacles*

Introduction

Many mental health and addiction problems have an early onset in childhood and adolescence; thus, early identification and intervention for mental health and/or addiction issues are important to improve youth's outcomes (1,2). However, a significant portion of families in Canada struggle to find help for their youth with mental health issues and experience difficulties in accessing support for their youth (3). Untreated mental health and/or addiction issues can add significant stress to the youth and their families (4) and create economic burden for society (5). Identifying and understanding the factors that are associated with barriers to accessing youth mental health and/or addiction services are crucial for service implementation to support families in navigating the mental health and/or addiction system.

Caregivers and family members play a significant role in recognizing the signs of mental health and/or addiction needs, as well as in navigating the complex mental health and/or addiction system for their youth (6). Recognizing that youth typically rely on their caregivers to seek support on their behalf, there are increasing interests in identifying caregiver-reported barriers to accessing youth mental health and/or addiction services. Recent systematic reviews highlighted a few major areas of barriers that parents perceived when they were accessing professional help for their child's mental health, including: systemic and structural issues (e.g., long wait times, cost of services, appropriate services were not available), experiences and perceptions of services (e.g., confidence in professionals, feelings of not being supported by professionals), knowledge about mental health and the process to navigate the mental health system (e.g., parents' perception of the severity and impact of child's problems, limited information on how to seek help), and family characteristics (e.g., living in rural area, language spoken by the family) (7,8). Overall, these studies illustrated the many barriers parents perceived in their help-seeking process and highlighted the need for improvement to the mental health and/or addiction care system.

Given research has shown that parents often have to be extremely persistent in overcoming different barriers to accessing appropriate mental health and/or addiction support for their youth (9), it is important to understand what characteristics, such as those related to youth and their families, are associated with these barriers among families. Previous research has shown that parents who reported barriers related to perceptions of mental health services (e.g., did not know whom to trust, child did not want to go) were more likely to be divorced and perceive more difficulties with parenting their child than those who did not report any barriers (10). Characteristics related to the youth, such as their diagnoses and personal vulnerabilities associated with their mental health and/or addiction issues, may also influence families' help-seeking experiences and barriers to care (9,11).

In Ontario, mental health and/or addiction services are offered through a variety of providers, including community-based mental health agencies, outpatient units or hospital based programs, schools, Children's Aid Societies, and private-sector service providers (12). Treatment from a family physician or a psychiatrist is covered by public health insurance (i.e., OHIP in Ontario). The costs of treatment from other mental health professionals (e.g., psychologist, psychotherapist, social workers) vary significantly in both the child and youth and adult mental health and addiction systems, depending on various factors, such as funding structure of the two systems, government funding available for the program, individual's insurance coverage, etc (13). Within the child and youth mental health and/or addiction system, youth typically age out of public services at age 18 (14). However, there are significant overlaps between the child and youth and adult mental health and/or addiction services and the age of transition out of child and youth services varies greatly among services in the public

and private sectors (15). Given the lack of continuity and integration between the child and youth and adult mental health services in Ontario, we were interested in the needs and service preferences of caregivers of a wide age range of youth with mental health and/or addictions concerns in Ontario, Canada (16). In our larger study (16), we have identified the barriers experienced by caregivers when accessing the appropriate mental health and/or addiction care for their youth. In the current study, we built on the larger study (16) and aimed to explore the youth, caregiver, and service use characteristics that were associated with these caregiver-reported barriers. Examining all these characteristics simultaneously will help to identify families who are more affected by barriers in their help-seeking process and further inform targeted interventions to ensure these families receive appropriate mental health and/or addiction care for their youth.

Methods

Participants and Design

This was a cross-sectional survey study of the province of Ontario, Canada. A detailed description of the study participants and procedures is documented in the publication of the full study (16). Eight hundred and forty caregivers age 35 to 65 in Ontario reported having at least one youth aged 30 or under who were currently their dependents and responded to the online questionnaire. A subset of 259 participants (30.83%, M_{age} = 45.93, SD = 7.11, Range = 35-63) were identified as caregivers of at least one youth with mental health and/or addiction concerns and completed the full survey. The subset was composed of all those caregivers who reported "1 or more" to the following two questions: "how many youth ages 30 or under are currently your dependants?" and "please indicate how many of these youth have any emotional, behavioural, mental health and/or substance use issues of concern" on the survey.

Procedure

We employed Lightspeed GMI, a participant panel service, to recruit adults who were between the ages 35 and 64, residing in Ontario, and caring for at least one youth up to age 30. We included caregivers of youth up to age 30 and with mental health and/or addiction issues in our analysis to fully capture the experiences of caregivers who were seeking support for their youth within the child and youth mental health and/or addiction care system. Without an integrated and coordinated transition system linking child and youth-serving and adult-serving mental health and/or addiction services in Ontario, many youth could be receiving support from child and youth mental health and/or addiction services until the age of 30 (17).

In terms of recruitment, a total of 41, 700 individuals who met the target criteria were invited to complete an online questionnaire hosted on SurveyMonkey®. The survey had a response rate of 2%, with a total of 840 caregivers, with or without youth mental and/or addiction concerns, responding to the survey. In the full study, we compared the frequencies of key demographic variables (e.g., gender, marital status) of our survey sample and the general population of Ontario (16). The results indicated that the sample was representative of the general Ontario population as the differences on these key demographic variables were no greater than 10% (i.e., within acceptable margins). All participants provided written consent and completed the background questionnaire. Participants who were identified as caring for at least one youth with mental health and/or addiction concerns answered additional questions regarding their mental health and/or addiction service use and needs for their youth of greatest concern. The questionnaire took approximately 20 minutes to complete. This study was approved by the Research Ethics Board at Sunnybrook Health Sciences Centre.

Measures

Survey items were informed by a comprehensive literature review on families' experiences in accessing youth mental health and/or addiction services and consultation with a team of graduate-level clinicians in youth and family mental health and/or addictions care. The survey was then piloted with a group of five caregivers who had experiences navigating the mental health and addiction system for their youths in Ontario to obtain feedback on the readability and comprehensiveness of the survey. Details regarding the development of the measures used can be found elsewhere (16). The full questionnaire is available on request from the authors.

Caregiver demographics. Participants provided information about their age, gender, relationship status, education level, size of their community, and their relationship with the youth.

Youth demographics and clinical characteristics. Participants provided information about their youth's age and gender. They were given an extensive list of diagnoses and were asked to indicate on the list the diagnoses their youth had received from a professional. Due to the extensiveness of the list, we have categorized the youth into five groups based on their diagnosis types: 1) mental health diagnosis only, 2) developmental diagnosis only, 3) mental health and developmental diagnoses, 4) substance use diagnosis only, and 5) concurrent issues (i.e., co-occurring mental health

and substance use problems). Details of the diagnoses classified under each group is included in Table 2. Participants also selected from a list of emotional, behavioural, mental health and substance use concerns that applied to their youth.

Mental health and/or addiction service use patterns. Participants indicated the types of mental health and/or addiction assessment and treatment that they were currently accessing and/or seeking for their youth from a list (e.g., treatment from a psychologist, in-patient hospital treatment program) and whether they were on any wait-lists for services.

Barriers to accessing appropriate mental health and/or addiction care. Participants rated their agreement with eight statements on barriers to accessing the appropriate mental health and/or addiction care for their youth on a scale of 0 (*not applicable*), 1 (*strongly disagree*), 2 (*somewhat disagree*), 3 (*neutral*), 4 (*somewhat agree*), and 5 (*strongly agree*). A score of 0 *(not applicable)* indicated that the participants did not experience the barrier at all. These statements were developed based on the literature on barriers to accessing mental health and/or addiction service for families (18). This included items such as "the cost of services is a barrier" and "the most appropriate treatment options are not readily available." A complete list of items was included in Table 3. A total score of barriers was computed by summing all items on the scale. The total score ranges from 0 to 40. A higher total barrier score indicated greater level of barriers perceived by the caregivers in accessing mental health and/or addiction services for their youth. This barrier scale had excellent internal consistency (α = .86). No other psychometric assessment was made of this scale.

Statistical Analyses

Descriptive statistics were calculated for all variables. Variables related to the caregiver's demographics (i.e., single parent status, employment status, size of the community, and level of education), youth's clinical characteristics (i.e., the presence of a mental health diagnosis, a developmental diagnosis, mental health and developmental diagnoses, a substance use diagnosis, and concurrent issues (co-occurring mental health and substance use problems) and number of presenting mental health and/or addiction issues) and mental health and/or addiction service needs (i.e., whether families were currently receiving and/or seeking services, whether families were on a wait-list for services) were entered into the linear regression model. These variables were selected theoretically based on the literature on predictors of mental health service use and barriers among youth. Independent categorical variables (e.g., caregiver's education level) with more than two levels were recoded as dichotomous variables. All linear regression assumptions were met. The data supporting the findings are available from the corresponding author upon reasonable request.

Results

Caregiver and Youth Demographics and Clinical Characteristics

The majority of the caregivers were female (70.7%), married (84.2%), and employed (76.4%). A total of 41 caregivers (15.8%) were in a single parent family and 154 caregivers (59.5%) lived in an urban area (i.e., population > 100,000 people). Approximately half of the caregivers (50.6%) completed at least a college or university degree. Table 1 outlines the demographic characteristics of these caregivers. Youth age ranged from 4 to 29 years (M_{age} = 16.7, *SD* = 5.3) and the majority of youth were male (62.5%). The most frequently reported diagnoses that the youth had received from a professional were mental health diagnoses, such as depression and generalized anxiety disorder. A quarter of the youth had concurrent issues. The most frequently reported substances used in an unhealthy or excessive manner were cannabinoids, cigarettes/nicotine, and alcohol. The most frequently reported issues of concern were difficulties with academics, outbursts of anger or rage, and difficulty sleeping. The mean number of issues of concern was 7.38 (*SD* = 5.3). Table 2 outlines the demographics and clinical characteristics of the youth with mental health and/or addiction issues.

Service Use Pattern and Barriers

Of the 259 participants, 60.2% (n = 156) were accessing mental health and/or addiction services and 64.5% (n = 167) were seeking these services. One-fifth of the sample (21.2%) were on a wait-list for a service. The total barrier score reported ranged from 0 to 40 and the mean total barrier score was 19.26 (*SD* = 9.65). Youth's motivation, availability of most appropriate treatment options, and cost of services were the most frequently reported barriers (Table 3).

Predictors of Barriers to Mental Health and/or Addiction Services

Variables that independently and significantly predicted greater levels of perceived barriers were: a youth with concurrent issues (B = 5.94, p < .001), seeking youth mental health and addiction services (B = 7.42, p < .001), accessing youth mental health and addiction services (B = 2.96, p = .009), caregivers having an education level of college/university degree or higher (B = 2.91, p = .006), and families living in a rural area (B = -2.97, p = .004). The overall

Table 1. Demographic characteristics of caregivers

Demographic	Caregiver % (n)
Gender	
Female	70.7 (183)
Male	29.3 (76)
Single parent status	
No	84.2 (218)
Yes	15.8 (41)
Education	
College/university degree or higher	50.6 (131)
Less than a college/university degree	49.0 (126)
Employment status	
Employed	76.4 (198)
Unemployed	18.9 (46)
Size of community	
Urban	59.5 (154)
Rural	40.5 (105)
Number of youth with mental health and/or addiction issues	
One	79.9 (207)
Two	17.0 (44)
Three or more	3.1 (8)

model accounted for 37.5% of the variance in perceived level of barriers to accessing appropriate mental health and/or addiction services (Table 4).

Discussion

In our study, more than 60% of the caregivers were accessing and/or seeking services for their youth with mental health and/or addiction needs. Consistent with previous research (7,19), youth's (lack of) motivation, availability of most appropriate treatment options, and cost of services were most frequently identified by caregivers in our study as barriers to accessing appropriate support for their youth. While the availability and costs of services are widely recognized barriers to mental health and/or addiction services (7), there is relatively limited research on youth's lack of motivation as a barrier to accessing help (20). A recent qualitative study of Canadian transition-aged youth showed that negative past experiences with the mental health and/or addiction system (e.g., lack of success in accessing mental health support, feeling hopeless about their help seeking process due to long wait times and high costs) and a lack of recognition of the importance of seeking help for their mental health problems may reduce youth's motivation to pursue help for their mental health concerns (21). On the other hand, youth who are connected with others who have sought help for their own mental health problems may have a more positive attitude towards seeking help for their mental health and/or addiction concerns (22). Our result is a noteworthy finding as it suggests that promoting youth's motivation to initiate and participate in treatment may be an effective way to improve youth's access to treatment within the current mental health and/or addiction system. Given that youth's lack of motivation was the most endorsed barriers by caregivers in our study, future research is needed to better understand factors that facilitate and hinder youth's motivation to seek and access professional support and explore ways, such as utilizing youth-led research and program development to enhance their motivation to engage in treatment (23).

We identified several factors that significantly predicted a higher level of perceived barriers to accessing mental health and/or addiction services among families. Consistent with existing studies, the presence of youth's concurrent issues emerged as a significant predictor of high level of perceived barriers. Youth with concurrent issues often do not perceive their substance use as a problem or may not recognize the need to seek or access mental health and/or addiction treatment and support (24). Further, individuals with co-occurring mental health and substance use problems usually present with complex needs that require support from separate treatment settings (25). Some mental health and/or addiction facilities also require youth to be abstinent from substances for a certain period to be eligible to enter their programs, further reducing the number of services that can accommodate youth's concurrent needs and create barriers in accessing services (25,26). Indeed, youth's (lack of) motivation and limited availability of appropriate treatment were commonly identified barriers experienced by families in the current study, suggesting that strategies to build trust with youth and increase coordination and integration of the mental health and addiction services are needed to support youth with concurrent issues.

In terms of service use patterns, families who were currently seeking mental health and/or addiction services reported a greater level of barriers to accessing mental health and/or addiction care than families who were not seeking support. These families involved in the help-seeking process might experience difficulties in identifying their youth's problems as well as knowing where or how to seek help (7,27). These caregivers might have been more actively involved in navigating the mental health and/or addiction systems and had more opportunities to encounter barriers in accessing appropriate services for their youth as compared with families

Table 2. Demographic and clinical characteristics of youth with mental health and/or addiction issues

Variable	Youth % (n)
Gender	
Male	62.5 (162)
Female	36.7 (95)
Transsexual/Gender non-conforming	0.8 (2)
Diagnosis type	
Mental health diagnosis only	54.8 (142)
Developmental diagnosis only	37.5 (97)
Concurrent issues	25.5 (66)
Mental health and developmental diagnoses	12.4 (32)
Substance use diagnosis only	0.4 (1)
Addiction concerns	
Cannabinoids	21.2 (55)
Cigarettes/Nicotine	18.5 (48)
Alcohol	14.7 (38)
Prescription narcotics	4.2 (11)
Stimulants	3.9 (10)
Club drugs	1.5 (4)
Hallucinogens	1.5 (4)
Other prescription drugs	1.5 (4)
Non-prescription opioids	0.8 (2)
Dissociative drugs	0 (0)
Issues of concerns	
Difficulties with academics	49.6 (126)
Outbursts of anger or rage	41.3 (105)
Difficulty sleeping	40.6 (103)
Lacking energy or motivation	39.4 (100)
Worrying constantly	38.6 (98)
Frequent or abnormal mood swings	38.2 (97)
Excessive technology use	37.8 (96)
Poor concentration or memory	33.5 (85)

Notes. Mental health diagnosis only included youth with the following diagnoses: depression, dysthymic disorder, generalized anxiety disorder, obsessive compulsive disorder and/or trichotillomania, panic disorder, bipolar disorder, anorexia nervosa, bulimia nervosa, post-traumatic stress disorder, schizophrenia, schizoaffective disorder, dissociative disorders, adjustment disorder, personality disorder, and other mental health disorders
Developmental diagnosis only included youth with the following diagnoses: attention deficit/hyperactivity disorder, oppositional defiant disorder, conduct disorder, and autism spectrum disorder, and other intellectual disability
Developmental and mental health diagnoses included youth with at least one mental health diagnosis and one developmental diagnosis.
Substance use diagnosis only included youth with alcohol/substance abuse and/or dependence.
Concurrent issues included youth with mental health diagnosis and alcohol/substance abuse and/or dependence and youth with a mental health diagnosis and are using legal and/or illegal substances in an unhealthy or excessive manner. Fifteen youth in this category also has at least one developmental diagnosis.

Table 3. Perceived Barriers to Accessing the Appropriate Mental Health and/or Addiction Services for Youth

Barriers		Caregivers' Perceived Barrier Scores		Number of participants who have indicated that they did not experience the barrier at all (i.e., selected N/A)
		M	SD	
1.	Youth's motivation to participate in mental health care	3.12	1.74	30
2.	Most appropriate treatment options are not readily available	2.71	1.66	35
3.	Costs of services	2.65	1.84	46
4.	Youth's knowledge about the mental health and addictions care system	2.50	1.70	51
5.	Caregiver's lack of knowledge about the mental health and addictions care system	2.47	1.56	32
6.	Confidentiality issues (i.e., unable to discuss this youth's personal health information with the people involved in care without the youth's consent)	2.31	1.80	53
7.	Youth's geographical location	1.99	1.65	61
8.	Availability of culturally-sensitive services	1.49	1.62	99
	Barriers total score	19.26	9.65	

Participants were asked to indicate the extent to which they agree or disagree with the statements that describe the different barriers to finding the right mental health and/or addiction care for their youth. They were provided with the following options to indicate their response: 0 (not applicable), 1 (strongly disagree), 2 (somewhat disagree), 3 (neutral), 4 (somewhat agree), and 5 (strongly agree). A higher score indicated greater level of barriers perceived by the caregivers.

Table 4. Linear regression predicting level of barriers experienced by families with youth with mental health and/or addiction concerns

Predictors	B	SE B	β	*t*	*p*
Has concurrent issues (Yes/No)	5.94	1.41	.27	4.22	< .001
Currently seeking services (Yes/No)	7.42	1.14	.36	6.49	< .001
Currently accessing services (Yes/No)	2.96	1.12	.15	2.64	.009
Caregiver's education level of college/university degree or higher (Yes/No)	2.91	1.06	.15	2.75	.006
Living in an urban area (Yes/No)	-2.95	1.03	-.15	-2.88	.004
Currently on a wait-list (Yes/No)	-1.56	1.32	-.07	-1.19	.237
Employed (Yes/No)	1.80	1.36	.07	1.32	.187
Has a mental health diagnosis only (Yes/No)	.74	1.54	.04	.48	.633
Single parent status (Yes/No)	.61	1.39	.02	.44	.660
Has a developmental diagnosis only (Yes/No)	.82	1.55	.04	.53	.598
Has a mental health and developmental diagnoses (Yes/No)	.05	2.37	.00	.02	.982
Number of issues of concerns	.08	.10	.05	.82	.412

who were not seeking support (28). On the other hand, it is noteworthy that caregivers who were accessing services reported a greater level of barriers than those who were not accessing services. These caregivers who were accessing services might have reflected on the many barriers they had experienced and the onerous process they had navigated before they were able to obtain appropriate support (9). Further, these caregivers might have youth with more severe concerns, which might make the help-seeking process more challenging for the caregivers and leading to more barriers experienced (29). Despite currently receiving support, the caregivers might also feel that their youths' mental health and/or addiction needs were not fully met or the services they received were not satisfactory; thus, contributing to more barriers to accessing services experienced by the caregivers (30). More research is needed to further examine the needs of these families of youth with mental health and/or addiction issues who were accessing and seeking services and the specific barriers that they encountered in accessing appropriate services for their youth. A better understanding of how identified barriers may change over time and with different levels of experience to the mental health and/or addiction care system can also be crucial to inform practices to support families across different stages of the help-seeking process.

Consistent with well-established research on service use, results from this study demonstrated that families living in rural communities faced greater barriers accessing mental health and/or addiction services for their youth when compared to families living in urban communities. The inaccessibility of mental health and/or addiction care in rural areas may be due in part to the limited number of mental health professionals available in rural areas (31,32). Further, individuals living in rural communities tend to experience a greater level of stigma and a lower sense of anonymity when accessing mental health and/or addiction treatment (18,33), which can prevent families in rural communities from accessing service providers that they trust and with whom they feel comfortable. Thus, improving access for families in rural areas may require a more tailored approach to address these specific individual and system factors that impede families from accessing support.

Another caregiver characteristic that predicted families' perceived barriers was the caregivers' educational level, such that caregivers who had completed at least a university/college degree or more reported a greater level of barriers to care than those with less than a university/college degree. This finding was inconsistent with previous research showing that caregivers with higher level of education are better able to identity their youth's mental health needs and navigate the service systems and have more resources to seek out mental health and/or addiction support (34,35). In our study, it is possible that services are less likely to offer support to families with greater resources. For instance, research on children's autism spectrum service use has shown that parents with different levels of education reported similar financial barriers, as caregivers with lower education may be more likely to be qualified for greater coverage for services through public health insurance than their own private insurance (36). Fulda and colleagues (37) also suggested that caregivers with higher education may have overly high expectations for mental health and/or addiction services for their children and are therefore more likely to have unmet expectations and experience barriers related to accessing mental health and/or addiction services. More research is needed to elucidate the influence of caregivers' education levels on their attitudes towards the help-seeking process and the differences in their perceived barriers and actual barriers experienced in their help-seeking process.

Limitations

While the strength of the current study is the examination of the factors associated with caregivers' perceived barriers to accessing care for their youth, the interpretation of the current study's results is limited by the fact that the measure of perceived barriers is new and was created for the study. Although the measure of barriers has excellent internal consistency (Cronbach's $\alpha = .86$) and has face validity (i.e., it was informed by a comprehensive literature review and consultation with clinicians), it might not capture all the barriers experienced by families at all stages of the help-seeking process. Nonetheless, it represents an important step in establishing some of the common barriers experienced by families seeking mental health care. Future research is needed to validate the measure of barriers used in the current study or to establish standardized measures that adequately capture the experiences of Ontario families in the mental health and/or addiction care systems. In addition, this study relied on caregiver's self-report and report of their youth's mental health and substance use issues and service use, which may be subject to recall bias (38). The perceived needs and barriers to care may also differ between caregivers and their youth (39). For instance, a recent study has shown that Australian youth and their parents reported similar perceived need for mental health care; however, they reported different perspectives on the extent to which these needs were met and the barriers to care (39). Future research should examine Canadian caregivers' and youth's perceived needs and barriers to care and their level of agreements for a comprehensive understanding of the gaps in youth mental health and addiction care. Further, all data were collected at one-time point in this cross-sectional

study. Conclusions on the causal effects of caregivers' and youth's demographics, clinical characteristics, and service use patterns on their barriers to care cannot be drawn. Longitudinal studies are essential to examine the factors that contribute to caregivers' perceived barriers to care during different phases of the help-seeking process. In addition, although we have ascertained the sample was representative of the general Ontario population based on a few key demographics variables, our survey response rate of 2% was low. As such, there may be other factors that may influence caregivers' participation in the study, such as their access to resources (e.g., technology, time to complete the survey). Further, it was not possible to obtain thoroughly comprehensive background information about all participants and their family members due to feasibility concerns. For instance, we did not collect information on families' income or socioeconomic status and research has shown that these factors may influence their access and utilization of services (7). Finally, we recruited caregivers of youth up to age 30 to fully capture their experiences within the child and youth mental health and/or addiction system as youth could be receiving support from the child and youth-serving services up to the age of 30 (17). This wide age range of youth could be a limitation to our study as caregivers of youth in different developmental stages may experience different levels of help-seeking barriers (e.g., youth's level of dependence on caregivers' support in accessing help, youth's motivation in accessing services) and report different predictors of these barriers. Given the small sample size of our study, we were unable to conduct sub-group analyses to examine how youth's age might impact predictors of caregivers' reported barriers and more generally, how different family and youth characteristics are associated with different barriers. Future research is needed to further investigate how youth of different ages navigate the mental health and/or addiction system with or without their caregivers' support and their experiences in the help-seeking process. An investigation of the associations between different family and youth characteristics and different types and levels of barriers would also increase our understanding on ways to remove those barriers that prevent specific groups of families from accessing care.

Conclusions

With a large proportion of families' caregiving for youth with mental health and/or addiction issues, identifying the family and youth characteristics and service use patterns associated with the barriers they experience when accessing mental health and/or addictions service will help inform specific strategies to target the obstacles encountered by the families. In spite of the limitations of the study, the findings from this study have several implications for the youth mental health and/or addiction system. First, a coordinated and integrated systems between mental health and addiction services may help to address youth's mental health and substance use issues concurrently and improve youth's ease of access to these services. Second, caregivers who were currently accessing and seeking mental health and/or addiction services for their youth reported a greater level of barriers to accessing appropriate care. Despite the fact that some families being connected with services, families who are navigating the mental health and/or addiction system are not provided with adequate care to meet their needs. Third, while it is well-established in the literature that resources are not sufficiently concentrated in rural areas, less is known about the unique struggles experienced by caregivers with higher level of education. Better understanding of their help-seeking process is needed to ensure these families are equipped with sufficient support and resources to locate mental health and/or addiction services that meet their needs and expectations. Considering caregivers can be "gatekeepers" to mental health and/or addiction services for their youth, policymakers and service providers should continually strive to understand caregivers' experiences in accessing treatment for their youth's mental health and/or addiction issues and the different factors that may hinder their help-seeking processes, in order to improve the accessibility of youth mental health and/or addiction care.

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Conflicts of Interest

The authors no financial relationships or ties to disclose.

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