

Article

Unmet Youth Mental Health Support Needs and Access Barriers During COVID-19: A Longitudinal Quantitative and Qualitative Study

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Abstract

Canadian youth experienced profound impacts to mental health (MH) support throughout the COVID-19 pandemic. Given the risk for long-term negative outcomes from unmet MH needs, it is critical to understand access barriers. The purpose of this study was to explore the longitudinal data and personal narratives on MH challenges, needs and access barriers. The Personal Impacts of COVID-19 Survey was administered to parents regarding their youth at baseline (November 2020–July 2021) and follow-up (November 2021–October 2022). Semi-structured interviews of selected youth and parents were conducted. Quantitative data from 507 baseline surveys, 177 follow-up surveys and qualitative data from 35 interviews were included in the study. A modified explanatory sequential/nested mixed methods design was used to analyze the data. Results showed that the use of MH supports among youth increased between timepoints, although 20% had persisting unmet needs for MH supports at follow-up. Youth described waitlist barriers and difficulties finding the “right” therapist, and parents described significant difficulties navigating the MH system that profoundly impacted their families’ ability to access care and mitigate negative MH outcomes. Increased clinician availability, school MH supports, parental education, and tools for navigating the MH system are needed to better support families.

Keywords: youth mental health; COVID-19 pandemic; mental health services; access barriers; child psychiatry; adolescent psychiatry

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1. Introduction

It is well established that the COVID-19 pandemic had major impacts on Canadians’ mental health (MH) [1–5] and on the provision of MH services [6–9]. The impacts of COVID-19 were particularly profound for adolescent populations, who experienced multiple stressors as a result of both the risks conferred by the SARS-CoV-2 virus itself and the preventative public health measures that were implemented. These stressors occurred during a developmentally crucial life period for youth [10–12]. Changes to daily life and

functioning such as home confinement and the disruption of activities, social isolation, and fear of disease (among other factors) were accompanied by deterioration of MH among young Canadians [11]: rates of Generalized Anxiety Disorder, depression, and Obsessive–Compulsive Disorder (OCD) were multifold of pre-pandemic levels [10], and pre-existing MH conditions typically worsened during COVID-19. Following COVID-19, some studies reported that children and adolescents were more at risk of experiencing MH challenges [5,11,13,14]. However, other studies reported contradictory results, documenting a short-term increase in MH challenges among the youth population [15–17] that recovered to pre-pandemic levels with no long-term adverse effects [17].

The impacts of COVID-19 on MH were further compounded by significant pandemic-related service disruptions that limited access to appropriate MH supports, particularly for vulnerable groups [6,12,18–23], and many youth and young adults experienced difficulty accessing MH support [4,5,15,20]. Timely access to MH care is critical, as delays in treatment are associated with poorer MH outcomes when treatment is eventually provided, and poor MH is also detrimental to other domains of life, including physical health and social and economic development [24,25]. This is particularly concerning given that many MH disorders emerge in adolescence or early adulthood [26]. Earlier age of onset is associated with a longer duration of untreated illness and consequently, poorer outcomes, and potential long-term sequelae [25–29]. Even prior to the COVID-19 pandemic, there have been repeated calls to improve the availability and accessibility of MH supports for youth in Canada, citing long wait times, fragmented care, and shortages of MH professionals [24,25,30,31].

These difficulties accessing MH support were further exacerbated by the COVID-19 pandemic, during which outpatient MH supports were vastly reduced or postponed, access to emergency departments and in-person services were limited, and many MH services pivoted to virtual service delivery [30,32–34]. Some of these disruptions reportedly improved following the earliest waves of the pandemic [32], but many services remained overwhelmed by the increase in MH support needs among Canadians. For example, as of 2021, MH-related outpatient and emergency department visits had increased up to 45% and 30%, respectively, among youth in BC [35]. Furthermore, several studies have documented unmet MH support needs in Canadian youth over multiple timepoints since the onset of the COVID-19 pandemic [10,12,36]. These studies highlight gaps in MH care experienced by young people, but do not explore in depth the barriers that may prevent them from accessing care. Given the impact that COVID-19 has had on youth MH and MH services, and the potential for long-lasting consequences, there is a pressing need to better understand and target access barriers to mitigate negative outcomes in the COVID-19 pandemic era [37].

Therefore, the aim of this study was to explore mental health support needs, barriers, and challenges during and after the COVID-19 pandemic. We conducted initial surveys to collect quantitative data to understand MH needs among Canadian youth following the first wave of the COVID-19 pandemic from November 2020 to July 2021 (T1). Baseline study data were analyzed [10] and presented to community partners and knowledge users (see Acknowledgments), who identified key areas requiring further exploration. Then, to further assess MH needs and the extent to which they were met, we performed two follow-up surveys from November 2021 to May 2022 (T2), and later from May to October 2022 (T3). Lastly, through exploratory qualitative interviews, we aimed to build on our quantitative findings by gaining deeper insight into the needs and barriers experienced by Canadian youth and parents. This information can be used to inform the future development of health systems to best address societal needs going forward.

2. Materials and Methods

2.1. Study Design

We used a modified explanatory sequential/nested mixed methods design (see Figure 1), in which an initial quantitative phase (QUAN) informed subsequent qualitative (QUAL) and quantitative (QUAN) data collection [38,39].

Subsequent data collection aimed to: (1) measure MH support needs over time (through multiple waves of the pandemic and as public health restrictions eased in a pandemic recovery era in Canada), using follow-up surveys (QUAN); and (2) explore individual experiences with MH supports in greater depth, using semi-structured interviews (QUAL). We specifically sought in-depth personal narratives to deepen our understanding of MH needs during COVID-19—including supports that were needed and/or accessed by Canadian youth, and self-reported barriers to accessing those supports or receiving effective care. QUAN and QUAL data were analyzed separately, and then integrated to assess the fit of both data sets and generate more comprehensive insights. All participants provided informed online consent or assent prior to their participation. The Children's and Women's Research Ethics Board at the University of British Columbia approved this study (H20-01043 approved on 15 May 2020 and H21-01895 approved on 4 May 2022).

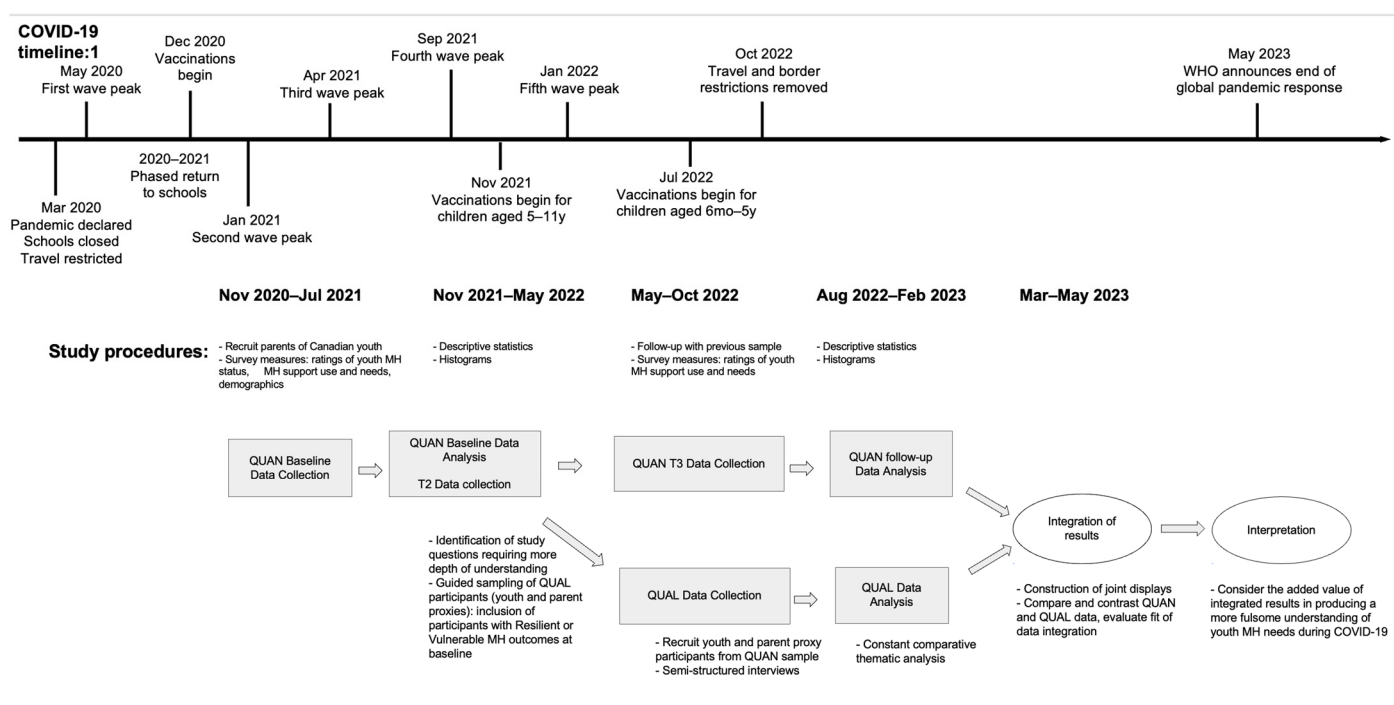


Figure 1. Flowchart of study procedures, in relation to COVID-19 pandemic course in Canada; QUAN: quantitative; QUAL: qualitative; MH: mental health. COVID-19 timeline is not to scale.

2.2. Quantitative Procedures

The Personal Impacts of COVID-19 Survey (PICS) was developed to assess long-term pandemic MH impacts and service provision in a representative group of 3000 Canadians [10]. This survey was originally designed by ES and HS, in collaboration with different stakeholders, including children, youth, parents, psychologists, psychiatrists and the research team, through an iterative process [40]. The PICS assesses the impact of COVID-19 and has various versions for self and parental reports [10,40].

Data was collected at baseline and follow-up timepoints (see below). The current paper presents longitudinal data on MH support needs (services accessed and unmet MH

support needs) among the PICS subsample of Canadian youth as reported by parent or caregiver proxy (see Stewart et al [10] for full study details).

Baseline data were collected from parents of youth between November 2020–July 2021 after the first COVID-19 wave in Canada (T1). Canadians over 18 years of age, with a child or youth aged 8–18 years, were recruited via social media and targeted in non-random approaches [41]. Parents provided proxy reports for their children and youth. MH support needs were assessed using categorical survey questions (typically Yes/No or Select all that Apply). Barriers to accessing MH support were assessed categorically at T1 (Select all that Apply), and the extent to which MH support needs were related to COVID-19 was assessed using a sliding scale indicator. In addition to completing survey questions about MH support needs, youth were screened (by parent-report) for relevant psychiatric problems. Individuals with a positive screen for depression, anxiety, or OCD [using validated, age-appropriate measures—Patient Health Questionnaire-9 (PHQ-9) [42,43], General Anxiety Disorder-7 (GAD-7) [44,45] and Obsessive-Compulsive Inventory-Children's Version (OCI-CV) [46], respectively], or a reported COVID-19-era suicide attempt, were categorized as having Vulnerable baseline MH status. Those without a positive screen or reported suicide attempt were categorized as having Resilient baseline MH status.

Additional rounds of quantitative data collection were conducted between November 2021–May 2022 (T2) and May–October 2022 (done concurrently with qualitative interviews; T3). Slight changes to question wording or response options were made for clarity and/or to capture greater detail than was obtained at T1. Barriers to accessing MH support were assessed at T3 using sliding scales to indicate the extent to which a potential barrier was relevant to that youth's experience.

Data processing and statistical analyses were done using R version 4.1.1. Data were summarized using descriptive statistics, including mean scores (and standard deviations) or median scores [and interquartile ranges] for continuous measures and numbers and percentages for categorical variables. Measure distributions were also analyzed visually using histograms.

2.3. Qualitative Procedures

Semi-structured interviews were conducted between May and November 2022 with two groups: (1) youth aged 8–18 years old, and (2) parents of youth aged 8–18 years old. Interview guides (see Supplementary Material) were developed for each group with the input of CS, AML, HS and SES based on their expertise as MH clinicians and/or researchers. The interview guides aimed to explore participants' (or participants' youth's) experiences during the COVID-19 pandemic, with a focus on MH, MH support needs, positive and negative experiences with MH support services, what MH supports would have been helpful during the pandemic, and suggestions for the improvement of MH supports. Participants were asked to describe their (child's) experiences and were not asked explicitly about quantitative survey response options (e.g., specific barriers to accessing support), to allow for inductive qualitative analysis as described below. However, similar lines of inquiry were used to allow for comparison with QUAN data (for example: Did you/your child access any MH support? What was most/least helpful from these supports? What challenges did you/your child have in accessing MH support?).

Parent proxy recruitment was informed by baseline survey data. Participants were invited to participate if they indicated interest in participating in a one-on-one interview at T1. We purposively recruited parents based on their child's MH screen at baseline, to ensure representation of youth with both Vulnerable and Resilient baseline MH status. Parents were contacted via email, and interested participants met with CS via Zoom to review the consent form, provide electronic consent using REDCap (Research Electronic Data Capture) [47] and complete their interview. Parent proxy interviews were conducted

by CS (MSc, female, trained in qualitative and quantitative methods with 7+ years of professional research experience).

Youth participants were recruited through one of two streams. First, a small number of youths had completed their own surveys at baseline (data was not included in quantitative analyses due to low follow-up response numbers) and indicated interest in a follow-up interview. These youth were first contacted through their parents' emails, who shared the study information with their youth. Second, we also contacted parents who agreed to follow-up to ask if their youth would be interested in participating in the study. If a parent indicated that their youth was interested and provided permission to contact the youth by email, the study invitation was then sent directly to the youth. Interested participants met with AML via Zoom to review the consent form, provide electronic consent using REDCap [47] and complete their interview. Youth interviews were conducted by AML (MSc, female, trained in qualitative and quantitative methods with 4+ years of professional research experience).

Both a respective parent and youth did not have to participate together in the study; a youth and/or parent were free to participate on their own. Interviews were conducted, recorded and transcribed via Zoom, then reviewed for accuracy by a research assistant. NVivo R1 [48] was used to store, organize and manage data. Thematic analysis was conducted concurrently with data collection. The two groups of interviews were largely analyzed separately by CS and AML; however, two parent proxy interviews, and two youth interviews, were independently coded by both CS and AML and reviewed to ensure relevant codes were being identified for each group. Analysis began with inductive line-by-line coding of basic conceptual units, followed by axial and hierarchical coding to identify main concepts and themes. The coding frameworks for each group were iteratively revised based on findings from new transcripts and applied to earlier interviews when relevant. CS, AML and SES met on several occasions to review and compare concepts and themes that were identified in youth and parent proxy interviews. Written memos were used to capture decisions and record salient themes throughout the analytical process.

2.4. Data Integration

QUAL data was first analyzed independently from QUAN findings; all codes were developed inductively from transcripts by CS and AML, without review of QUAN data, which was analyzed by JB. Joint displays were then prepared by CS in order to compare and contrast findings from both sources. The purpose of merging the data was (1) to determine the fit between the two data sets (i.e., whether the findings were confirmatory or discordant from one another), thereby strengthening confidence in findings that converged across QUAL and QUAN data [38,39], and (2) to use the QUAL data to expand upon and enrich the findings from QUAN data [38]. Given the study objective of understanding MH support needs and access barriers, the qualitative sample intentionally included a higher proportion of participants with a vulnerable baseline MH status. This sampling approach facilitated deeper exploration of MH support needs, barriers, and challenges that may not have been fully captured in the quantitative survey data. Accordingly, QUAL findings were interpreted not only as (potentially) explanatory of QUAN results but—in particular—as providing contextualized insight into the experiences of participants with novel, exacerbated, and/or unmet MH needs. QUAL findings that had not been captured by QUAN data collection were reviewed and discussed in the context of our overall findings.

3. Results

3.1. Demographics

Five hundred and seven participants completed baseline parent proxy surveys (T1), and 177 completed follow-up surveys; of those, 96 completed T2 only, 31 completed T3 only, and 50 completed both T2 and T3. The majority of parent participants were reported as being White and holding university degrees; see Table 1 for full demographic information. Participants who completed follow-up surveys (T2 or T3) reported a lower average age of their index child (9.1 years [SD = 5.4 years; T2] or 9.0 years [4.8; T3] vs. 10.1 [5.7]), as compared to baseline respondents. T3 respondents were more likely to have a male child (58% vs. 50%), less likely to live in a rural area of Canada (1.7% vs. 6.1%), and more likely to have a Bachelor's degree (42% vs. 34%) than baseline respondents. Although these are notable numerical differences between the assessment timepoints, none of these comparisons was statistically significant (all p values > 0.05 for between-group Wilcoxon rank sum test for continuous variables and Fisher exact test for categorical variables).

Table 1. Demographic information for survey and interview participants.

Characteristic	Parent Proxy Survey Responders			Parent Proxy Interviews
	Baseline <i>n</i> = 507	T2 <i>n</i> = 146	T3 <i>n</i> = 81	<i>n</i> = 19 *
Age of child	10.07 (5.72)	9.1 (5.4)	9.0 (4.8)	13.34 (2.88)
Unknown	8	38	21	
Age of parent				
Under 20 years	0 (0%)	0 (0%)	0 (0%)	0 (0%)
20–29	18 (3.6%)	3 (2.8%)	0 (0%)	0 (0%)
30–39	196 (39%)	46 (42%)	25 (42%)	3 (16%)
40–49	214 (43%)	44 (40%)	229 (48%)	8 (42%)
50–59	65 (13%)	16 (15%)	6 (10%)	8 (42%)
60–69	3 (0.6%)	0 (0%)	0 (0%)	0 (0%)
Over 70 years	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Prefer not to answer	1 (0.2%)	0 (0%)	0 (0%)	0 (0%)
Missing	10	37	21	
Gender of youth				
Female	238 (47%)	49 (45%)	24 (40%)	8 (42%)
Male	254 (50%)	57 (52%)	35 (58%)	11 (58%)
Other	15 (3.0%)	4 (3.6%)	1 (1.7%)	0 (0%)
Unknown		36	21	
Ethnicity of youth				
East/Central Asian	16 (3.2%)	3 (2.7%)	1 (1.7%)	0 (0%)
First Nations/Metis	10 (2.0%)	2 (1.8%)	1 (1.7%)	1 (5.3%)
Multi	69 (14%)	17 (15%)	7 (12%)	3 (16%)
Other	23 (4.5%)	1 (0.9%)	1 (1.7%)	0 (0%)
South Asian	6 (1.2%)	2 (1.8%)	1 (1.7%)	0 (0%)
White	383 (76%)	85 (77%)	49 (82%)	15 (79%)
Unknown		36	21	
Immigrant (youth)	29 (5.7%)	5 (4.5%)	3 (5.0%)	2 (11%)
Unknown		36	21	
Rural location	30 (6.1%)	6 (5.6%)	1 (1.7%)	2 (11%)
Unknown	18	38	21	
Northern or Southern location				

Northern	13 (2.7%)	3 (2.8%)	1 (1.7%)	0 (0%)
Southern	473 (97%)	104 (97%)	59 (98%)	19 (100%)
Unknown	21	21	21	
Education of parent				
<Bachelor's	154 (31.0%)	29 (27%)	13 (18%)	5 (27.3%)
Bachelors degree	168 (33.8%)	37 (34%)	25 (42%)	7 (37%)
Graduate degree	167 (33.6%)	42 (39%)	24 (40%)	7 (37%)
Prefer not to answer	8 (1.6%)	1 (0.9%)	0 (0%)	0 (0%)
Unknown	10	37	21	
Household Income				
<\$75,000	46 (15.2%)	15 (20%)	10 (25%)	6 (46.2%)
\$75,000 to 99,999	40 (13%)	9 (12%)	7 (18%)	3 (23%)
\$100,000 to 149,999	85 (28%)	25 (32%)	9 (23%)	2 (15%)
\$150,000 and greater	106 (35%)	25 (32%)	10 (25%)	2 (15%)
Prefer not to answer	23 (7.7%)	3 (3.9%)	4 (10%)	0 (0%)
Unknown	207	69	41	6
Worry about money for food:				
Not at all	379 (75%)	81 (74%)	46 (77%)	13 (68%)
Slightly	35 (6.9%)	4 (3.6%)	4 (6.7%)	2 (11%)
Moderately	16 (3.2%)	6 (5.5%)	1 (1.7%)	1 (5.3%)
Very	20 (3.9%)	4 (3.6%)	5 (8.3%)	2 (11%)
Extremely	12 (2.4%)	2 (1.8%)	0 (0%)	0 (0%)
Not applicable	4 (0.8%)	12 (11%)	4 (6.7%)	0 (0%)
Prefer not to answer	41 (8.1%)	1 (0.9%)	0 (0%)	1 (5.3%)
Unknown		36	21	
Number of people currently living in home (not including respondent)				
1		7 (6.4%)	6 (10%)	2 (11%)
2		30 (28%)	23 (38%)	2 (11%)
3		40 (37%)	14 (23%)	7 (37%)
4		21 (19%)	9 (15%)	5 (26%)
5		10 (9.2%)	7 (12%)	2 (11%)
6		1 (0.9%)	1 (1.7%)	1 (5.3%)
7		0 (0%)	0 (0%)	0 (0%)
8		0 (0%)	0 (0%)	0 (0%)
Unknown		37	21	
Lifetime psychiatric diagnosis (youth)	94 (19%)	17 (15%)	9 (15%)	8 (42%)
Unknown		36	21	
Problems with alcohol or drugs (youth)	3 (0.6%)	1 (0.9%)	0 (0%)	0 (0%)
Unknown		36	21	
Any complex medical condition (youth)	85 (17%)	21 (19%)	8 (13%)	8 (42%)
Unknown		36	21	

* $n = 19$ because two parent proxies participated with two index children.

Interviews were conducted with 18 youth participants and 17 parent proxy participants. The average age of the youth of parent proxy participants was older than that of T3 survey participants (13.3 years [2.9] vs. 9.0 years [4.8]). These youth were also more likely to have a psychiatric diagnosis (42% vs. 15%) or a complex medical condition (42% vs. 13%), than T3 survey participants. Demographic information is not available for youth participants, as they did not complete quantitative surveys.

3.2. Sources of MH Support During COVID-19

Quantitative reports of MH supports that were needed and/or accessed by survey participants at T1 and T2/T3 are shown in Table 2 and Figure 2 (baseline responses were similar between the overall cohort and T2/T3 respondents; see Table S1.) The total proportion of youth who had accessed MH supports during COVID-19 was higher among respondents at T3 (35%) than respondents at T1 (24%). A total of 25% of respondents at T2 reported accessing MH supports since their previous assessment (which was, on average, 287 days prior); approximately half of those were newly acquired supports in that time period (i.e., those respondents had not accessed supports at T1; 47%). The most common sources of MH support accessed by youth included a private counsellor or therapist (52% at T1, 54% at T2), followed by school counsellors/staff (42% at T1, 30% at T2) and family or friends (41% at T1, 32% at T2; see Figure 2A). Other sources of MH support included psychiatrists/psychologists, family doctors, and community mental health teams. The proportion of youth accessing a given source of support was lower at T2 in comparison to T1 for all sources except private counsellors/therapists.

Table 2. Youth MH support access and needs during the COVID-19 pandemic.

Survey	Response at Baseline (<i>n</i> = 507)	Response at T2 (<i>n</i> = 146)	Response at T3 (<i>n</i> = 81)
Since the pandemic first impacted where you live (baseline assessment) or since the last survey you completed (follow-up assessment), has your child obtained support for their mental health?			
No	248 (49%)	68 (47%)	NA
No support needed	130 (26%)	41 (28%)	NA
Yes	124 (24%)	36 (25%)	NA
Prefer not to answer	5 (1%)	1 (0.7%)	NA
During COVID-19, have you received support for this child's own mental health?			
No support needed	NA	NA	49 (60%)
MH support needed but not received	NA	NA	4 (5%)
Yes	NA	NA	28 (35%)
Since the pandemic first impacted where you live (baseline assessment) or since the last survey you completed (follow-up assessment), has your child needed but not received supports for their mental health?			
No	384 (76%)	124 (85%)	NA
Yes	108 (21%)	20 (14%)	NA
Prefer not to answer	15 (3%)	2 (1%)	NA
Which of the following mental health supports has this child needed but not received since COVID-19 began? (Check all that apply)			
No support needed	NA	NA	65 (80%)
Informal MH support	NA	NA	2 (2.5%)
Professional/formal MH support	NA	NA	14 (17%)
During COVID-19, who has provided support for this child's mental health? (Check all that apply)			
Informal MH support	NA	NA	19 (23%)
Professional/formal MH services	NA	NA	27 (33%)
No support needed	NA	NA	42 (52%)

NA= Not Available.

A significant minority of respondents reported unmet MH support needs for their youth during COVID-19 (21% at baseline, 20% at T3). Notably, even youth who had accessed MH supports were reported to have outstanding unmet needs (see Table 2 column T3): while only 5% reported not receiving any needed support for their child's MH, approximately 20% reported needing but not receiving informal or formal MH support—indicating that some of the youth who had accessed MH support still had unmet need. (Of these participants, 38% had reported unmet need at both T1 and T3). A total of 14% of

respondents at T2 reported having unmet need since their previous assessment. For those with unmet MH support needs, the most commonly needed supports were a publicly funded psychiatrist or psychologist (49% at T1, 64% at T3) or a private-pay counsellor or psychologist (49% at T1, 71% at T3; see Figure 2B). Participants also reported needing MH support from school counsellors/staff, community MH teams or support groups.

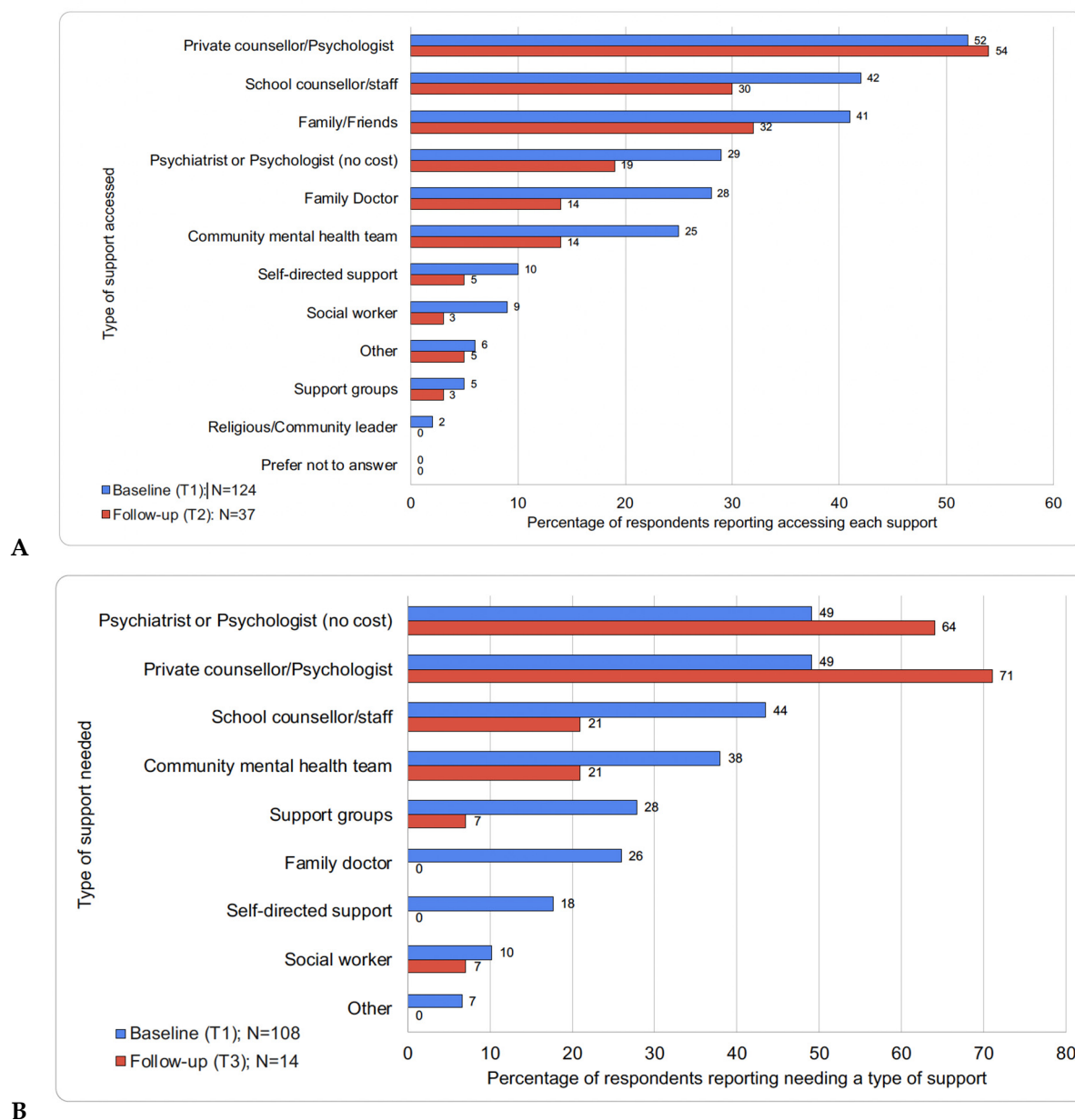


Figure 2. Sources of Youth MH supports during the COVID-19 pandemic. (A). Sources of youth MH support at baseline and follow-up. (B). Type of MH support needed at baseline and follow-up, for youth with unmet MH needs.

3.3. Informal Supports

During their interviews, youth participants often discussed using informal MH supports—in particular, relying on friends for emotional support—as an important component of coping with their MH struggles. Some youth described frequent, casual interactions with friends to distract them from concerns (“I talk to my friends all the time”—Youth 4746), while others described purposeful and explicit discussions with their friends about MH:

“Whenever I’m having like, it’s not really a panic attack, It’s kind of like in between an anxiety and panic attack; normally I end up calling my best friend. And that definitely helps cause she definitely calms me down a lot. So that definitely is one of the main things I do, is just kinda... I just kind of open up to people when I’m ready.” — Youth 795

Receiving support from friends was sometimes the main or primary source of support for youth participants, with some describing a preference for this over speaking to a trained therapist. Several youth also described receiving support from their family—either directly (i.e., discussing emotions, MH or coping), or through the facilitation of external supports: “Because do moms and dads have all the answers? No” (Youth 1030). Youth often described positive experiences with their supportive relationships, as well as using previously learned skills such as mindfulness or other stabilizing strategies in non-crisis situations.

Parents typically discussed their own role in supporting their youth’s MH, either by directly providing emotional support, accessing parent-directed educational resources to learn how to help their child, or by connecting their child to formal or informal supports. Some parents discussed accessing informal supports together with their child—such as crisis or telephone lines, self-directed or web-based resources, or practicing mindfulness or Cognitive Behavioural Therapy (CBT) techniques. Others were unsure whether their child—typically older or more independent youth—actually used the online resources or phone applications that they had discussed together. Parents commented on their child(ren) interacting virtually with their friends as a pandemic coping mechanism, but did not often discuss this explicitly as a form of receiving MH support. Some parents also acknowledged their child receiving support through school—such as from an adolescent support worker—and having “just someone to talk to” there.

3.4. Formal Supports

Both youth and parent participants discussed accessing formal supports, most often through private counselling or therapy. Positive experiences were described with MH clinicians with whom a youth “clicked”, where there was a good therapeutic relationship and engagement. Some parents also discussed positive experiences with MH clinicians who had a specific expertise (e.g., expertise with neurodevelopmental disorders), or with a highly engaged or supportive family doctor or pediatrician:

“There are people who are negligent, and then there are people who are amazing, and it’s the people who are negligent that you’re gonna hear about. And it’s the hard working people like my GP, who sits here and works in some whatever office in [name of small city], you know, who honestly has kept our kid alive, who are not going to get a parade.” — Parent 676

In addition to youth receiving personal counselling, a number of parents also described receiving formal resources themselves in order to support their child, such as counselling about how to support or manage their child’s MH.

Several participants had existing formal MH supports in place prior to the COVID-19 pandemic. For some, these were valuable supports that were stripped away during COVID-19, but for others, these were important sources of support and stability throughout the pandemic. Specifically, several youth and parents discussed the importance of having a psychiatrist and/or medication regimens that were helpful through periods of COVID-19-related stress:

“Medicine’s definitely helped. It doesn’t help a lot in a single day, but over the course of the few months I’ve been taking it’s helped me a lot. I probably wouldn’t be in a good state right now. I’d probably be upset and that stuff, if I

wouldn't have taken it. I don't know what it's called, but it's helped me a lot with the anxiety problems... I don't really like it, but I'll do it, because I know it will help me." — Youth 3721

3.5. MH Support Needs Relative to the COVID-19 Pandemic

The joint display in Figure 3 shows QUAN and QUAL participant responses regarding the degree to which the youth's need for MH support was related to the COVID-19 pandemic. A greater proportion of MH support needs were related to the COVID-19 pandemic at T1 than T3. QUAL findings expand on this by describing the nature of the effects of the pandemic on youths' MH. In general, many participants described significant MH struggles and support needs during early waves of the pandemic when there was a large degree of uncertainty and fear. As public health restrictions eased later in the pandemic, many participants reported improvements to MH and less pressing support needs. The easing of social distancing restrictions seemed particularly beneficial for many youths' MH, though several described new MH stressors that were related to changing restrictions (e.g., difficulties returning to school, anxiety about being exposed to COVID-19 with fewer public health measures). In addition, some participants acknowledged difficulty distinguishing whether improvements to MH were due to loosening restrictions, accessing MH supports, or both.

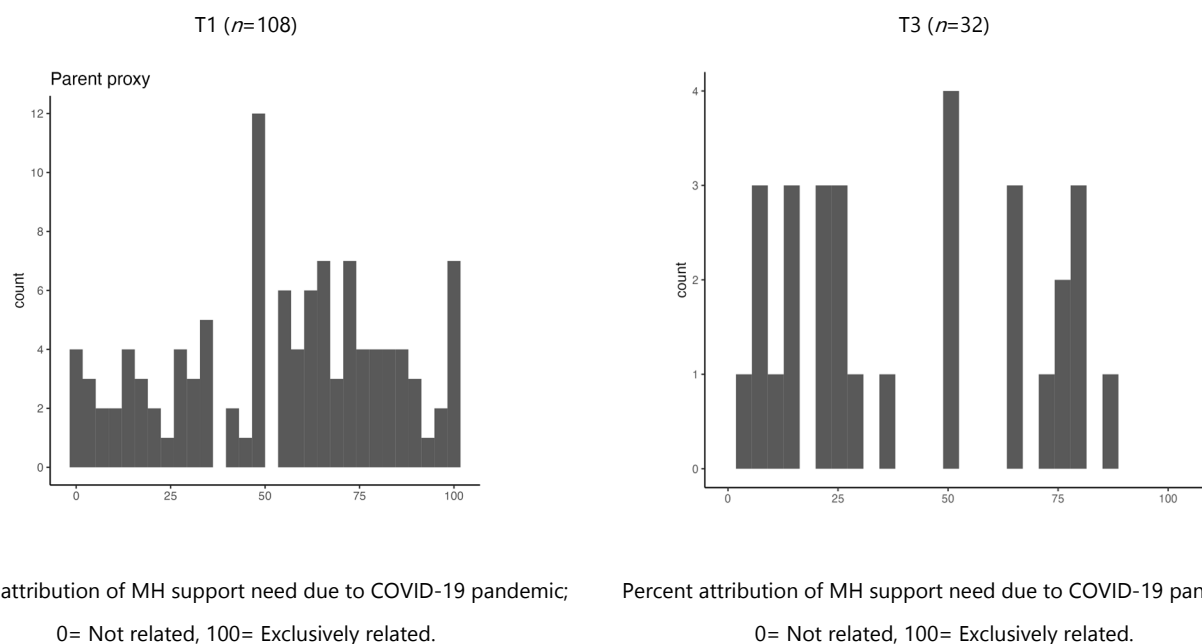
3.6. Barriers to Accessing MH Supports

The joint display in Figure 3 shows T3 QUAN data regarding the degree to which various personal and systemic barriers affected participants' youths' access to MH supports, along with relevant QUAL findings and integrated interpretation. The proportion of respondents who reported experiencing each barrier at baseline (T1) is shown in Supplementary Figure S1.

QUAL findings expanded on several of the barriers to accessing care; though interview participants were not explicitly asked about each barrier that had been queried in the surveys, most were discussed spontaneously, particularly by parent proxies. Difficulties navigating the MH system—knowing where to get help, limited availability, and cost of services—were discussed frequently and were major points of concern for many parents. These issues were often discussed as systemic problems within the healthcare system, as opposed to personal factors (as they were presented in the QUAN survey), and seemed to be exacerbated for parents whose youth was experiencing a mental health crisis (see Figure 4 for quotes). Even when barriers did not prevent access to MH supports entirely, they often still caused strain—for example, through delaying treatment or reducing the amount or frequency of MH support that was accessed by the youth and/or other members of the family. Several parents with extended health benefits described forgoing their own MH treatment in order to save their counselling benefits for their child(ren) who were struggling; others travelled, paid out-of-pocket, or arranged non-monetary payment (i.e., trading professional services) in order to access MH supports for their youth.

"We would call [different MH units], and they were like 'We're not taking anyone', you know. And we're like—this kid needs help, what are we going to do? To the point where my husband and I ended up getting, you know, like PCR testing somewhere privately, and then taking him across the border and taking him to the [United] States and accessing private mental health services, because we could not access anything in a timely manner for a child who is struggling so much with everything that was going on. And that's what we had to do." — Parent 676

Parent proxy survey response distribution*



Major theme: Struggling with MH during COVID-19

Parent quote

"I definitely think COVID was like that spark to the fire, you know. I don't think she would have gone through such a dark time... because there would be more availability emotionally on my behalf and my husband's behalf, and I think the healthcare supports would have been less over-taxed. And so we would have maybe accessed better help sooner. Because it feels like everybody just went into a fog, and everybody was just trying to figure things out, so I definitely think COVID was a major factor in her mental health and where she landed, and just processing it and coming out the other side and how quickly or slowly that happened, like it definitely [was] affected". - Parent 2529

Youth quote

"I have anxiety. So having that immense anxiety about not knowing what's gonna happen next was a very difficult time period... With my mental health, it definitely took a turn, like quite a lot. [Because of COVID-19] it was way, way more jarring than before, just like the amount of things that were happening in my life. That set it off track a little bit. I think the pressure of COVID and things like that added quite a lot to the situation I was in." - Youth 2066

Interpretation

Expansion

Many participants described the negative impact that the COVID-19 pandemic had on their/their youth's MH, which at times led to deterioration and a need for MH supports. Participants described several ways in which COVID-19 impacted MH: situations where COVID-19 "triggered" the onset of a MH problem; situations where MH problems, though pre-existing, were exacerbated by fear of COVID-19 and/or by challenges imposed by public health restrictions; and situations where the focus of anxiety shifted almost exclusively to COVID-19-related worries. However, a number of participants had pre-existing MH concerns, which, although impacted by COVID, did not require additional MH support beyond what was already being accessed (or did not substantially differ from their pre-pandemic MH status). Some participants even described resilience due to past experience managing MH concerns. Over time, and after the easing of many public health restrictions in Canada, MH concerns were less specific to COVID-19.

Figure 3. Mixed methods findings regarding the relation of MH support needs to the COVID-19 pandemic. Columns A and B: Respondent attribution of MH support needs to the COVID-19 pandemic at baseline and T3. C and D: Example quotes and major themes (bolded) from parent proxy and youth interviews about the impact of COVID-19 on youth MH support needs. E: Mixed methods interpretation of QUAN + QUAL data. * Participants were asked “To what extent are your child’s MH support needs related to the pandemic?”, and indicated their response on a sliding scale: 0 = Not related to the COVID-19 pandemic; 100 = Exclusively related to the COVID-19 pandemic.

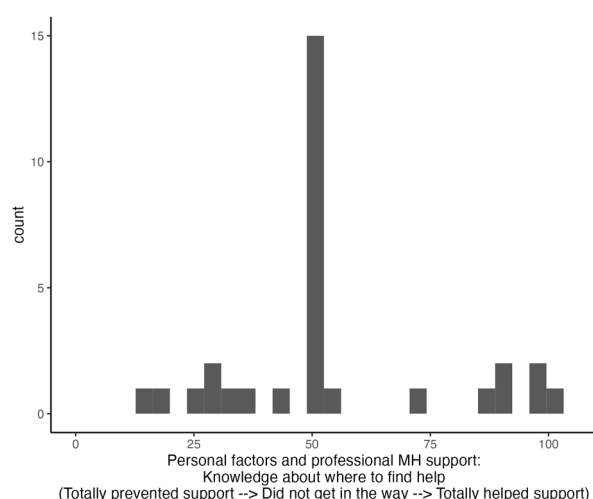
Many parents were frustrated by the inequity of the current system in which financial resources are required to access care in a timely manner. Several parents tried accessing informal supports as a stop-gap while waiting for formal support, but found that informal options had insufficient expertise for the situation or were also overwhelmed by high demand, resulting in long wait times.

Youth participants discussed access barriers less often than parents, although several described difficulties accessing MH supports during COVID-19 due to service closures and limited availability (see Figure 4). Some youth felt that there should have been more MH services made available and/or more communication about available services, particularly during the first wave of the pandemic. There were also mixed opinions expressed regarding virtual delivery of MH care supports: some found it unhelpful and “just couldn’t connect” with counsellors online, while others preferred virtual care due to the ease and comfort of accessing help from home.

Personal factors and professional MH support (n=31)*

Parent proxy survey response

Knowing where to find help



0= Totally prevented support,

50= Neither prevented or helped ,

100= Totally helped get support

Major themes and supporting quotes

Theme: Difficulty accessing MH supports

Parent Proxy

“I feel like it’s hidden. It’s challenging for me, as an individual, to find the right care at the right time... It’s almost, like, a secret, and it’s almost like, if you’re lucky enough to know, or you’re lucky enough to have a pediatrician who knows who to call, you can find it. But it’s not really evident how to find this.” - Parent 2925

“It’s overwhelming to navigate the whole system... I needed support, like it’s incredibly overwhelming as a parent to figure this out when it feels like I’m in crisis, but I have to support my child who’s in crisis... Because you’re just in survival mode it’s like, I don’t

Youth

“I think [finding a counsellor] was pretty easy... it’s quite accessible. And like, the database is huge, so it’s like, you had to be kind of intentional with what you’re looking for, because there are many different treatment options and specialties as counsellors. So that’s kind of a lot to take in. But now that I know kind of what I need to get done and what I’m looking for, it’s quite straightforward, but it just takes a little while to get the hang of. - Youth 3782

need a bunch of detailed instructions
on how to get onto the life raft,
somebody pull me onto this life raft.”
- Parent 2529

Interpretation

Expansion (partial discordance)

A number of parent proxies described major difficulties navigating the MH system that negatively impacted their youth's MH treatment and recovery. These accounts contrasted somewhat with survey responses that were largely neutral/mixed. However, the qualitative data also revealed considerable heterogeneity in experiences. While many participants expressed overwhelm or frustration around figuring out where or how to find help, some reported no difficulty, and several parents reported significant knowledge of the MH care system (e.g., due to previous personal or professional experience) that facilitated access to supports.

Youth participants did not often express difficulty knowing how to get help, as finding formal supports was typically undertaken by parents on behalf of their youth.

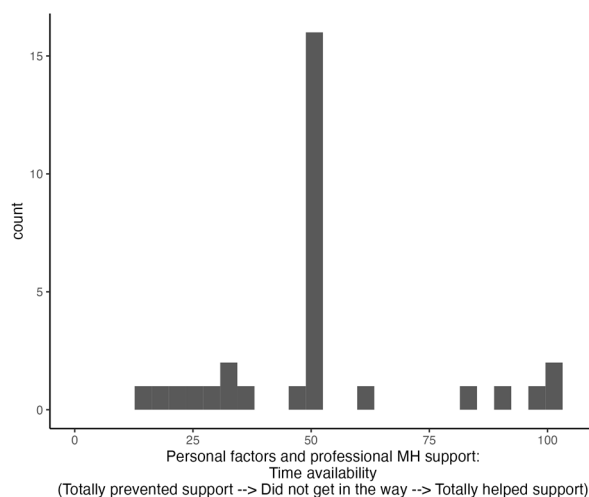
Taken together, these findings suggest that although not universal, difficulty with knowing where to find help can pose a significant barrier for families when it does arise—particularly in times of crisis when immediate support is needed. Qualitative findings highlight the variability and potential consequences of navigation challenges that may not have been fully captured by survey responses.

Parent proxy survey response

Major themes and supporting quotes

Limited time availability

Theme: Difficulty accessing MH supports



0=Totally prevented support,
50=Neither prevented or helped,
100= Totally helped get support

Parent Proxy

Youth

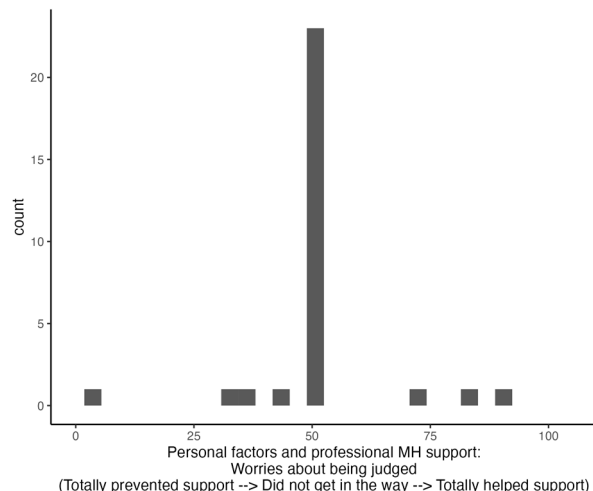
“It was lucky I’m at home, and so I could have the time to just call and call and call [MH supports] over and over until I could get a human, and email [MH supports] until somebody responded, and so I think we were pretty lucky. Yeah, so it was hard. I think because I’m at home, also because English is my first language - so I don’t know what that situation would have been like for somebody else trying to find that, figure that out.” - Parent 5839

NA

Interpretation

Expansion

While participants occasionally discussed time availability, they discussed it in terms of the time and energy investment required in order to find appropriate resources, rather than the time required to actually attend appointments. This may have been influenced by the COVID-19 pandemic, during which MH supports were overwhelmed (see below) and were generally accessed virtually (thus requiring less time and travel).

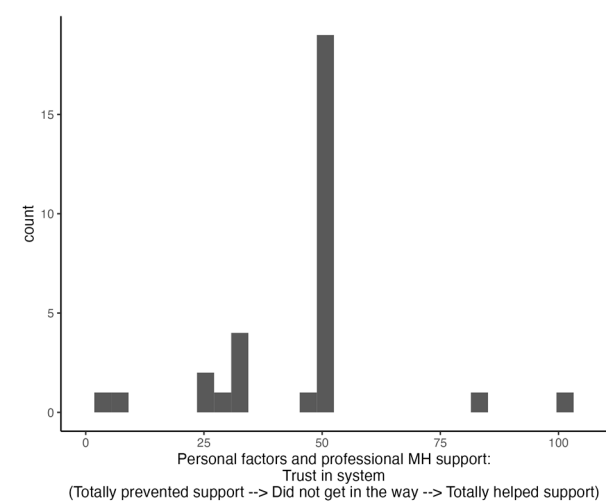
Parent proxy survey response	Major themes and supporting quotes					
<u>Worries about being judged</u>  0= Totally prevented support, 50= Neither prevented or helped, 100= Totally helped get support	Theme: Difficulty accessing MH supports <table><tr><th>Parent Proxy</th><th>Youth</th></tr><tr><td> "She has not wanted to go [to the psychiatrist] yet - she keeps saying if it gets worse then she'll go, so I think she's more open to it. But I mean, I can't make her go if she's not wanting to... I think the psychiatrists ask difficult questions and then she's not comfortable sharing a lot of those things with someone because she's, again, worried about the judgment and even though they're a psychiatrist and that's their job, and I, you know, try to explain the confidentiality piece to her, she just doesn't want a stranger knowing her business." - Parent 344 </td><td> "I don't know, it's not like I hate strangers [laughs] getting to hear about my life, which is basically what this is. But like, it's just kind of like, "Oh, great! I have to go tell people what happens in my life 24/7", and give them my whole life story from when I was a child to now; in less than an hour, and have to short form that, and tell them everything, and if you find anything that they think is very problematic they tell my whole parents about it and then it just... I don't know, I don't like it." - Youth 795 </td></tr></table>		Parent Proxy	Youth	"She has not wanted to go [to the psychiatrist] yet - she keeps saying if it gets worse then she'll go, so I think she's more open to it. But I mean, I can't make her go if she's not wanting to... I think the psychiatrists ask difficult questions and then she's not comfortable sharing a lot of those things with someone because she's, again, worried about the judgment and even though they're a psychiatrist and that's their job, and I, you know, try to explain the confidentiality piece to her, she just doesn't want a stranger knowing her business." - Parent 344	"I don't know, it's not like I hate strangers [laughs] getting to hear about my life, which is basically what this is. But like, it's just kind of like, "Oh, great! I have to go tell people what happens in my life 24/7", and give them my whole life story from when I was a child to now; in less than an hour, and have to short form that, and tell them everything, and if you find anything that they think is very problematic they tell my whole parents about it and then it just... I don't know, I don't like it." - Youth 795
Parent Proxy	Youth					
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Interpretation

Expansion

Several youth and parent proxies described reluctance and worry about attending MH appointments and having someone "know [their] business". Survey scores had indicated that worry about being judged did not often affect access to MH supports; while qualitative findings are similar in that few participants discussed this type of worry as an access barrier, they also suggest that when present, worry about being judged can prevent youth from engaging with MH supports.

Parent proxy survey response	Major themes and supporting quotes	
<u>Trust in MH system</u>	Theme: Difficulty accessing MH supports	
	Insufficient quality or availability of MH supports	
	Parent Proxy	Youth
	"I think some of the help that we got through mental health services in town was neutral to damaging. Like it felt very minimizing, you know, like me sharing [what my child was going through], and being told to use breathing techniques, you know, is	NA



0= Totally prevented support,
50= Neither prevented or helped,
100= Totally helped get support

like thanks... Really I actually just need some concrete ways and resources to get myself and my kid out of crisis. Like I don't need to remember to take a deep breath... I think I had a right to feel elevated, it's actually pretty necessary [in order to respond and] be on it and attentive when you've got somebody who is doing themselves harm." - Parent 333

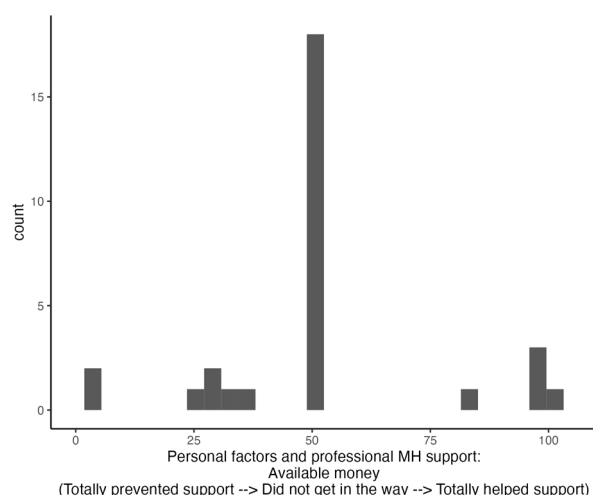
"It was just disgusting how they treat you when you're in there. Disgusting. They've got Indigenous designs on the walls, but there's no spirit there... These are sick people, and one patient had to use the bathroom, and she was in there, I guess, too long, and the cop banged on the door, 'Get out!' Awful. I will never access mental health support again through the ER ever... Yeah, it was not appropriate. Not okay at all. Not a place I would ever access again." - Parent 3915

Interpretation

Expansion (confirmation)

Though trust in the MH system was not discussed by many parents (and was not discussed by youth), some described negative experiences that made them sceptical that their child's MH needs would be taken care of, and/or made them reluctant to return to certain MH supports. These parents described how the care that was offered was insufficient or even harmful, due to lack of appropriate assessment/ intervention, or due to psychologically and culturally unsafe spaces. These qualitative findings help describe the nature of distrust that can sometimes impede MH support access, as shown in the quantitative data.

Parent proxy survey response	Major themes and supporting quotes	
Available money	Theme: Difficulty accessing MH supports	
	Parent Proxy	Youth
	"And then part of the challenge, both my pediatrician and I felt, was the cost of care. So, the cost of mental health care is exorbitant for most people. We're middle class, we're	"My particular cost of counselling with my counsellor is, I think... for 80 minutes, it's \$180 with my current counsellor. So it's not, like, the cheapest thing, but I definitely am



comfortable, and we feel like it was burdensome, and so how do people with fewer resources even access care? I don't know if they even can. Also, I have health benefits, and they don't come anywhere near covering mental health needs." - Parent 2925

happy that I am with my current counsellor. The counsellor that I have been getting through, I guess the school system or whatever, was not a good fit for me. So I'm certainly, like, willing to pay a little bit more money to feel more comfortable talking to a counsellor. I think that that's kind of important." - Youth 3782

0= Totally prevented support,

50=Neither prevented or helped,

100= Totally helped get support

Interpretation

Expansion (slight discordance)

Many parents described financial challenges accessing MH care; several described significant sacrifices that had to be made in order to afford MH care, and even those who self-described as "fortunate" sometimes struggled with the cost of care. However, some participants were able to access additional private supports because of their financial resources.

This expands upon, and contrasts somewhat with, survey results that were largely neutral/mixed. Qualitative data suggest that although cost may not always prevent access to care, it can cause substantial financial strain for families or affect the frequency or consistency of accessing supports. Youth did not typically discuss financial considerations of accessing MH supports.

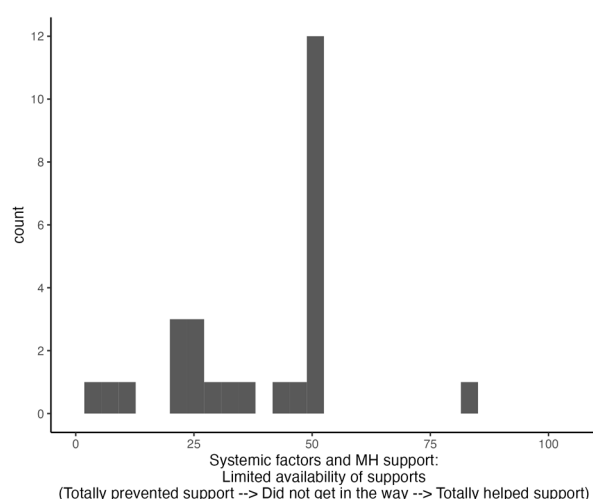
Taken together, the findings indicate that financial barriers exist on a continuum, ranging from manageable costs to considerable financial hardship, and that the impact of cost on MH care access and utilization may not be fully captured by survey measures alone.

Systemic Factors and MH support (n=32)*

Parent proxy survey response

Major themes and supporting quotes

Limited availability of supports



Theme: Difficulty accessing MH supports

Insufficient quality or availability of MH supports

Parent Proxy

"Sometimes if you would go on the websites [for MH services], it would be that they basically couldn't even respond for six months, like they just couldn't even triage people. Just, they were booked solid or there's nobody available or they couldn't even talk to you. They were so busy, or there was nobody answering the phones, and

Youth

"My mom signed me up for [therapy] sessions, and it really helped with my anxiety... She actually tried to get the sessions made in COVID, but she couldn't get one in for me until after... She signed me up for one in the middle of COVID, but we couldn't get into one until almost

0= Totally prevented support,	you would leave a message and no-	after [the COVID-19 pandemic]." -
50= Neither prevented or helped,	body would call back. So yeah, so	Youth 2054
100= Totally helped get support	then when [a counselling office]	
	called me back and said "We think we	
	have somebody", I was like, "Oh my	
	god!", I felt like I'd won the lottery." -	
	Parent 5839	

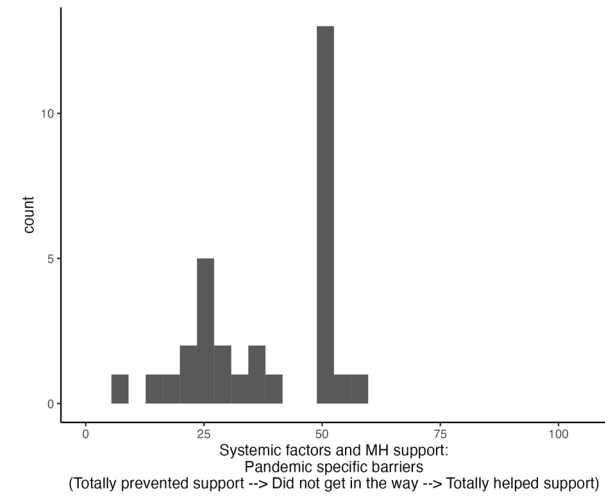
Interpretation

Confirmation (expansion)

Participants spoke at length about the limited availability of MH supports, and described this barrier as the most impactful on their families' experience with care. Many described long wait times, difficulty finding appropriate or specialized services, and disruptions in continuity of care, all of which contributed to frustration, delays in support, and unmet needs. Survey data further reinforce these findings, showing that limited availability of supports was among the most impactful barriers to MH support, often preventing youths from accessing care altogether.

Parent proxy survey response	Major themes and supporting quotes
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Pandemic-specific barriers



0= Totally prevented support,
50=Neither prevented or helped,
100= Totally helped get support

Theme: Struggling with MH during COVID-19	
Difficulty accessing MH supports	
Insufficient quality or availability of MH supports	
Parent Proxy	Youth
"[Our child's mental health] constantly went downhill. And then we started trying to access other support for him, and so many of those supports were on hold or not happening because of COVID, and then other things were just overwhelmed because of COVID. At one point we were calling the suicide prevention hotline, and we got like, "Sorry we are too, we're overloaded with calls. Hang up and try your call again." Boom!... And we're like, this kid needs help, like what are we going to do?" - Parent 676	"I mean initially, at the start of the pandemic, I don't think there was too much put in place, and that was the worst part of the pandemic. Like when things were really uncertain in the beginning. At that time, you couldn't really go to a mental health place or anything. And then there were probably online versions, but they probably weren't... I don't know, I wasn't super aware of the resources initially, and then past that starting point, I probably needed them less and less." - Youth 5840
"I really wanted to find a face-to-face person in [name of City], but we couldn't. So, [my child] is doing online [counselling], but that would not be her first choice. That's just the only	"Everything was closed and stuff. Probably a lot of people are trying to reach those places, but couldn't, because, I don't know. Probably most of it was closed because people couldn't go to their jobs and get

person we could find who had a schedule that fit, and the compromise was 'Okay, then you have to do it online because the other people who you want, we can't match up with them'." - Parent 2343

the phone, so maybe some of them were at home, but limited. So maybe some people are phoning in, but then only a certain amount of people could get it. So it was just a matter of time before we got, like, some help... COVID just kind of hit, too, and it just destroyed everything." - Youth 1030

Interpretation

Expansion (confirmation)

A number of participants described COVID-19-specific impacts, such as MH service closures or overextended programmes, that made it very difficult to access care in a timely manner. Several also described how the MH care system, which was already overloaded prior to COVID-19, was unprepared for the added strain imposed by the pandemic and was unable to provide basic services at times.

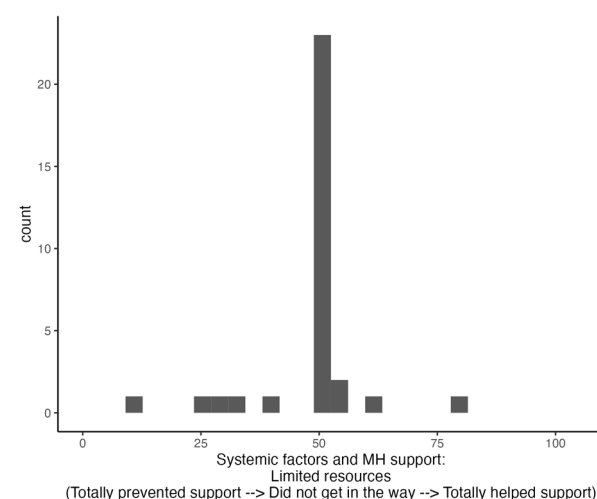
Some participants also expressed that virtual MH care was difficult or not as helpful for them/their child compared to previous in-person MH support (though others expressed preference for virtual MH care; see 'Limited resources' in the next row).

These descriptions confirm and expand upon survey data by describing how the challenges imposed by COVID-19, combined with existing challenges in the MH care system, contributed to significant barriers in accessing MH supports.

Parent proxy survey response

Major themes and supporting quotes

Limited resources



0= Totally prevented support,
50= Neither prevented or helped,
100= Totally helped get support

Theme: More MH supports are needed

"I think phone appointments, which never used to happen before COVID, that is huge, too. And being able to meet on Zoom, and especially now that I don't have transportation, and I, you know, use a walker to get around, so I don't want to take the bus. Drop-in and phone appointments have really, really helped." - Parent 3915

"I think one thing that came out of the pandemic that's been really helpful, is that you can do counselling stuff online, and supports can be online and are a lot more accessible than they were prior to the pandemic, because we had to, like, get to that point just to keep going through the pandemic. I think it's been really helpful to be able to do all my counselling online. I don't have to worry about commuting to a site, like after school and getting on a bus and going anywhere. I can just come home and sit down and join my online thing. I think that's like, one major thing that I'm really appreciative of is the fact that there are things that we can access, like, at home, online, very easily. And

that's been really good." - Youth
3782

Interpretation

Expansion

Participants did not frequently discuss resources (beyond the cost of services and their financial or insurance resources, discussed above), aligning with the predominantly neutral survey findings. However, some participants highlighted how virtual appointments made access to MH care significantly easier by removing the need for some of the resources that were previously required to access care, such as transportation and time.

Figure 4. Role of personal and systemic barriers to youth accessing MH care. Survey responses of the impact of specific barriers on accessing MH supports for youth at T3 are shown in histograms, accompanied by example quotes and major themes (bolded) from the parent proxy and the youth. * Participants—who indicated that their child accessed MH support, or needed but did not receive MH support—were asked “How much have the following [systemic/personal] factors either kept this child from or allowed them to obtain supports that they need?”, and indicated their response on a sliding scale: 0 = Totally prevented my child from getting needed support; 50 = Did not get in the way or help my child; 100 = Totally helped my child to get support.

Several additional barriers to MH care that were not queried in the QUAN surveys were described in participant interviews. First, many youth and several parents described difficulty or frustration with finding the “right” therapist—that is, finding a positive therapeutic relationship that enabled effective MH support:

“I went to therapy, like I have a therapist right now that I’m very happy with, but I’d gone through therapy, or like therapist changes. Like I didn’t quite click with some of my therapists, so I had to try to find one that was a good fit for me... we just weren’t a good match, like we just didn’t click.” — Youth 2066

It sometimes took multiple attempts with different therapists, over periods of many months, before finding a MH clinician who “fit” and who the youth found to be helpful. Several parents described their youth “quitting” or being reluctant to attend counselling because of a lack of connection with the therapist(s), and parents expressed frustration about their inability to fix this issue. Sometimes this lack of rapport was related to the difficulty finding available, consistent supports or being shuffled around to different clinicians at public MH services:

“Having to reiterate all of this from the beginning every time you meet a new person on a crisis line, or a new person in mental health services or whatever [was unhelpful]. Because then you’re never actually getting, you’re just getting the response to your situation but none of the depths... Like no, no deep response, no interventions that are really coming from a place of understanding.” — Parent 333

Additional social factors were identified that impacted access to MH care: living in a small municipality with limited access to MH experts, and having youth with complex needs. COVID-19 had a particularly negative impact on neurodiverse youth, in part due to the removal of existing MH, neurobehavioural, and medical supports that sustained their MH during pre-pandemic times (see Table 3).

Throughout their discussions about barriers to accessing MH supports, both youth and parent participants made suggestions for how the MH system could more effectively meet the youth’s outstanding support needs; see Table 3 for specific recommendations.

Table 3. Youth and parent participant suggestions for improving MH service delivery.

Expressed Need	Participant Suggestions for Meeting Need	Example Quotes
Easier access to MH supports	Youth: Online MH campaigns about available services Multiple access options (in person, online, texting) Parents: Mental health advocate or point-person for navigating system Flexible access options (e.g., online and in person, extended hours) Clear instructions on how to access MH help in a crisis situation Better integration or referral systems across MH services	“I know there’s like things like websites where you can like text people and let them know that you’re going through things and stuff like that, but maybe letting people know that those resources are out there because not everyone knows. I think that would have been very helpful to be able to have more resources like that, because you’re not always in like a safe environment, depending on where you are.” — Youth 2066 “It would be nice if it was we just got funneled to our appointment. I find especially for mental health (but also with other things) that you really have to do the work to get it all figured out and to remember to follow up and to schedule... You always have to follow up and kind of be on top of things. I think that if things were easy, things would just fall into place like, “This is your appointment; this is the process; this is how your kid will be looked after.” It would make it so much easier for parents.” — Parent 1779
MH support through schools	Youth: School counsellors with more MH expertise School counsellors who can connect students to external resources Parents: Emotional well-being and MH literacy taught and supported through curriculum Access to counselling and supports through school Integration of external MH teams with school supports (educational and emotional)	“I think helping with, like our mental health during that time, like definitely counseling could have been given, and things like that. But what I know from our counseling, and what I have been through with the counseling at our school, it wouldn’t have done much just because of their expertise... they didn’t really know what to do in that situation... Or not just counseling, but better help, you know, because most of the time people just go to counselors to get their courses like fixed or anything like that... they should be able to help kids find resources outside of school or get better resources for in the school.” -Youth 2066
More MH supports	Youth: More counselling supports available Parents: Increased funding and staffing levels Increased MH supports for non-crisis situations Quick access to emergency MH supports for crisis situations Increased access to and funding for counseling Follow-up care after discharge from emergency care Informal/approachable peer support groups Community Indigenous cultural supports	“I see all the levels of supports that are there struggling from a lack of funds and a lack of people right... when we look at the big picture of things like mental health causes physical health problems. Physical health is fully funded. Right? How much could we cut out of physical health needs if we actually just dealt, helped support people who were struggling with their mental health. I just find it really sad... we’re not in a place where nobody’s getting harmed right, there is harm happening [to our family]. And still the resources that are available are so small. And part of that is people and part of that is funds right?” — Parent 333
Empowering parents/families to support child MH	Parents: Education and awareness of what MH problems look like, and what to do when they arise Practical tools for how to support their child’s MH	“Whenever we’re offered a parenting thing, it’s huge. Like it’s huge because I don’t know what to do... I don’t know what to do with them as teenagers and I don’t know how to deal with self-harm and I don’t know how to deal with—like I have no idea. So, like parent education or even just options out there... But

	MH literacy training for parents and primary care providers	it's hard to even know, I don't even know where most people would begin with accessing help. And a lot of people don't have GPs either, but even if you do have a GP, GPs often don't even know where to begin it feels like." — Parent 5839
COVID-19-specific supports	Youth: Alternate vaccine forms for children with needle phobias More availability and awareness of online supports during the early pandemic (i.e., when in-person services were shut down)	"I would have really liked if they got like a nose version of the vaccine, because I don't really do well with needles." — Youth 2840
	Parents: MH check-ins for families (e.g., through school or a public health nurse) Pediatric and/or MH supports at vaccine clinics	"I think, for the vaccine clinics, there should have been child psychologists and counsellors on site to help kids. We tried seven times to get him vaccinated... I know they were strapped with staffing and were trying to get as many people vaccinated as possible, but it was a stressful situation even for adults. I think felt like mental health supports for children getting vaccinated would have been good." — Parent 1779
	Parents: Case manager to connect families to supports and coordinate with different clinicians; increased integration between members of the MH/medical team Increased awareness among hospital departments about how to connect families to MH supports Long-term consistency in treating clinicians to maintain progress through a therapeutic relationship Access to MH clinicians with expertise/familiarity with other issues	"In some ways it looks like our kids are doing really good on paper, right? When we had support. When we had all these, the wraparounds and the family integration and community integration. Our kids look like they were doing good and well, and they were. And then, when all of these things fell away, it, you know those underlying things are still there, and you know mental health is a lifelong ongoing thing that needs support. I think we're really seeing the fallout for it... it just really feels like mental health supports have absolutely become a back burner issue especially, and they're like, 'You just deal with it. You're the family, you deal with it'." — Parent 676

4. Discussion

This study adds longitudinal breadth and depth of understanding to the MH needs and support access challenges experienced by Canadian youth throughout the COVID-19 pandemic. We found that participants often accessed both formal and informal MH supports, with private-pay counselling being the most common and consistently accessed type of support. Although the use of MH services was greater over time, approximately one in five youth consistently had unmet MH support needs. Needs were primarily expressed with respect to formal MH supports (via clinical counselling, psychiatrists, or community MH teams), as identified at baseline after the first COVID-19 wave (T1), confirmed at follow-up during the pandemic recovery (T3) and then detailed in youth and parent interviews. During the early waves of COVID-19, MH support needs were largely attributed to pandemic effects; over time, these needs persisted and were less specific to COVID-19. Nonetheless, pandemic-related barriers continued to impact access to MH care at T3.

Previous survey-based findings of unmet MH needs in Canadian youth during COVID-19 have had conflicting results. The rate of unmet MH support needs reported by our sample (20%) is similar to that reported for a young Canadian community sample (16.5%) early in the pandemic [12]. In contrast, Gorfinkel et al. [36] conducted a school-administered survey of Grade 11 students in British Columbia (mean age = 17) and found

that 40.8% had unmet MH support needs, double the rate observed in our cohort (mean age = 9) and similar to the rate reported for a clinical sample (45%; mean age = 21) [12]. This difference may be accounted for by age, given our past findings of increasingly poor MH outcomes between the ages of 8 and 18 [10]. Moreover, youth in older grades are more likely to report elevated stress and psychological distress, having accessed MH supports, and having unmet MH support needs during the pandemic [49]. Indeed, some interview participants described increased stress and anxiety in older youth who experienced or were approaching major transitions into or out of high school. Alternatively, our quantitative findings may underestimate unmet MH support needs over time, as those completing T3 follow-up surveys tended to be those who reported better outcomes at baseline (i.e., younger age, male, with educated parents) [10]. Our quantitative data are also limited to parent proxy report, which may underestimate actual youth MH support needs due to limited awareness of their child's MH experiences. This is entirely plausible, given that 39% of youth in Ontario report rarely or never talking to a parent about their problems or feelings [49].

Participants reported difficulty accessing MH supports via both survey and interview responses; in particular, parents struggled with knowing where to get help, the limited availability of MH supports, and the cost of services, and discussed these challenges as entrenched failures of the healthcare system. These barriers have been reported in the Canadian MH system for some time [30], but have been further exacerbated by COVID-19-related challenges [4,50], which was discussed by both youth and parent proxy participants. Indeed, a recent report by our team—exploring how to support youth mental health through the pandemic recovery period—highlighted the importance of mental health service integration to help young people, their families and providers navigate the many actors and organizations supporting youth mental health [51]. Barriers to MH support became more impactful for families experiencing acute MH concerns, with several parents describing crisis situations in which they were unable to access support and several family members' MH began or continued to deteriorate. When MH supports were accessed, participants sometimes described negative experiences—such as lack of clinical expertise or lack of emotional or cultural safety (issues that have been previously reported in Canada) [50,52,53]—that impacted the quality of care and subsequent willingness to return to that service. These issues, though not frequently discussed, were reported by participants with minoritized identities and/or who lived in small communities, consistent with previous reports [50,52–54]. It is important to note that while the barriers reported here did not always prevent youth from obtaining MH support (as shown by survey findings), they often still caused challenges for families in the form of treatment delays and/or reductions in the frequency of care, as described in multiple participant interviews. Thus, the impact of these barriers may be more significant than quantitative findings alone would suggest, and require careful consideration of not just whether MH supports can be accessed, but how they can be accessed quickly, consistently, equitably and effectively.

Importantly, our qualitative analysis identified an additional factor affecting participants' experience with MH supports. Those who had accessed MH supports frequently discussed the importance of the therapeutic relationship between the youth and their counsellor/MH clinician, and how this determined whether or not the support provided was experienced as helpful. Youth who accessed a counsellor with whom they “clicked” described positive impacts on their coping and MH, whereas those without such a relationship struggled to make progress toward their treatment goals. Therapeutic alliance is a key factor in psychotherapeutic success [55]—particularly for adolescents and youth [56]—but was often a quality that was difficult for youth and their parents to find in their search for MH support. An effective therapeutic relationship is challenging to achieve in a public health system in which there is high clinician burnout and turnover [57]—which,

again, has been further compounded by the COVID-19 pandemic [58]; it is then left up to the family to access private therapists and invest the time required to find a good youth–clinician match and/or build an effective relationship over time. This further adds to the disparity between families with and without the ability and resources to access private therapies, and emphasizes the need to retain clinicians in publicly funded positions. Further funding and scaling-up of MH service delivery is needed [30] to ensure that the components required for an effective therapeutic alliance—including regular contact, consistent care, and the development of trust and an authentic relationship [59,60]—are made available in public healthcare spaces.

Our study findings included mixed perspectives on virtual care. Pandemic-specific barriers—including discomfort with telehealth—were frequently rated as negatively impacting MH care access (QUAN). Virtual MH supports were sometimes reported as being less helpful than in-person services (QUAL, particularly by parent proxies)—consistent with previous reports that the majority of youth prefer in-person counselling [36] and that people may experience difficulty establishing a therapeutic alliance online [61]. Many youth, however, expressed a preference for online MH support in their interviews—citing discomfort expressing their feelings face-to-face, or ease of accessibility with online counselling. Previous work has identified that virtual care is well-suited for certain individuals, including younger people [32], those with access to a private space [32], people facing transportation or scheduling barriers [62], and those who prefer anonymity [61] or find in-person sessions overwhelming [63]. However, virtual care may not be feasible or appropriate for everyone, particularly individuals who lack access to technology or privacy [32,61,62], do not speak English [61], live in unsafe environments [61], are very young or unwell [50,62] or are neurodiverse [50]. It therefore seems that while virtual care will be a fixture in our MH care system going forward [61,62], care must be taken to foster therapeutic relationships [63,64], and virtual care should be one of multiple options that should be made available for youth in Canada. Indeed, both youth and parent proxy interviewees expressed desire for multiple, flexible access options (see Table 3).

Throughout participant discussions of barriers to MH care, many expressed a strong need for additional MH funding and supports—in particular, through schools and primary care. The provision of MH supports through schools has been recommended in previous work [29,36,65], as well as by the Mental Health Commission of Canada [6], particularly in response to the increased MH challenges caused by the pandemic [29]. Parents in our study wanted MH supports in schools: to facilitate early identification of MH problems and easy access to support; to be closely integrated with external MH supports and other services to ensure continuity of support; and to teach MH awareness and promotion to youth (see Table 3), as has been argued in the literature [6,29]. Youth participants also wanted to be able to access support through their schools, either directly in the form of counselling, or through referral to external resources. The integration of MH literacy and support through schools could increase awareness of early signs of poor or declining MH, and help normalize support-seeking for students who experience discomfort reaching out for support [29] or who doubt that they are “sick enough” to access support [66], which was expressed by several youth in our study. Providing easy access to support earlier in the presentation of MH challenges—such as through schools—can help prevent the escalation of MH problems to crisis situations, at which point much more resource-intensive supports are required [16,29,67]. Indeed, the urgent need for MH literacy and integrated MH services was prioritized in both BC and Ontario—through the expansion of Integrated Child and Youth teams in BC school districts [68], and the introduction of MH legislation, curriculum and funding for Ontario schools [69]—both representing important steps towards strengthening school-based MH supports for youth.

Parents also discussed their desire for improved access to MH care through primary care. Up to 80% of Canadians rely on their family physician for mental health support [70], and MH concerns were the most common reason for primary care appointments during the COVID-19 pandemic [71]; however, MH services through primary care are limited [70]. Parents specifically wanted primary care providers to be able to provide direction in terms of what MH supports are available and how they can be accessed, given the difficulty they reported with knowing where and how to get help. Several parents in our cohort described “amazing” primary care providers who were knowledgeable and able to provide additional support and/or quickly connect their child to community MH services; however, this was considered an exception by most parents, as primary care providers are often disconnected from other MH supports [72] and/or are challenged by time constraints and the management of multiple indications [73]. Furthermore, 13–31% of Canadians do not have a family physician [74,75]. Thus, many parents in our study expressed needing an “advocate” or “point-person” to connect them to appropriate services, such as a clinician navigator [76,77]. Navigators were also desirable for parents of children with complex needs, who must access MH supports in addition to multiple other clinical and social services [77]. When discussing MH supports in schools, primary care, and other clinical settings, parents emphasized the need for support before symptoms escalated to a MH crisis, and for the integration of MH services across settings in order to provide holistic and cohesive support for youths’ physical and mental well-being.

In addition to formal supports, youth participants also described the importance of receiving MH support from their relationships, particularly from friends. In contrast, parent proxy interviews rarely included such discussions, suggesting that parents may not always be aware of the support their youth receive from their friends, or that they may not recognize these relationships as important MH supports. Having supportive peer relationships is a protective factor against suicide, depression, anxiety and stress [78], and these relationships should not be discounted. COVID-19 had profound impacts on social networks, and efforts should be made to foster openness and connectedness among youth; feeling understood and supported — “having someone to talk to” — is a valuable form of support for youth in our study and in the literature [59]. Addressing MH through school programming could have secondary impacts on the informal support youth receive through their peer networks by normalizing conversations about MH. Relatedly, support from family and friends is a facilitator of receiving MH care [53,59]. Many parents in our cohort experienced difficulty managing their child(ren)’s MH in addition to their own, and reported feeling lost and unsure of how to support their child during the pandemic. Conversely, the pandemic also provided some families with new opportunities to discuss emotions, stress, and MH [79], as reported by some of our participants. Empowering parents to support their child’s MH (see Table 3) may enhance youth engagement with both informal and formal MH support.

Limitations

Parents who completed interviews were more likely to have a youth with a psychiatric disorder or a complex medical condition than survey respondents. Our qualitative sampling procedures were designed to ensure representation of youth with both resilient and vulnerable MH status in order to explore their experiences with MH care and access barriers, so a higher rate of psychiatric disorders is expected; however, some self-selection bias may be present in our interview sample, with those experiencing more difficulty in accessing care being more likely to participate. Our recruitment strategies also resulted in some interview participants being related (parent, child, sibling pairs); some perspectives could therefore be related amongst families. In addition, while youth perspectives were

captured in qualitative interviews, quantitative youth-reported data was not available due to low response numbers ($n = 8$).

There was a reduction in the number of surveys collected at the follow-up time points (T2 only [$n = 96$], T3 only [$n = 31$], Both [$n = 50$]) compared to the baseline ($n = 507$). Different participant-related or social factors may have contributed to the high rate of attrition, including the COVID-19 pandemic and the time intervals between baseline and follow-ups; therefore, the results should be interpreted with caution, as this reduction may have affected the statistical power and representativeness of our sample. Although not statistically significant, there were notable numerical differences in the characteristics of follow-up respondents versus baseline-only respondents: follow-up respondents were more likely to have a bachelor's degree and a child who was younger and male—a group that tends to have better MH outcomes than others. The PICS, which was used in this study, was developed iteratively with contributions from multiple stakeholders [10], and some minor changes were applied to the wording of the questions at different time points; therefore, it may not be directly comparable over time due to changes to survey design and question wording, and this may have affected our ability to reliably capture the longitudinal data. Thus, our follow-up survey data may underestimate rates of MH support needs and access during the later stages of COVID-19.

The majority of our QUAN and QUAL participants were White and had some university education, and the majority of baseline survey participants had an annual household income over \$100,000 CAD. Therefore, our data are not generalizable to the Canadian youth population, and the data we collected lack the experiences of people of various races, genders, and education levels, and diverse, marginalized communities (low income, newcomers, remote location, or Indigenous communities). Further research is needed to be more representative of all Canadian youth and the barriers that may be experienced by different communities.

5. Conclusions

This mixed methods study illuminates details of the COVID-19-era experiences of Canadian youth with respect to MH supports and unmet needs. Youth and their parents experience challenges accessing MH services that have been exacerbated by the COVID-19 pandemic. Difficulty navigating the MH care system, limited availability of supports, and the cost of MH care are major barriers to receiving MH services. Additional MH funding and support provision via schools, MH navigators or advocates, flexible access options and parental education are needed to better support Canadian youth and families.

Supplementary Materials: The following supporting information can be downloaded at: <https://www.mdpi.com/article/10.3390/covid6070122/s1>, Parent proxy interview guide; Table S1: Baseline responses about MH needs for all T1 respondents, and for those with follow-up data; Figure S1: Barriers to obtaining MH supports at baseline, for youth who needed but did not receive MH supports (parent proxy report; $n = 108$).

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Abbreviations

MH	Mental health
PICS	Personal Impacts of COVID-19 Survey
QUAL	Qualitative
QUA	Quantitative

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