Barriers and Facilitators to Accessing Mental Healthcare for Black Children & Youth:

A Scoping Review

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ABOUT THE PATHWAYS TO CARE PROJECT

Pathways to Care is a community-driven and youth-led systems change project committed to transforming the mental healthcare system for Black children, youth and their families.

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TABLE OF CONTENTS

ABSTRACT

There is evidence to suggest that Black children and youth in Canada face surprisingly large challenges to getting mental healthcare. So, the goal of this scoping review was to map current information on the barriers (things that prevent) and facilitators (things that help) to care for Black youth in Canada. For our scoping review, we looked at both scholarly articles and grey literature published between January 2005 until May 2019. We searched through six (6) databases for relevant academic articles: CINAHL, PsycINFO, PubMed, EBSCOhost, Social Science Citation Index, and Applied Social Sciences Index & Abstracts. We sourced Grey literature (i.e., book chapters, reports and presentations) from community recommendations and Google.

Thirty-three (33) sources were included in our search. We coded the data and analyzed them by following guidelines set out by a process called "Thematic Analysis." In our search, we found that barriers to care for Black youth happened at multiple levels of society, including at the systems-level, Provider-patient level, and personal and community-level. At the systems level, wait times, poor access to doctors and mental health professionals were identified as some of the barriers to care. At the Provider-patient level, racism and discrimination, a lack of culturally competent care, and a lack of support within organizations prevented proper access to care. Lastly, personal and community barriers such as stigma made accessing care more challenging. Support from family and friends, as well as a good relationship with providers, were noted as things that helped Black youth gain access to care.

The findings of this review suggest that Black children and youth face many barriers to accessing the Canadian mental healthcare system even though it is considered to be universal. These findings suggest that an increase in funding, including mental healthcare in the universal healthcare system, and a greater effort on delivering culturally competent, care are needed to increase access to care for Black children and youth. Research that follows this report should focus on Black youth, should draw from community-based research, and should explore the multiple overlapping identities of Black youth in relation to mental illness.

INTRODUCTION

The mental wellbeing of children and youth is b ecoming a national public health issue in Cana da (Archie et al. 2010). In fact, one out of every five children in Canada who needs mental healthcare is unable to access it (Canad ian Mental Health Association [CMHA] 2020).

Good mental health in children and youth is important, as illnesses may not necessarily go away on their own as children gtow into adults (Lipman & Boyle 2008).

Recently, there have been calls from the community highlighting the need to address mental health in Canadian Black children and youth (Patel 2015; Taylor & Richards 2019). Understanding the barriers and facilitators that affect access to mental healthcare for Black children and youth is especially important because they face unique challenges, including racism (Lalonde, Jones & Stroink 2008), higher levels of poverty (Khenti 2013), and social exclusion (Adjei & Minka 2018). Beyond that, Black youth who do not access mental health treatment are likely to face difficulty in school, family conflict and increased interaction with the justice system (Planey, Smith, Moore & Walker 2019).

MENTAL HEALTH IN BLACK POPULATIONS

Canada is home to one of the most ethnically diverse populations in the world. 20% of Canadian residents are foreign-born (Chiu 2017). Black people represent the third-largest population of racialized people in Canada, nearing 3.5% of the total population (Statistics Canada 2016). As race-based data related to all health outcomes are not collected in Canada, there is very little information about the rates of mental illness in this population. Though research in Canada is limited, evidence from the United States (US) does shed insight on potential challenges and areas of concern.

A national survey of American adolescents found that 46.8% experienced some form of mental illness before the age of 18 (Planey et al. 2019; Merikangas et al. 2010). Furthermore, Black youth in the US are more likely to be diagnosed with major depressive disorder (MDD) than white youth and six times more likely to die by suicide due to their depression (Williams et al. 2007). Beyond that, Black youth with MDD were likely to remain untreated. In a national sample of youth with major depression, Black youth in the US were less likely to receive mental healthcare in a hospital clinic than white youth (Cummings & Druss 2011). Futhermore, racism has implications for the prevalence of mental illness in Black populations. In a review conducted by Paradies (2006) which focused on defining and conceptualizing racism in health research, almost half of the included studies' outcomes focused on mental health. Self-reported racism was also associated with poorer mental health outcomes (Paradies 2006).

MENTAL HEALTH IN CANADA

A great deal of research has identified the social and economic challenges that affect the mental health of Black children and youth. Black youth access mental healthcare through both the criminal justice system and through the emergency room at much higher rates than other populations. This suggests that Black youth are not receiving care for their unless they are 1) interacting with the justice system or 2) are showing enough signs and symptoms that they need intense intervention (Anderson 2015; Anderson, Cheng, Susser, McKenzie & Kurdyak 2015). The higher rates of access through the justice system and emergency room visits may be due to both the over-policing of Black youth and at the same time, the fact they may delay seeking care until symptoms can no longer be managed. There is also evidence to suggest that it is very difficult to get access to mental healthcare for Black youth in Canada through treatment and that there is a reliance on the justice system to get care (Finlay et al. 2019). Beyond that, Black Canadians may delay or avoid seeking care because of their mental health challenges and their lack of trust in mental healthcare professionals.

Many activists in the Black community have described mental health and addiction issues as a “crisis” (Taylor & Richards 2019). Given the challenges Black children and youth face in terms of mental health, the state of the mental healthcare system is concerning. The current conceptualization of mental healthcare systems is neither designed for young people nor accessible to them (Macdonald et al. 2018). What's more, Black youth in Canada need to navigate this insufficient system with the added challenges of discrimination and institutional racism (Arday 2018). Identifying the barriers and facilitators to mental healthcare in Canada is necessary to understand the access needs of Black children and youth in Canada and reduce the challenges to accessing care for Black children and youth.

So, the purpose of this scoping review is to address the gap in existing research related to how Black children and youth access the mental healthcare system in Canada. In keeping with that goal, the primary research question was:

What are the barriers and facilitators to accessing mental health and addictions care for Black youth in Canada?

WHAT IS A SCOPING REVIEW?

A Scoping review is a research activity where you try to "map" what other researchers are saying about a topic (Pham et al., 2014). When you do a scoping review, you are trying to provide an overview of the material and give a summary of what has been said.

METHOD

For our scoping review, we followed the protocol for scoping reviews outlined by Arksey and O'Malley (2005) and Levac, Colquhoun, and O'Brien (2010). For this review, the authors followed the PRISMA reporting guidelines for scoping reviews. Suggestions provided by the Joanna Briggs Institute Reviewers' Manual (2015) added to our method and reporting. There are six steps needed for a scoping review:

- **Identifying the research questions**
- **Identifying relevant studies**
- **Study selection**
- **Charting the data**
- **Collating, summarizing and reporting the results**
- **Consultation**

IDENTIFYING RELEVANT STUDIES

Reviewers met throughout the search process to determine the best course of action.
Topics discussed included:

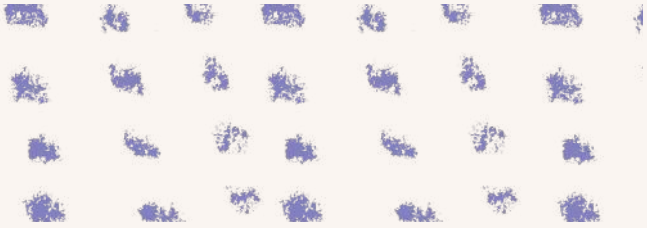
1) Purpose of the scoping review
2) Keywords
3) Population, context, and outcome
4) Databases to search

1) PURPOSE

To identify and map the current state of mental health and addictions care for Black children and youth (population) in Canada.

2) KEY WORDS

Black, Youth, Family*, Canada, Mental Health, Substance Use and Addiction, Best Practices, and Community Organizations



3) POPULATION, CONTEXT & OUTCOME

Population

Black children and youth (childhood-30 years old) living in Canada.

Context

Settings where mental healthcare and addictions services are accessed by and offered to Black children, and youth

Outcome

Barriers and facilitators to care

4) DATABASES SEARCHED

CINAHL, PsycINFO, PubMed, EBSCOhost, Social Science Citation Index (SSCI) and Applied Social Sciences Index & Abstracts (ASSIA)

IDENTIFYING RELEVANT STUDIES II

Inclusion criteria for the peer-reviewed articles were:

1) Peer-reviewed
2) Focused on the Canadian context
3) Original studies using qualitative and quantitative data
4) Focused on Black youth residing in Canada and mental health namely, the barriers and facilitators to accessing mental healthcare, and best practices for mental healthcare
5) Published in English
6) Conducted between 2005-2019

STUDY SELECTION

The final search was done on May 14th, 2019. The software reference manager, Mendeley, was used for the management of citations and for the identification of multiple copies of the same article. References were then imported in Covidence, a software designed to manage systematic reviews for further analysis.

GREY LITERATURE SEARCH

Grey literature was found through a variety of methods. Colleagues familiar with the subject and stakeholders of the Pathways to Care project provided some sources.

Other grey literature sources were found through Google by searching the names of well-known mental health organizations that worked with Black communities. Once organizations were identified, the websites of other organizations that they partnered with were also searched for relevant grey literature. If reports were not available to be downloaded, we requested them through e-mail.

A Google search was started using a combination of the key terms "Black," "youth," "mental health," "addictions," and "Canada." In the search process, Canada was replaced with provinces and cities across Canada to make the search more specific.

CHARTING THE DATA

Data were taken and noted from source material into Microsoft Excel using the following categories: Authors/organization, year of publication, title, objective, province/territory, population demographics (age), population demographics (race), sample size (if applicable), method and source type (if applicable), barriers, facilitators, and gaps in research.

ANALYSIS

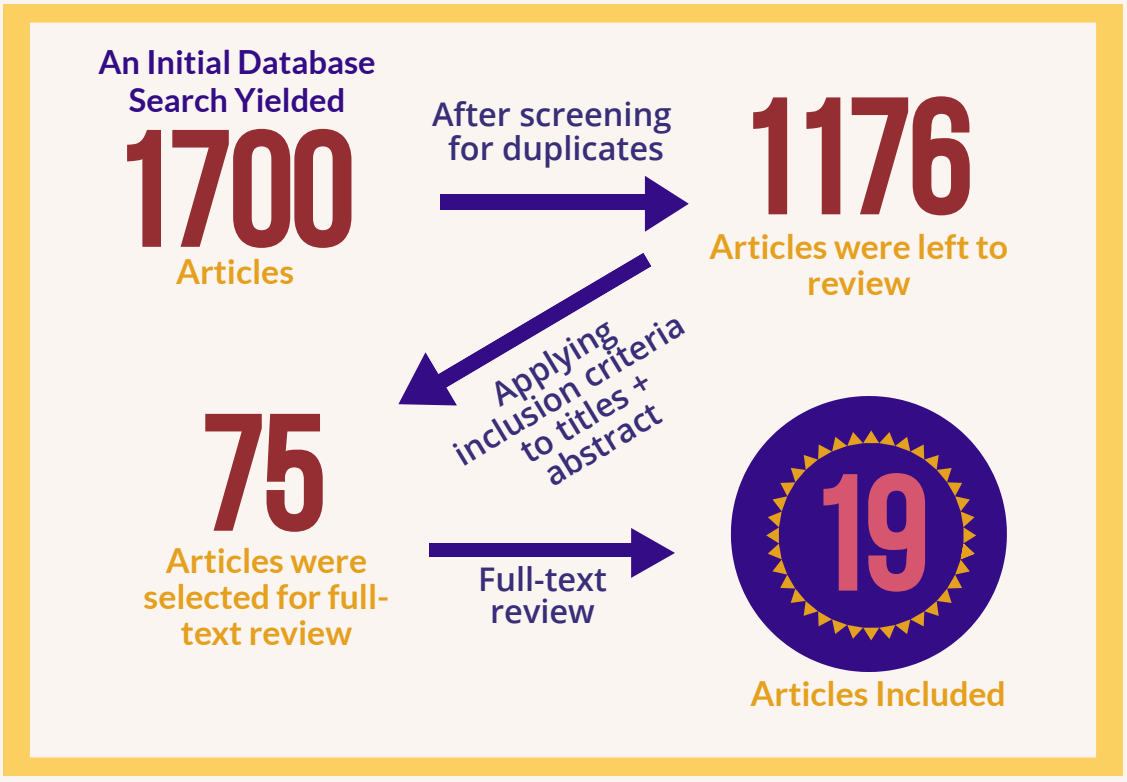
The datasets we created in Microsoft Excel were uploaded into Nvivo 12 for further analysis. Themes were coded according to standard methods for thematic analysis (Braun and Clarke 2009).

RESULTS

Our first search through all the databases found 1700 articles. After the first search, we screened for duplicates in Mendeley. After the screening, 1176 articles were left to be assessed for relevance. Articles were then uploaded into Covidence to do more screening. Both authors analyzed the titles and abstracts of articles that were left to ensure they met the inclusion criteria. Of the 1176 articles reviewed, 1101 didn't meet the inclusion criteria, and 75 were left for full-text review. Again, both of the authors reviewed the full texts independently. 19 articles were included after the review. If there were disagreements, both authors reviewed the article together and determined if it met the inclusion criteria.

Thirty (30) grey literature documents were identified as possibly relevant to the scoping review based on the title and date of publication. After a full-text review, 14 grey literature documents met the inclusion criteria. Grey literature sources were assessed with the same criteria used for the peer-reviewed literature (except making sure they were pee-reviewed). In total, 33 articles and grey literature documents were included in the scoping review (see PRISMA-SCR map).

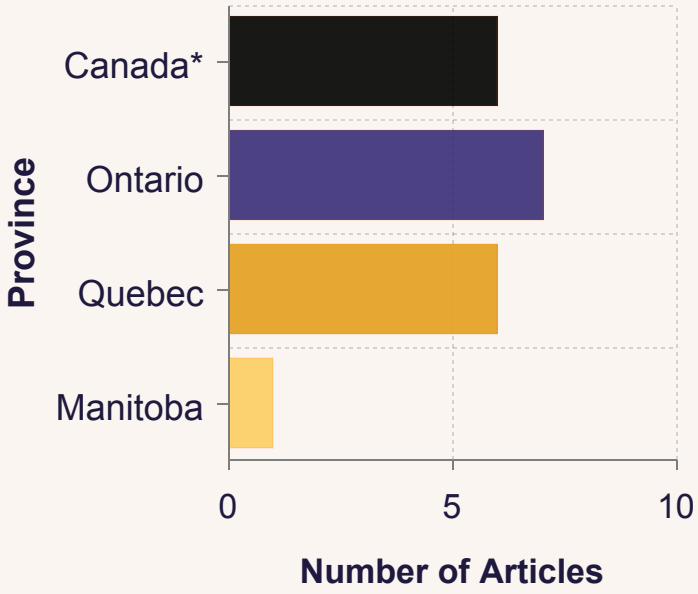
STUDY SELECTION - JOURNAL ARTICLES



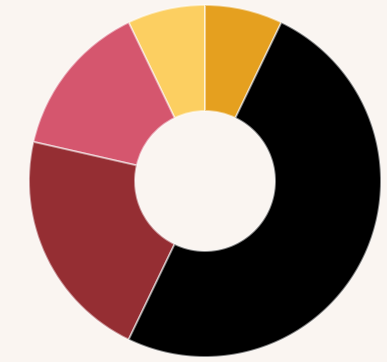
CHARACTERISTICS OF SOURCES

The research articles included in this scoping review were mostly located in Ontario and Quebec. More specifically, 36.8% were conducted in Ontario (n = 7), 26.3% (n = 5) were located in Canada, 31.6% (n = 6) in Quebec (5 of which took place in Montreal), and 5.3% (n = 1) in Manitoba. For grey literature, most of the studies were done in a few places. 14.3% (n = 2) of grey literature material was written or conducted with a population that lived in Canada. 78.6% (n = 11) were in Ontario, of which six were in Toronto and surrounding areas, and 7.1% (n = 1) were in Quebec, specifically in Montreal

Setting of Research Articles



Methodology for Grey Literature



Quantitative	1
Qualitative	7
Mixed-Methods	3
Other Data	2
None Listed	1

Method

Peer-reviewed studies were mostly quantitative (73.7%, n = 14), while 26.3% (n = 5) were qualitative in nature. The methodology of grey literature sources was more varied: 3 reports (21.45%) used a mixed-methods approach, 50% (n = 7) used a qualitative approach, including community-forums, panel consultations, engagement sessions, roundtable discussions, and key informant interviews. Two sources (14.3%) relied on other sourced data to form recommendations, and one source (7.1%) used a quantitative approach with surveys. The final source was a PowerPoint presentation that did not list a methodology

*Sources that listed "Canada" as their location instead of a city or province

CHARACTERISTICS OF SOURCES II

Study participants in grey literature sources who fell under the umbrella category of “African, Caribbean, and Black” were described as “Black,” “of African descent,” and others were described as belonging to “racialized communities.” Sources described their samples by countries of origin where race had to be assumed by the authors, such as “Ghanaian,” “St. Vincentian”, and “Sudanese” and of “West Indian” descent (a common alternative for Caribbean). Common population descriptors in peer-reviewed articles included "African," "African-American," "Caribbean," "Black-African," "Black-Caribbean," "Black." Other descriptions included "Black," as described in the Canadian census, "Caribbean-Canadian," "Afro-Caribbean," "immigrant and refugee populations from Africa," as well as "migrant populations from Africa." Many peer-reviewed articles included other populations in addition to "Black" people.

Nine sources mentioned a theory or approach. The most common was an anti-oppressive framework, which was used by four sources (Black Health Alliance 2015; Lovell & Shahsiah 2006; McMurtry & Curling 2008; Seiler, Shamonda & Thompson 2011). Three sources used an anti-racist approach (Hasford, Amponsah & Hylton 2018; Black Health Alliance 2015; Lovell & Shahsiah 2006). There was overlap in the use of both anti-racis t and anti-oppresive theories. This is most likely because they are closely related and often draw from each other. Lastly, the use of socio-cultural theories, which related environment to mental illness, was also common (Emerson, Minh & Guhn 2018; Tranulis, Corin & Kirmayer 2008; Whitley 2016).

Descriptions of Participants

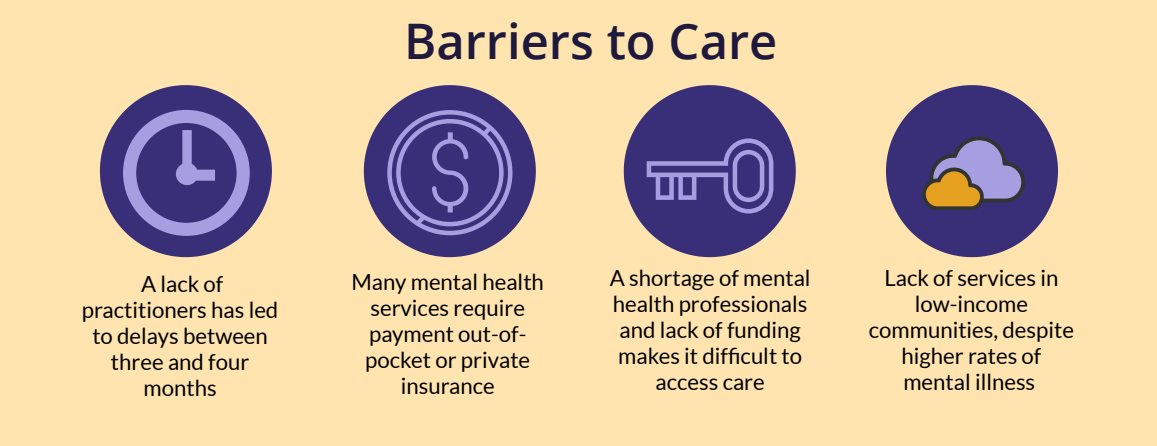
BARRIERS TO CARE

Systemic Barriers to Care

Many of the obstacles to care related to structural problems within the mental healthcare system in Canada. Barriers included wait times to access mental healthcare practitioners, poor access to practitioners (especially Black practitioners), and geographical and financial barriers to care. Lastly, adverse (or negative) pathways to the mental healthcare system were identified as barriers.

Wait times in the mental healthcare system for Black children and youth were noted as a significant barrier. Anderson et al. (2015) found that Black-Caribbean populations waited on average, 16 months for care, more than twice the wait experienced by white patients, who waited for seven. Black patients also had delays in referrals between three and four months (Anderson et al. 2015). One explanation for wait times connected them to a lack of funding for evidence-based psychological services delivered by psychologists and other mental health professionals (CMHA 2018). Other reasons for wait times were: a shortage of mental health professionals, including psychiatrists, psychologists, nurses, and social workers (McMurtry & Curling 2008), as well as a poorly defined system of care (Lovell & Shahsiah 2006).

Poor access to mental health professionals often led to poor follow-up and worse mental health as a result (CMHA 2018). Access to family doctors is often the first pathway to mental health and addiction services, and 80% of Canadians depend on them for mental healthcare (CMHA 2018). Still, many Black youth have poor access to family doctors (Anderson, McKenzie, & Kurdyak 2017). Anderson et al. (2015) identified that only 35% of Black-Caribbean and 51% of Black-African participants had access to a family doctor, compared to 62% of White participants. What's more, family doctors play a large role in mental healthcare, but they may be unable to meet the mental healthcare needs of Black youth properly (CMHA 2018). Access to Black mental health professionals highlighted as important (Office of the Provincial Advocate for Children & Youth 2018). But, there are not enough Black professionals in the mental healthcare sector to meet demand (Shahsiah & Ying Yee 2006).



Challenges related to finances were often mentioned as a barrier to care (Whitley 2016). Mental health and addiction services in Canada (except for hospital services) either require payment out-of-pocket or private insurance coverage from “good, stable employment” (CMHA 2018). The need for upfront payments for care may turn away Canadians who are un- or underemployed and cannot afford them. Medications are a barrier if the patient has to pay for them first before getting reimbursed (CMHA 2018). The financial barriers to care may add to challenges related to race, as large differences exist in access to mental health professionals for Black children and youth. White participants were far more likely to receive mental healthcare through a psychologist because of their increased access to private insurance (Archie et al. 2010). These challenges may also impact how Black youth manage their mental illness as stress related to finances was also as a barrier to recovery (Whitley 2016).

Black youth are underrepresented in treatment-oriented voluntary services. They are also overrepresented in forced services such as prisons and correctional facilities and hospitals (Ontario Ministry of Children and Youth Services 2016). Though access to care in hospitals helped to reduce financial barriers to care, it is linked to less use over time and unhappiness with mental health services. In this review, findings suggest youth were not comfortable accessing hospitals (McMurtry & Curling 2008). Hospitals were seen as harmful to mental health (van der Ven, Bourque, Joober, Selten, & Malla 2012) and not compatible with recovery (Whitley 2016). Being hospitalized was also associated with a lack of follow-up. Lovell and Shahsiah (2006) noted that patients often regretted seeking mental healthcare, especially when they were treated in psychiatric and hospital-based care. Unfortunately, Black youth were likely to be committed against their will or knowledge (van der Ven et al. 2012) and to first get treatment at hospitals (Anderson et al. 2017).

Black children and youth are also accessing care through the criminal justice system (Alexander 2018). In a study by Archie et al. (2010), 23% of Black youth were introduced into mental healthcare treatment by police. Black youth are often not treated for mental illness due to a lack of access (Ontario Ministry of Children and Youth Services 2016) and underfunding of services that meet the cultural needs of Black youth (CMHA 2018). Stigma from within the community is also a barrier (Anucha et al. 2017). Often, when the mental health needs of Black youth aren't met through mental health services, the lack of care leads to contact with the criminal justice system (McMurtry & Curling 2008; Office of the Provincial Advocate for Children & Youth 2018). Black youth entering care through the criminal justice system is of concern because it is often unprepared to address mental illness, which encourages further run ins with the justice system (Office of the Provincial Advocate for Children & Youth 2018).

Provider-patient Related Barriers to Receiving Care

Many challenges to receiving care were identified, including racism and discrimination, difficulty taking ideas about anti-racism and putting them into action, and a lack of organizational support for providers.

Racism and discrimination

Racism that occurs throughout society contributes to the likelihood and severity of mental illness (Anderson et al. 2015) and makes gaining access to mental health services more difficult (Shahsiah & Ying Yee 2006). Furthermore, racism is historically entrenched in the way we teach and think about mental health (Alexander 2018). Racism overlaps with the stigma of mental illness to encourage further prejudiced treatment of Black youth seeking care from mental health providers (Lovell & Shahsiah 2006).

Putting anti-racism ideas into practice

Many treatment programs focus on a European point of view (Shahsiah & Ying Yee 2006) and fail to provide culturally competent care (Archie et al. 2010). Programs also lack understanding of the complex needs and intersecting oppressions that Black youth encounter (Office of the Provincial Advocate for Children & Youth 2018). Eurocentric care can reinforce stereotypes (Alexander 2018) and further silence clients (Shahsiah & Ying Yee 2006). When Eurocentric and culturally incompetent care is centred in treatment, the result is ineffective care that often fails to address the realities of Black clients (Shahsiah & Ying Yee 2006).

A lack of cultural understanding can have serious consequences. The consequences identified in this review included improperly diagnosing mental illness (van der Ven et al. 2012), over or under-medicating (Shahsiah & Ying Yee 2006), improperly medicating (Tranulis et al. 2008) and misunderstanding patients' cultural descriptions of their experiences. Clients often used religious examples to describe their mental health, which was misunderstood by providers (Tranulis et al. 2008; van der Ven et al. 2012). The experiences of racism and culturally incompetent care added barriers to care. Treatments that did not include holistic aspects of mental healthcare (Black Health Alliance 2015; Shahsiah & Ying Yee 2006) often resulted in Black youth not having their needs met and mistrusting their mental healthcare provider (Office of the Provincial Advocate for Children & Youth 2018).

Mistrust of the mental healthcare system was mentioned as a reason for withdrawing from mental health services (Hasford et al. 2018). Among immigrant and refugee youth, only 3.8% discussed looking for mental healthcare, mainly because they did not trust the approaches used (Woodgate & Busolo 2018). Lastly, cultural stigma (Hasford et al. 2018), and marginalizing stigma from healthcare professionals (Ferrari et al. 2015; Shahsiah & Ying Yee 2006) were also named as barriers to care.

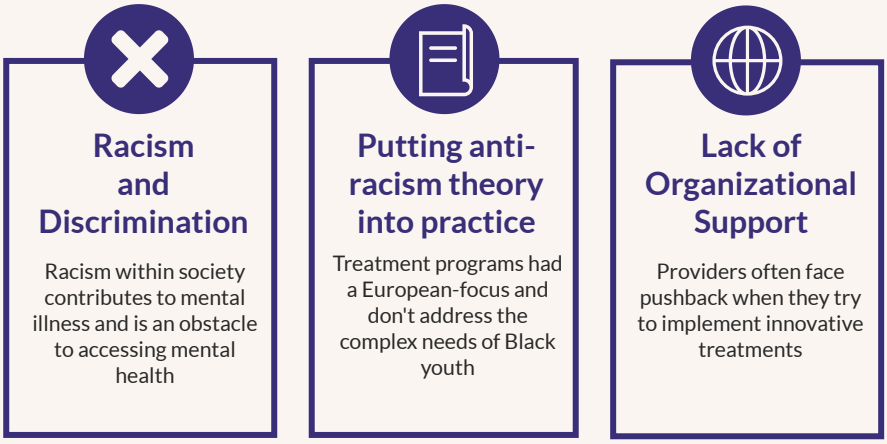
In addition to racism and discrimination impacting access to the mental healthcare system, practitioner challenges related to their organizations also presented as a barrier. When practitioners wanted to provide culturally competent care, they faced limitations related to practice. Many practitioners found that there was a “conceptual gap” (Shahsiah & Ying Yee 2006) between identifying the need to use anti-racist theory in their work and incorporating it into treatment. Beyond that, service providers did not have the tools to provide anti-racist services (Shahsiah & Ying Yee 2006). There was also a clear need to redefine mental health to reflect a more holistic definition (Shahsiah & Ying Yee 2006). Racism is a determinant of health (Mikkonen & Raphael 2010), and many organizations want to implement anti-oppressive standards; however, practices were often conceptual and not always enforced.

Lack of organizational support

Similarly, a lack of organizational support was mentioned as a barrier for practitioners wishing to provide mental healthcare to Black children and youth. Barriers for practitioners took many forms and included organizational restrictions related to funding requirements and difficulties related to challenging the way that services were delivered. Practitioners faced pushback when implementing innovative programming, and risked marginalization when they challenged current practices to better provide appropriate services (Shahsiah & Ying Yee 2006). Often, this was related to restrictions placed on organizations by funders, whose focus was on evidence-based treatments (Shahsiah & Ying Yee 2006). This focus on evidence-based treatment created tension when practitioners believed those treatments were not the most effective for their clients (Shahsiah & Ying Yee 2006).

Challenging the status quo surrounding race and treatment was difficult when senior employees were mostly White (Shahsiah & Ying Yee 2006). Organizations often made claims about their values and goals concerning anti-racism and anti-oppression, but changes were often surface-level. Racialized service providers in these organizations were placed in the role of "tokens", without having their suggestions for improving care heard.

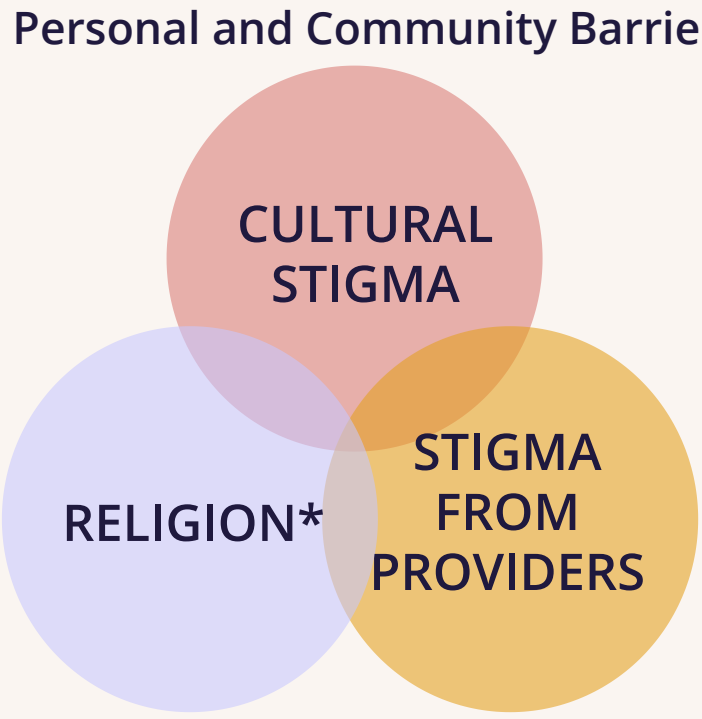
Provider-patient Related Barriers to Receiving Care



Personal and Community Barriers

Black youth may avoid or delay seeking care due to cultural stigma (Hasford et al. 2018; Whitley, Wang, Fleury, Liu, & Caron 2017). Mental illness in the Black community is stigmatized (Whitley 2016) and simultaneously unacknowledged by the community (Anucha et al. 2017). Furthermore, in Black communities, mental illness is often attributed to religious interference (Tranulis et al. 2008). Religiosity is helpful in the development of personal schemas surrounding mental illness (Whitley 2016). However, challenges arose when spiritual forces were invoked as the sole cause of illness (Tranulis et al. 2008), and when religious intervention was upheld as the only treatment (Ferrari et al. 2015).

Stigma intersects with the experience of racial discrimination (Shahsiah & Ying Yee 2006), which may lead Black youth to ignore signs and symptoms (Ferrari et al. 2015). Moreover, stigma often led to a lack of discussion, causing youth to look for treatment on their own or delay seeking care, in fear of judgment from their family and community (Anucha et al. 2017; McMurtry & Curling 2008) and to avoid being labeled as “crazy” or “mentally ill” (Lovell & Shahsiah 2006). As a means to self-medicate and shield their illness from family and friends, cannabis was often used as a coping mechanism (Ferrari et al. 2015). Stigma also had implications for treatment adherence (CMHA 2018; Whitley et al. 2017). Stigmatization from mental health providers was considered to be particularly harmful (Ferrari et al. 2018, Shahsiah & Ying Yee 2006) and caused patients to regret seeking treatment (Ferrari et al. 2015; Shahsiah & Ying Yee 2006).



*Religion also helped patients to describe their thoughts and perceptions on their mental illness (Whitley 2016)

FACILITATORS TO MENTAL HEALTHCARE

Family and friends were noted as facilitators to care and as sources of emotional support (Shakya, Khanlou, & Gonsalves 2010). Beyond that, support from family members and friends positively impacted recovery from mental illness (Black Health Alliance 2016). Studies have shown that friends or family initiated between 36-56% of “help-seeking,” respectively (Archie et al. 2010; Ferrari et al. 2015). However, this relied on family recognizing symptoms and realizing that mental illnesses is causing them (Archie et al. 2010).

Family involvement also has an impact on staying in treatment, particularly for younger children. For parents of children aged 4-15 with externalizing mental illness symptoms, parents' beliefs in the ability for treatments to be effective, and their ability to manage their child's behavior impacted treatment engagement and dropout rates (Shanley & Reid 2015). However, this relied on a family-centered approach and clinicians working to adapt treatments and strategies to include parents’ perceptions. In contrast, with a slightly older population, family involvement may cause clinicians to perceive that patients may be less in need of services. This may lead to less assertive follow-up and may increase the likelihood of disengagement (Anderson, Fuhrer, Schmitz, & Malla 2013).

As stated before, many Black youth have challenges accessing mental health providers. However, youth identified that having a “connection” to mental health service providers was important to them (Office of the Provincial Advocate for Children & Youth 2018). Youth considered this connection to be a source of “social support” (Whitley 2016). Lastly, religion and religious institutions were mentioned as facilitators to mental healthcare (Whitley 2016), and youth identified religious spaces as being comfortable to seek support from (Shakya et al. 2010). Religious competence in treatment may also assist patient recovery (Whitley 2016).

DISCUSSION

Given the importance of addressing mental health challenges in youth (Lipman & Boyle 2008) and the calls from community organizations for action on mental health in Black Canadian populations (Black Health Alliance 2016; Taylor & Richards 2019), understanding the barriers and facilitators to mental healthcare is necessary. The findings of this review respond to those calls by collecting and summarizing the range of current knowledge related to Black youth and mental healthcare access in Canada. Commitment to community is a driving force of this scoping review (Chambers et al. 2018). So, sources were taken from both academic articles and work done by community organizations. The findings of this review contribute to the current research on this topic.

Barriers were varied and occurred at multiple levels of society. Systemic level barriers included: wait times, poor access to mental practitioners, and geographical and financial barriers to care. Often, when Black youth did access the system, it was because they were involved in the justice system, or because they were showing enough symptoms to need outside intervention.

In the treatment setting, receiving adequate care that met the needs of Black youth was also difficult. Racism and discrimination from practitioners impacted the experience of getting care for Black children and youth. This was reinforced by care that failed to meet the cultural needs of Black youth. Mental health providers themselves faced limitations in thinking about and implementing anti-racist theories and standards into their work. Interpersonal barriers included stigma and mistrust of the mental healthcare system. Internalized stigma and perceived stigma from the community made it less likely that Black youth would seek out mental healthcare. Beyond that, stigma often caused Black youth to hide their mental illness. Black youth who experience mental illness were further impacted if they were stigmatized by their healthcare providers. This experience may result in Black youth regreting seeking treatment.

Recommendations for Future Research

Across all sources, there appears to be a shortage of research that explores the experiences of mental illness and barriers to care for Black youth. This especially true for Black youth who inhabit multiple identities that are oppressed (Emerson et al. 2018). There is a need for further peer-reviewed research on barriers to care for Black youth with anxiety, depression, and those who experience challenges with addictions. More research into what interventions work best Black youth and the usefulness of adapting current evidenced-based interventions would go a long way to improve access to care.

Research should question the impact of racism on mental health, both from a qualitative and quantitative standpoint (Anderson et al. 2017). Youth perspectives of treatment effectiveness, cultural competence, and the Eurocentric focus of treatment needs to be considered (Black Health Alliance 2015; F.A.C.E.S. of Peel Collaborative 2015). Ideally, this research should use a community-based participatory research (CBPR) approach and involve youth throughout the research process.

Community organizations and providers would benefit from research that explores and evaluates different approaches to treatment. This research should consider the experience of racism and barriers to access. They should also be evaluated for feasibility over time (CMHA 2018). The impact of racism and culture on the diagnosis of mental illness is of concern. Further evaluation of diagnosis and treatment protocols for Black youth is necessary. Likewise, there is a need for a review of current diagnostic and referral practices of organizations that want to serve Black youth. Strategies to avoid negative pathways to care and wait times should also be reviewed. These evaluations would benefit from analysis on the impact of race-based data collection on organizational practice (Adeponle, Thombs, Groleau, Jarvis, & Kirmayer 2012; Anderson et al. 2013; van der Ven et al. 2012).

Black communities have been requesting the collection of race-based data for some time (Black Health Alliance 2015). Although this review did not focus on research related to the rates of mental illness in Black children and youth, the fact that no current research relates to the prevalence of mental illness is of concern. Beyond that, the lack of research that focuses on which mental illnesses affect Black children and youth the most is a glaring gap in current research.

Implications

The articles and grey literature included in this scoping review had implications for mental healthcare in Canada. First, there needs to be a strong effort in the mental healthcare system to ensure that Black youth are not falling through the cracks of a poorly designed system (Lovell & Shahsiah 2006). More funding for the Canadian mental healthcare system is needed, particularly as it relates to Canada's single-payer plan. Two aspects of healthcare have been historically not funded in Canada: prescription drugs and mental healthcare. Recently, the Liberal federal government announced funding for a national pharmacare program (Ballingall 2019). The findings of this article strongly suggest that a similar measure should be taken for mental healthcare.

In noting that a universal mental healthcare system would help to reduce disparities, it is necessary to consider the effects of enforced care and hospitalization. Hospitalization was linked to decreased use and dissatisfaction with mental health services (Whitley 2016). Similarly, coordination needs to occur to prevent Black youth with mental illness from interacting with the justice system as a result of that illness, though this will require transformational change within both the mental healthcare and justice systems (Corrigan & Boyle 2003; Finlay et al. 2019). A universal healthcare system that is expanded to include mental health would address many of the financial barriers to accessing mental healthcare (Archie et al. 2010). But, it may be insufficient in addressing all disparities to access. As evidenced by existing racial inequities in accessing care in Canada (Nestel 2012), universal healthcare alone will not reduce disparities if it does not consider the effects of racism on mental healthcare. The findings of this review clearly show that Black children and youth require mental healthcare that is culturally responsive and is affirming the reality of racism and other forms of oppression (Archie et al. 2010; CMHA 2018; Hasford et al. 2018; Office of the Provincial Advocate for Children & Youth 2018). Afrocentric standards of care must be implemented, and practitioners must be aware of the unique needs of Black children and youth to close the gap that currently exist between ideas and action (Shahsiah & Ying Yee 2008).

Funding should be set aside to aid mental health organizations and researchers to innovate novel mental health treatments and adapt existing evidence-based practices to be culturally competent. There is also a need for more diversity in senior leadership roles in mental health organizations. More diversity may lead to more flexibility in mental healthcare provision.

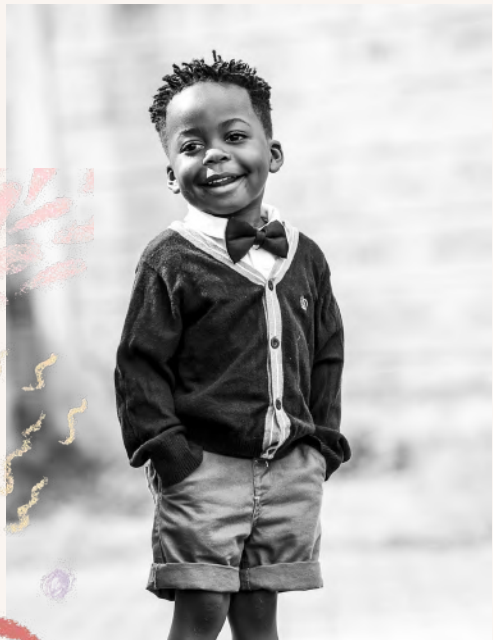
CONCLUSION

There is a lot that is still not known about the barriers and facilitators to accessing mental healthcare for Black children and youth. So, the purpose of this scoping review was to address gaps in research on this topic.

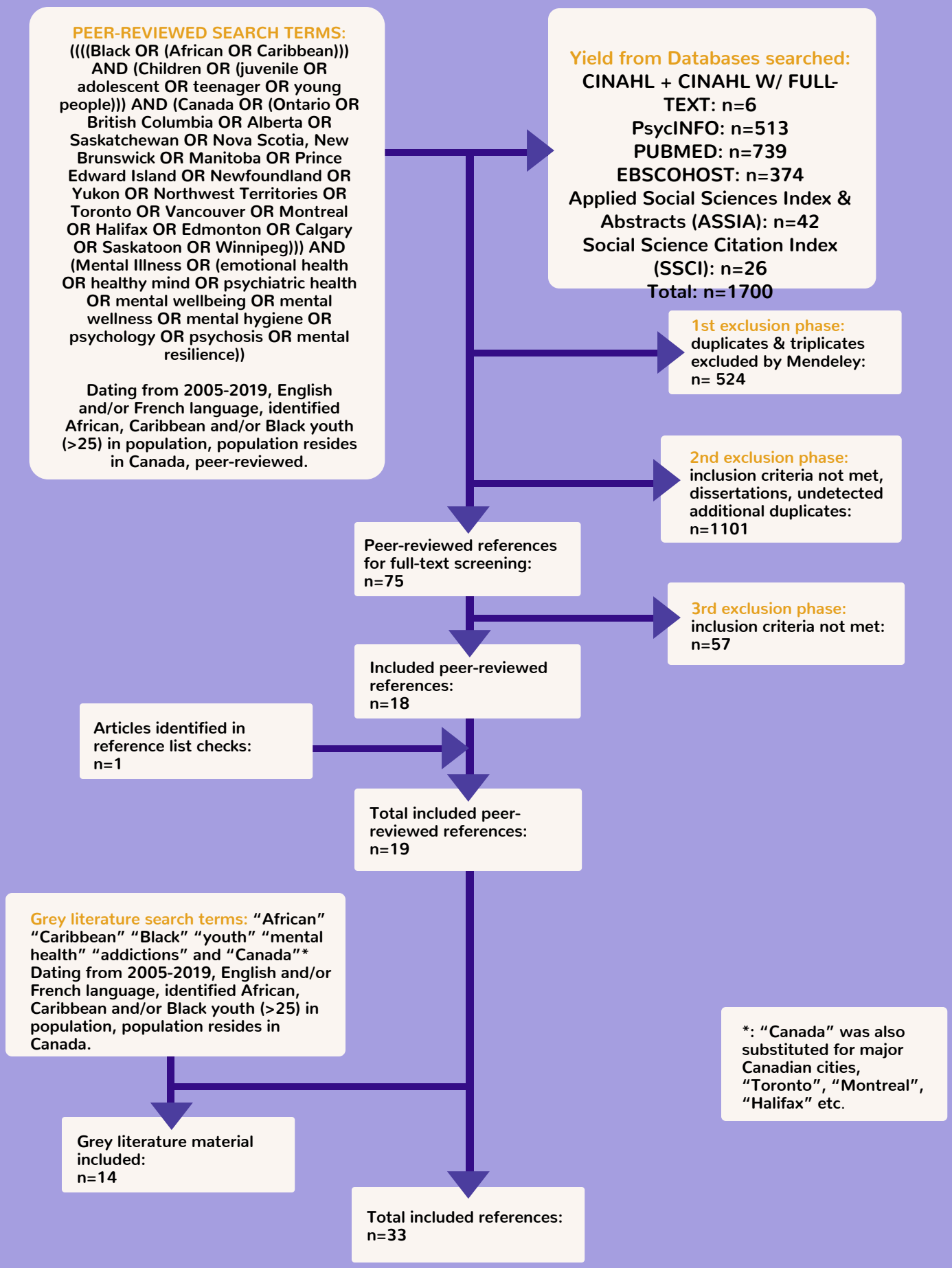
A review was conducted on sources that focused on Black youth in Canada. The review resulted in 33 sources. Many barriers to care were identified, including barriers at the systems level and negative pathways to care, including interactions with the justice system and hospitals. Certain things about receiving care from providers caused more challenges for Black children and youth.

Racism and discrimination from providers and organizational challenges related to coming up with innovative ways of doing care made addressing mental health in Black youth people more difficult. Lastly, personal and community barriers related to cultural stigma also hindered access to care. While there were fewer facilitators, family and community, and a connection with mental health providers were considered to aid access. The implications of these findings highlight that despite a universal healthcare system, many challenges remain for Black children and youth accessing mental healthcare. The findings suggest that the current organization of the healthcare system in Canada is harmful to youth. Many of these challenges further implicate practitioners and organizations and highlight the importance of adapting to the needs of Black children and youth.

Research that focuses on Black youth that is rooted in community-based participatory research approaches is imperative. Moreover, further research should explore facilitators, developmental needs, and intersecting identities in the context of mental illness. By synthesizing and summarizing existing research, this article answers a call from the Black community in Canada. It provides a basis for further research with this population.



PRISMA-ScR Map



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