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Barriers in Accessing Child Mental Health Services for Parents and Caregivers

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Barriers in Accessing Child Mental Health Services for Parents and Caregivers

by

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MSW Clinical Research Paper

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

Millions of children in the United States suffer from untreated mental health problems. However, much of the literature available on barriers to mental health does not address the barriers children face in accessing services. This systematic review was designed to explore the research question: What are the barriers parents and caregivers face in seeking and receiving mental health services for children in the United States? A systematic search was conducted for peer-reviewed articles since 2000 using the following search terms: *child, mental health, mental health services, parent, parental, help-seeking, barriers, cultural barriers, unmet, and treatment*. These search terms were entered in the following electronic databases: PsychInfo, Social Work Abstract, Google Scholar, and Summon. Ten articles were identified and included in this systematic review based on meeting inclusion and exclusion criteria as well as a quality assessment. Through a review of the 10 articles, barriers that parents and caregivers face in meeting their children's mental health needs were identified. The obstacles identified from the articles were categorized into four groups: logistic barriers, financials barriers, child characteristics, and parental characteristics and beliefs. Future research is required to further understand the role parents play in accessing mental health care for their children and strengthen the generalizability of current findings. It is important for social workers to understand the barriers which parents and children face in accessing services in order to increase the accessibility of children's mental health care.

Keywords: children, mental health, barriers, parents, caregivers

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Introduction

Many factors can impact the ability for parents to access mental health services for their children, and barriers frequently arise. Parents can be faced with many obstacles that make it difficult access or physically getting to services. When children have unmet mental health needs, they struggle to develop and can acquire problems later in life, such as depression, substance abuse, problems in school, homelessness and run-ins with the law (National Federation of Families for Children's Mental Health [FFCMH], 2008).

One of the problems that have been recognized as impeding care delivery to children with mental health needs focuses on their parents' access to service delivery. While this is a major issue, limited literature exists on the barriers that children face in accessing mental health services. It is important to identify the barriers parents and caregivers face in order to decrease those obstacles, allow access to children's mental health. The present study intends to analyze the available literature on the barriers parents and caregivers face in accessing mental health services for their children. This systematic review aims to explore the research question, what are the barriers parents and caregivers face in seeking and receiving mental health services for children in the United States?

Prevalence

Mental health disorders are one of the leading causes of disabilities worldwide (Merikangas, Nakamura, & Kessler, 2009). In the United States, about 20 percent of children suffer from a diagnosable mental disorder (Child Mind Institute Speak Up for Kids, 2015; FFCMH, 2008; Glied, & Cuellar, 2003; Holm-Hansen, 2006; Merikangas, 2010; Nanninga, Jansen, Kazdin, Knorth, & Reijneveld, 2015; National Alliance on Mental Illness [NAMI], n.d; Perou et al., 2013; Power, Eiraldi, Clarke, Mazzuca, & Krain, 2005; Shatkin, & Belfer, 2004).

Yet, less than 30 percent of these children suffering from mental illnesses receive services for mental health (Burns, Costello, Angold, Tweed, Stangl, Farmer, & Erkanli, 1995; FFCMH, 2008; Nanninga et al., 2015; Power et al., 2005). However, the children that do receive services are at risk of dropping out of treatment. About 30 to 65 percent of children terminate prematurely from treatment because of various barriers that clients may encounter, as well as the level of engagement of mental health practitioners with their clients (Manfred-Gilham, Sales, & Koeske, 2002). This means that millions of children in our country are going without the help they desperately need.

Previous literature has focused on identifying which children are more likely to have unmet mental health needs. According to the literature, school-age children (age 5-18) are more likely to receive services than children under age five (Power et al., 2005). A study by Kataoka et al. (2002) conducted a secondary data analysis on three national surveys on the rates of mental health service use by children and adolescents. The study found that school-age children are as much as three times more likely to receive mental health services than children between the age of three to five years-old (Kataoka et al., 2002). Most mental health issues are identified in the schools, which may account for the age difference in children who receive mental health services and children who do not (Burns et al., 1995). This may be because children's behaviors may be recognized as a problem once they are compared to other children. When analyzing gender differences, previous literature has found that boys are more likely than girls to obtain services (Katoaka et al., 2002; Power et al., 2005). Racial and ethnic differences have also been identified between children receiving mental health care and children not receiving care. Caucasian children are more likely than African American or Latino children to obtain services (Katoaka et al., 2002; Power et al., 2005). Minority youth with behavioral or learning problems are less likely

to have high quality assessments and treatments for their mental health needs (Bussing & Gary, 2012). Overall, minority parents and caregivers are less likely to seek mental health services for their children or participate in research projects. Additionally, children living in poverty or children who are a part of the child welfare system are two to four times more likely to have mental health problems than other children in the United States (Glier & Cuellar, 2003).

Millions of children today are not receiving the mental health services they desperately need. Some mental health problems in childhood can improve with age; however, many issues are more long-term (Cuellar, 2015). Children who have unmet mental health problems are at a greater risk of having long-term negative consequences later in life (Cuellar, 2015). Some examples of negative consequences later in life include lower educational attainment, lower employment rates, lower wages, and higher rates of crime (Cuellar, 2015). About 70 percent of youth in the juvenile justice systems have a mental illness (Child Mind Institute Speak Up for Kids, 2015; FFCMH, 2008; NAMI, n.d). In addition, these youths are at risk of incarceration as adults (Child Mind Institute Speak Up for Kids, 2015). This high percentage of youth with mental illness in the judicial system may indicate a relationship between an increased risk to commit a crime and unmet mental health issues. In addition, of the youths who commit suicide, 90 percent had an underlying mental illness (Child Mind Institute Speak Up for Kids, 2015; FFCMH, 2008; NAMI, n.d). This means that millions of deaths may have been prevented if only these youth had received the appropriate mental health services. The staggering prevalence of children and youth with unmet mental health needs should be of great importance to professionals because these issues can become more severe later in life.

Trends in Children's Mental Health

The first child mental health efforts were in the early 1900s aiding abandoned youth who were in trouble with the law, but providing mental health services rather than punishment (Lourie & Hernandez, 2003). However, a policy was never created from this movement for children's mental health services (Lourie & Hernandez, 2003). In 1965, Congress established "The Joint Commission on the Mental Health of Children," where they advocated for children's mental health needs. Unfortunately, a mandate was again never developed (Lourie & Hernandez, 2003).

One of the more influential pieces of national legislation addressing children's mental health needs was the "Individuals with Disabilities Education Act" (IDEA) which was first created in the mid-1970s (Lourie & Hernandez, 2003). This act required that all children with a disability receive an education tailored to their needs. In the 80s and 90s, two more programs were developed to address children's mental health needs, the "Child and Adolescent Service System Program" (CASSP) and the "Comprehensive Community Mental Health Services for Children and their Families Program" (Lourie & Hernandez, 2003). However, these programs did not create meaningful and comprehensive mandated mental health services for children and still today there has never been a policy or plan of action to address this (Lourie & Hernandez, 2003; Shatkin & Belfer, 2004). The authors describe policies on children's mental health as informal and lacking uniformity. Current mental health policies for children's mental health, focuses on the financial aspect of service delivery. These policies affect how health insurance for children's mental health care pays for services or the policies affect how government funds are distributed to mental health agencies for children (Glied & Cuellar, 2003).

Since the 1980s, there has been an increase in the number of children receiving treatment and an increase in the number of evidence-based treatments available for children's mental health needs (Glier & Cuellar, 2003; Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001). Evidence-based practice is defined as a "body of scientific knowledge about service practice," (Hoagwood et al., 2001). Evidence-based treatments for children differ from treatments for adults, in that they must take developmental stages and family dynamics into account (Hoagwood et al., 2001). Much of the increase in treatment is due to the role of primary care physicians. Between 1985 and 1999, the percent of children's physician visits that also included a mental health diagnosis and psychotropic medication prescription nearly tripled (Bussing & Gary, 2012). The efforts by primary care physicians to identify mental health problems increased the awareness of mental health and the availability of some form of services to address mental health issues (Glier & Cuellar, 2003). However, many of these physicians misdiagnose or over-diagnose children (Glier & Cuellar, 2003). In an article by Glier and Cuellar (2003), they examined the trends and issues in children's mental health and found that the average patient visit to a general physician that included the prescription of a psychotropic drug lasted only about 20 minutes, which suggests that assessments are not very in-depth. In a survey by Pidano, Honigfeld, Bar-Halpern, and Vivian (2014), of the 72 pediatric primary care providers surveyed, over one third of providers reported having no specialized training in behavioral pediatrics and almost half of providers reported having no relationship with a mental health specialist. These findings suggest that doctors may be ill-equipped to correctly diagnose mental health issues, let alone be the sole provider of mental health services.

In recent years, there has also been a decrease in inpatient care for children and an increase in outpatient and community-based care services (Glier & Cuellar, 2003). In 1996,

inpatient settings only accounted for about one third of the total government mental health spending (Glied & Cuellar, 2003). Instead, funding for alternatives to inpatient care increased, such as funding for service development (Lourie & Hernandez, 2003). Examples of alternatives to inpatient care include partial hospitalization, case management, use of child psychiatrists, and other community-based services (Glied & Cuellar, 2003). Like adults, children's mental health care is subject to health insurance coverage. Many children who are uninsured are not receiving mental health care due to its high costs (Glied & Cuellar, 2003). This may also account for why primary care physicians are more often sought out for mental health services.

Today, most mental health services are provided in a school setting (Burns et al., 1995; Cuellar, 2015). The most common forms of treatment are focused on parents and teachers, social skills, cognitive skills, and focused on managing symptoms (Cuellar, 2015). Although more children are receiving mental health care in the United States than ever before, there are still millions of children who face significant barriers to care. Many times, children are labeled delinquent or educationally disabled in order to get the necessary mental health services (Lourie & Hernandez, 2003). Although more children than ever are being identified and treated for mental health issues, there is still a huge gap between children who have met and unmet mental health needs. Understanding the possible barriers to receiving the necessary treatments is vital to create more effective programs for all children with mental health problems.

Barriers For the purposes of this systematic review, barriers will be defined as an obstacle in accessing mental health services. About one third of parents who feel their child has a mental health need reported facing difficult barriers to care (Mendez, Carpenter, LaForett, & Cohen, 2009; Owens, Hoagwood, Horwitz, Philip, Poduska, Kellam, & Ialongo, 2002). In the study by Mendez et al. (2009), the authors interviewed 201 parents participating in a community-

based preventative intervention program about their barriers to participation in the program. The authors found that the greater number of barriers that a parent reported decreased their attendance in the program (Mendez et al., 2009). These obstacles can occur at all stages of the help-seeking process (Powers et al., 2005). Parents and children may face numerous struggles in accessing children's mental health services. Not only do barriers create an obstacle to receiving care, but they also increase the likelihood that a child will prematurely terminate care (Kazdin et al., 1997).

In a study by Manfred-Gilham, Sales, and Koeske, (2002), the authors interviewed 33 mental health therapists and 30 case managers about the potential barriers their clients face and their use of engagement strategies with their clients. The study found that about 30 to 65 percent of families prematurely terminated mental health services for their child (Manfred-Gilham, Sales, and Koeske, 2002). Some examples of barriers include scheduling, location of services, transportation, cost/insurance, mental health policies, child behaviors, gender, race/ethnicity, cultural beliefs, language spoken, stigma, family issues, recognizing mental health, parental perceptions, and relationship with the therapist.

Scheduling In a study of parental perceived barriers among 201 low-income parents, about 50 percent reported that work schedule conflicts prevented them from receiving mental health services for their child (Mendez et al., 2009). A similar study by DeRigne (2010) analyzed a subsample of the National Survey of Children with Special Health Care Needs consisting of 1,301 parents who reported the reasons for unmet mental health need of their children. DeRigne (2010) found that parents reported difficulty getting appointments and inconvenient appointment times as a barrier. Similarly, the 201 parents interviewed from a community-based preventative intervention program in the study by Mendez et al. (2009) also identified complications

scheduling appointments when they needed to find child care services for other children. In addition, there are not enough mental health providers to accommodate all the children who would benefit from services, which creates long waitlists for appointments (Children's Defense Fund, n.d.). When services are not coordinated between service providers, it creates more difficulties for the parent to meet appointments (Cuellar, 2015).

Location/Transportation Depending on a family's location, mental health resources may not be readily available, especially to people in rural communities (Children's Defense Fund, n.d.; Power et al., 2005). In the study by DeRigne (2010) of the subsample of parents from the National Survey of Children with Special Health Care Needs, the results showed that about 10 percent of parents did not have mental health services close to their home. In both the study by DeRigne (2010) and the study by Mendez et al. (2010), the authors found that about 10 percent of parents reported having transportation problems to mental health services. When parents face few options when it comes to easily accessible agencies, it creates a significant obstacle in getting their child to their mental health appointments.

Cost/Insurance In addition to the quantity of services, the out-of-pocket costs and gaps in insurance coverage may prevent parents from obtaining mental health services for their children (Cuellar, 2015; DeRigne, 2010; Holm-Hansen, 2006; Kazdin et al., 1997; Power et al., 2005; Saechao, Sharrock, Reicherter, Livingston, Aylward, Whisnant, Koopman, & Kohli, 2012). A study by Saechao et al. (2012), interviewed a focus group of 30 first-generation immigrants to the United States on the stressors and barriers to using mental health services. They found that poverty and low income was identified as a serious barrier to mental health services (Saechao et al., 2012). In the study by DeRigne (2010), about 20 percent of parents reported that mental health services cost too much and two percent of the sample reported being uninsured. Families

in poverty have a harder time obtaining health insurance, and consequently, affording mental health. In addition, poverty may cause indirect barriers, such as affording to take time off work to attend appointments and having access to transportation (Holm-Hansen, 2006; Saechao et al., 2012). When families have insurance, many times their insurance will only cover certain treatments for only a designated amount of time (Cuellar, 2015). Costs can be a significant obstacle for all families that prevents their child from accessing necessary services.

Policies In a study by Gould, Beals-Erickson, and Roberts (2012), they obtained all 50 U.S. state mental health plans and analyzed them for gaps and barriers to mental health services. They defined gaps as non-existing services and barriers as problems that prevent access to services. Their study found that 84 percent of state plans identified at least one gap in their system. A lack of service providers was the most cited gap in the state plans (Gould et al., 2012). A shortage of providers contributes to the many challenges that parents face, such as difficulties scheduling and locating nearby mental health services. The study also found that 90 percent of state mental health plans recognized at least one barrier in their system with the most identified barrier being a lack of funding (Gould et al., 2012). As seen in the previously stated literature, parents often identify financial limitations as a significant obstacle to mental health care.

Child Problems Specific child mental health issues, as well as child behaviors, can increase or decrease the likelihood of parents seeking professional help. Multiple studies have found that the more severe a child's mental health issues are, the more likely it is that that child will receive services (Kazdin et al., 1997; Power et al., 2005). In addition, the type of mental health issues affects the likelihood of seeking services. In a study by Thompson (2005), the author interviewed 269 caregivers from a larger longitudinal study. In analyzing the children who received mental health services, 22 percent had externalizing problems, six percent had

internalizing problems, five percent had major life events, and 23 percent sought services for other problems (Thompson, 2005). In this study, children with internalizing problems were the least likely to seek services. Therefore, internalizing symptoms may be a barrier for children to receive the necessary services. Lastly, the study by DeRigne (2010) also found that parents reported children refusing to go to treatment as a barrier to mental health services. When children oppose going to mental health appointments, it can create challenges as well as stress for the parents. Other characteristics of the child, such as their gender, can also cause unique complications in receiving mental health services.

Gender Some studies have explored the differences in rates between girls and boys who receive mental health services. Some studies have found that girls are less likely than boys to receive services (Burns et al., 2015; Thompson, 2005; Power et al., 2005). In a study by Burns et al. (2015), 1,015 children identified with behavioral problems from a larger longitudinal study were interviewed along with their parents. The study found that boys were more likely than girls to have a mental health diagnosis and to have used mental health services in the past (Burns et al., 2015). Similarly, the study by Thompson (2005) found that girls were significantly less likely to receive mental health treatment than boys. The author stated that this may be as a result of the finding that girls were also less likely to be identified as needing mental health care (Thompson, 2005). However, these differences have not always been found in other literature (Thompson, 2005).

Race/Ethnicity Racial and ethnic differences have been found in children who receive and do not receive services. Lower rates of service utilization have been found in minorities (Power et al., 2005). Additionally, minority parents have sometimes been shown to report more barriers, but in other studies this difference has not been shown (Power et al., 2005; Stevens et

al., 2006). In a small qualitative study of 30 first generation immigrants by Saechao et al. (2012), all the parents reported discrimination as a barrier to accessing mental health services. The inconsistencies in the literature of the relationship between race/ethnicity and barriers to mental health services, indicates a need for further study.

Culture/language Cultural beliefs about mental illness could influence parents about the causes of mental illness and ways to treat it (Holm-Hansen, 2006; Children's Defense Fund, n.d.; Saechao et al., 2012). For example, some cultures may contribute mental illness to an issue of spirituality and seek out religious leaders for help. In the small qualitative study of 30 first-generation immigrant parents, all the parents reported language differences as a barrier to mental health (Saechao et al., 2012). If a parent does not know much English, it can be extremely difficult for them to find services and be able to participate effectively in services for their child. The study also found that half of the parents reported differences in cultural practices as an obstacle to mental health care (Saechao et al., 2012). If a parent has a certain cultural practice that differs from the agency, it may be difficult for the parent to find services that accommodates their beliefs.

Stigma Fear of judgement from neighbors, family, or community members may also discourage seeking mental health services (Golberstein, Eisenberg, & Gollust, 2008; Holm-Hansen, 2006; Saechao et al., 2012). A study by Golberstein et al. (2008), surveyed 2,782 undergraduate and graduate students on perceived public stigma towards mental health service use. The study found that stigma was higher amongst males, older students, international students, students with lower income backgrounds, and students with current mental health problems (Golberstein et al., 2008). In Saechao et al.'s (2012) study of 30 first-generation immigrants, about 67 percent of parents identified stigma as a barrier to seeking mental health

services for themselves. Although these two studies do not address the stigma of children's mental health, it does exemplify the stigma towards mental health that adults identify. Many times parents are blamed for their children's mental health issues, which creates a barrier in seeking help (Holm-Hansen, 2006).

Problem Recognition Knowledge of what mental illness is and how to recognize it can play a role in seeking child mental health services. If parents do not recognize their child's behaviors as needing professional mental health services, they will not seek it out (FFCMH, 2008; Power et al., 2005). Believing that a child's behavior is normal or a phase instead of a mental health concern, parents will be less likely to seek services. In order to recognize a mental health problem, a parent must be able to identify the severity, the functional impairment, caregiving burden, and problem onset (Power et al., 2005). Therefore, the first step in seeking services is to recognize that there is a problem.

Parental perceptions Individual perspectives also cause significant obstacles for families. Some individuals feel mental health is a personal issue, and the individual should be self-sufficient to fix their problems (Holm-Hansen, 2006). Similar to problem recognition, if a parent feels that he or she should be able to solve their child's problems, then they will not seek out professional services. Research has found that parents' perceived barriers to mental health treatment for their children significantly predicted participation and early treatment termination (Kazdin et al., 1997; Kazdin et al., 1997). How parents and caregivers perceived the barriers they faced was a better predictor than both family and child characteristics. In addition, one study found that parents' treatment selection was influenced by trust, social support, social validity, and help-seeking patterns (Power et al., 2005). If parents perceive obstacles to treatment as a

large barrier, then they will be less likely to seek services than parents who do not view the same obstacle with the same severity.

Therapist relationship Similar to parent perceptions is how parents view their relationship with their therapist when they do seek out services. When parents have a positive expectation towards treatment they are more likely to seek out services (Morrissey-Kane & Prinz, 1999). When both therapists and parents perceived higher rates of barriers to treatment, parents were more likely to drop their child out of treatment (Kazdin et al., 1997). A study by Manfred-Gilham et al. (2002), interviewed 33 mental health therapists and 30 case managers about the potential barriers their clients face and their use of engagement strategies with their clients. They found that when therapists perceived that parents may have barriers to treatment, they are more likely to discuss it with clients, be more accommodating to parents, and make more of an effort to engage with their clients (Manfred-Gilham et al., 2002). Therefore, it is important for clinicians to be able to identify the potential hurdles parents may face in order to make mental health services more accessible and to foster a stronger relationship with clients.

A barrier can include anything that causes difficulty in accessing or seeking mental health services. Much of the available literature focuses on barriers to mental health for adults or has inconsistent findings. Although many barriers may apply to parents seeking services for their children, there are also many unique circumstances when a family is involved. It is important for clinicians to understand these obstacles families face in order to make services more accessible for children. Taking this need into consideration, this systematic review analyzes the available literature on the barriers that children and their families face in accessing mental health services. From reviewing the available research, this project will ask the following research question; what

are the barriers parents and caregivers face in seeking and receiving mental health services for children in the United States?

Methodology

The purpose of this systematic review of the literature is to explore the question: What are the barriers parents and caregivers face in seeking and receiving mental health services for children in the United States? With the prevalence of issues in children, it is vital to understand why approximately 80 percent of children do not receive services (Burns et al., 1995; FFCMH, 2008; Nanninga et al., 2015; Power et al., 2005). Acknowledging this gap in understanding, this research aims to provide social workers with the necessary information to reduce the barriers which parents and children face in accessing services. It is important to identify the barriers that children and families face in order for social workers to meet the needs of children with mental illnesses. For this research project, a systematic review of qualitative and quantitative research on the barriers to children's mental health services was used. The articles were found using specific search criteria, review protocol, and quality assessment measures.

Search Strategy

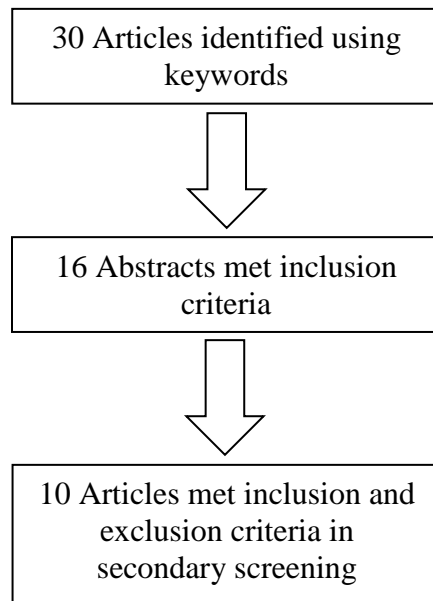
A systematic search was conducted for all peer-reviewed articles since 2000 for parental and child barriers to children's mental health care and services in the United States. The following search terms were used in combination with each other: *child, mental health, mental health services, parent, parental, help-seeking, barriers, cultural barriers, unmet, and treatment*. These search terms were entered in the following electronic databases: PsychInfo, Social Work Abstract, Google Scholar, and Summon. Titles and abstracts were screened for inclusion and exclusion criteria. With this search strategy a total of 30 articles were identified.

Review Protocol

The following inclusion and exclusion criteria were applied. For inclusion in the systematic review the articles must a) pertain to children's mental health (age birth-17), b)

pertain to parental and caregiver barriers in accessing mental health services, c) have a peer-reviewed qualitative or quantitative design, d) be a sample taken from the United states, and e) have been published after 2000. Because of the limited data available, inclusion of both quantitative and qualitative was applied. In addition, by including these study methods, the research can provide both breadth and depth in the findings. Articles published before 2000 were not included in order to gain insight into the current state of research on the topic. Exclusion criteria included articles that focused on specific populations, such as child welfare or specific ethnic groups. To keep the generalizability of findings as high as possible, articles pertaining to specific populations were excluded. Sixteen articles met the inclusion and exclusion criteria. After an additional screening, six articles were eliminated due to inclusion and exclusion criteria. In Figure 1, a flow chart illustrates how this process ensued:

Figure 1. Flow Chart of Article Selection.



Quality Assessment

The quality of the data is an important factor in analyzing and reporting reliable findings. The following quality assessment tool was used to assess the quality of each article to determine inclusion in the systematic review. During the secondary screening of the articles for inclusion and exclusion criteria, a quality assessment was conducted. For each of the following criteria, the article was rated as: Y – item addressed; N – item not addressed; P – item partially addressed; NS – item not stated; or NA – not applicable. The following is the list of the quality criteria for both qualitative and quantitative studies:

- Was the purpose of the study discussed?
- Was the sampling strategies clearly stated?
- Were participant withdrawals/drop-outs addressed?
- Were the methods of data collection clearly stated?
- If stated, do questions have more than one meaning?
- Can the results be generalized?

The 10 articles identified for this systematic review were moderate to high quality as was determined by the quality assessment. Table 1 illustrates the quality assessment checklist for the 10 articles chosen for this study.

Table 1. Quality Assessment Checklist.

Article	Purpose of the study discussed	Sampling Strategy clearly stated	Withdrawals/ drop-out addressed	Methods of data collection clearly stated	Questions do not have multiple meanings	Can results be generalized
Bannon & McKay, 2005	Y	Y	Y	Y	Y	P
DeRigne et al., 2008	Y	Y	NA	Y	Y	P
Fulda et al., 2009	Y	Y	Y	Y	Y	Y
Girio-Herrera et al., 2015	Y	Y	Y	Y	Y	Y
Owens et al., 2012	Y	Y	Y	Y	Y	P
Smith et al., 2005	Y	Y	Y	Y	Y	P
Thurston & Phares, 2008	Y	Y	Y	Y	Y	P
Turner et al., 2015	Y	Y	NA	Y	Y	P
Yeh et al., 2005	Y	Y	NA	Y	Y	Y
Young & Rabiner, 2015	Y	Y	Y	Y	Y	P

Data Analysis

After meeting the inclusion criteria, articles were analyzed to find the barriers in which parents and caregivers face in accessing mental health services for their children. Each article was systematically reviewed three times and findings were summarized into a table. Once the reported barriers from the study results were identified, they were coded into relevant categories. Four barrier categories were developed: logistic, financial, child characteristics, and parental characteristics and beliefs.

Findings

This systematic review of the literature focuses on exploring the barriers parents and caregivers face in seeking and receiving mental health services for children in the United States. It seeks to answer the question: What are the barriers parents and caregivers face in seeking and receiving mental health services for children in the United States? Much of the current literature pertains to adult mental health barriers, barriers to medical care, or demographics of children who receive and do not receive mental health services. Ten articles were found pertaining to the challenges that parents and caregivers encounter when deciding or finding mental health services for their children. The 10 articles that were selected for this systematic review are peer-reviewed studies, published 2000 or later, pertain to children’s mental health, and address the barriers that parents and caregivers face in obtaining those services. Table 2 below provides an overview of the articles.

Table 2. Article Overview.

Article	Method	Location	Age of child	Sample Size
Bannon & McKay, 2005	Longitudinal Quantitative	United States inner city	≈10	146
DeRigne et al., 2008	Quantitative	United States	0-17	7,237
Fulda et al., 2009	Quantitative	United States	0-19	9,639
Girio-Herrera et al., 2015	Quantitative	Rural OH	5-5yr 11mo	597
Owens et al., 2012	Quantitative	MD		116
Smith et al., 2005	Mixed methods	Midwest United States	≈12.86	46
Thurston & Phares, 2008	Quantitative	United States	5-23	194
Turner et al., 2015	Cross-sectional Quantitative	Texas, Louisiana, and Mississippi	≈5.1	238
Yeh et al., 2005	Longitudinal Quantitative	Urban United States	6-17 ≈14.07	175
Young & Rabiner, 2015	Quantitative	NC	9-13	194

The articles were analyzed to find similarities, differences, and themes in the most commonly reported barriers. Ten of the articles used surveys and questionnaires to collect data, and only one of the articles included some qualitative measures. The barriers were identified and categorized into four types of barriers. Table 3 below summarizes the four types of barriers and the articles that had findings related to these types of barriers.

Table 3. Types of Barriers.

Type of Barrier	Article	Barriers
Logistic	Bannon & McKay, 2005 Fulda et al., 2009 Owens et al., 2012 Smith et al., 2005 Young & Rabiner, 2015	Appointment times Inconvenience Child care Limited availability Location/distance Number of children Time Transportation
Financial	DeRigne et al., 2008 Fulda et al., 2009 Girio-Herrera et al., 2015 Owens et al., 2012 Thurston & Phares, 2008 Young & Rabiner, 2015	Cost Insurance SES
Child Characteristics	DeRigne et al., 2008 Fulda et al., 2009 Girio-Herrera et al., 2015 Owens et al., 2012 Smith et al., 2005 Thurston & Phares, 2008 Yeh et al., 2005	Age Gender Problem severity Problem type
Parental Characteristics/Beliefs	Bannon & McKay, 2005 DeRigne et al., 2008 Fulda et al., 2009 Girio-Herrera et al., 2015 Owens et al., 2012 Smith et al., 2015 Thurston & Phares, 2008 Turner et al., 2015 Yeh et al., 2005 Young & Rabiner, 2015	Advised not to Confidence in recommendations Doubt Friend/family disapproval Mother education Not necessary/solve on their own Past negative experience/attitude Race/ethnicity Service preference Stigma Tired/overwhelmed Trust

Logistic Barriers

Of the 10 articles reviewed, five of the research articles (50%) found that logistic barriers were reported by parents and caregivers. Logistic barriers are barriers that external of the parent of child, such as transportation to services or scheduling an appointment. In a study conducted by Bannon and McKay (2005), they conducted telephone interviews with 171 caregivers in an urban outpatient setting and monitored their session attendance rates. The study found that about 55 percent of parents reported at least one concrete or logistic barrier. In contrast, a study conducted by Owens et al. (2012), interviewed the teachers and caregivers of 116 seventh graders from a school based prevention program and found that only 20.7 percent of parents reported a structural or logistic barrier. In addition, effects of children's mental health on their parents related to structural barriers, in that parents reported more stress due to additional responsibilities (Owens et al., 2012). One possible explanation for this discrepancy is the setting of the study. The study by Bannon and McKay (2005) was conducted in an outpatient setting while the study by Owens et al. (2012) was conducted in a school setting. These parents may feel overwhelmed by the mental health needs of their child and thus may find logistic barriers as a larger obstacle than parents who are not as overwhelmed.

In four articles (40%), time was one of the most commonly reported logistic barriers. About 30 percent of parents from Bannon & McKay's study (2005) reported not having enough time to bring their child to mental health services. About 6 percent of parents from the study by Owens et al. (2012) reported long wait times as a barrier. In a study by Young and Rabiner (2015), 275 parents from a larger longitudinal study with children age nine to 13 from 17 different schools in North Carolina participated and were given questionnaires on potential barriers to mental health services. Their study found that racial/ethnic differences between

parents who reported time as a barrier to mental health. They found that Hispanics reported long wait times as more inhibiting than Caucasians (Young & Rabiner, 2015). The authors felt that because many of the Hispanic parents were first generation immigrants, they may have a harder time navigating health care systems and therefore the process may take longer for them. In a study by Smith et al. (2015), 46 parents of children admitted into an inpatient psychiatric facility and who had previously been referred to outpatient services participated. The parents were given three open ended questions and the Barriers to Participation Scale by Kazdin, Holland, and Crowley (1997). The study showed that parents reported that appointment times, agency hours, and waitlists created major barriers in accessing mental health services for their children. The authors stated that this may be due in part to inconvenient times available from the agencies.

The second most common logistic barrier was location or distance to an agency, as well as transportation to appointments. Owens et al. (2012) found that about five percent of parents reported transportation issues, whereas Bannon and McKay (2005) found that 38 percent of parents reported transportation issues. This inconsistency in transportation as a barrier may be due in part to the different location of the studies. In addition, 6.9 percent reported services were too far away (Owens et al., 2012). Parents also identified transportation and distance to services as more of a barrier for mental health care than for medical care (Young & Rabiner, 2015). In a study conducted by Fulda et al. (2009), 9,639 participants in their national survey were grouped into four categories of socioeconomic status (SES), and reported barriers in each SES category were examined. In the lowest and second lowest SES group, location in the United States significantly affected predicting if all of the child's mental health needs were met. The study found that children living in the Midwest and South were more likely to have their mental health needs met compared to the Northeast United States (Fulda et al., 2009). The authors stated that

this may be due to differences in sufficiency of public mental health services which is determined by state policies.

Other logistic barriers that were identified by parents from the studies include finding child care, number of children, lack of knowledge about resources, and lack of access to care. From Bannon and McKay's study (2005), 17 percent of parents reported child care problems as a barrier to mental health services for their child. In the study by Fulda et al. (2009), the number of children in a household was significant for predicting unmet mental health needs for a child in the lowest income group. In addition, a lack of access to care and access to additional mental health services was identified as a barrier by parents and caregivers (Smith et al., 2005). These parents advised other parents with child with mental health problems to be proactive and persistent in scheduling appointments and calling multiple agencies in order to find available services (Smith et al., 2005). The authors suggest that agency policies may not be meeting the needs of their clients in terms of availability and that there may be limited resources that affect the ability to schedule an appointment.

Financial Barriers

Of the 10 articles identified for this systematic review, seven articles (70%) found that parents reported financial barriers to children's mental health services. In four articles (40%), parents and caregivers identified cost and budget issues as one of the most common barriers. About 10 to 14 percent of parents identified cost and budget as a barrier (Girio-Herrera et al., 2015; Thurston & Phares, 2008; Owens et al., 2012; Young & Rabiner, 2015). In the study by Fulda et al., (2009), variations in the types of barriers parents and caregivers reported varied by SES status. Most of the children with unmet mental health needs fell in the lowest SES category. As SES and income increased, so did the likelihood that children's mental health needs would be

met (DeRigne et al., 2008; Fulda et al., 2009; Yeh et al., 2005). DeRigne et al. (2008) conducted a study on the National Survey of Children with Special Health Care Needs of children with unmet mental health needs and found that children who had unmet mental health needs came from households with lower incomes. In the lowest income group, only about 72 percent reported having all their child's mental health needs met and was statistically lower from the other income groups (DeRigne et al., 2008).

In two of the seven articles identifying financial barriers, type of insurance coverage also affected access to mental health services. In the study by DeRigne et al. (2008), the results showed that uninsured families' children were about three times more likely to have unmet mental health needs. However, the results from the study by Fulda et al. (2009) found that there was no significant association between being uninsured versus privately insured and receiving needed child's mental health care. Having private insurance only or public insurance only was found to decrease the likelihood of a child having unmet mental health needs by about 20% (DeRigne et al. 2008). Having a combination of private and public insurance decreased the likelihood of a child having unmet mental health needs by about 35 percent (DeRigne et al., 2008). This may be due to the limitations for mental health in these insurance type and that a combined use of insurance provides more options for mental health (DeRigne et al., 2008). In addition, in the lowest SES category in the study by Fulda et al. (2009), Medicaid and State Children's Health Insurance Program (SCHIP) were positively associated with receiving all needed children's mental health services. However, having SCHIP in the highest SES category was negatively associated with receiving all needed children's mental health services (Fulda et al. 2009).

Child Characteristic Barriers

In seven articles (70%), child characteristics were identified as barriers to accessing and receiving children's mental health services. Researchers have identified several common child characteristics as variables that influence access to care, such as, gender, age, problem type, and problem severity. The data on gender and its relation to unmet mental health needs is inconsistent throughout the research. DeRigne et al. (2008) found that children with unmet mental health needs tended to be male, but Thurston and Phares (2008) found that boys tended to receive more services than girls. In their study, the authors surveyed 194 parents on the barriers they face and their attitudes towards mental health services (Thurston and Phares, (2008). In addition, Owens et al. (2002) and Fulda et al. (2009) found that gender did not affect the types of barriers reported or the likelihood of having unmet child mental health needs. In three articles, older children were less likely to receive services or have their mental health needs met and younger children were more likely to have these needs met (DeRigne et al., 2008; Fulda et al., 2009; Yeh et al., 2005). Fulda et al., (2009) stated that this may be due to the fact that as children get older and enter school, the need for more mental health care may become more visible; however, due to mental health stigmas or the feasibility of accessing more care, parents may not seek out the additional help their child needs.

Another barrier related to child characteristics is the mental health problem type and severity. In a study by Smith et al. (2005), parents identified common barriers they encountered, which included their child's mental health concerns improving and their child now having different problems from the initial mental health concerns. Smith et al. (2005) stated that these barriers may be due to the parent not understanding the length of time needed for treatment and that they may see an improvement in their behaviors as a sign that services are no longer needed.

In addition, Smith et al. (2005) speculates that a child acquiring different problems may indicate problems that require other services such as learning or medical services and therefore, mental health services are no longer needed. Yeh et al. (2005) surveyed 175 caregivers in an urban setting and also found that having more child problems was significantly related to later mental health service use. However, DeRigne et al. (2008) found that most of the children with unmet mental health needs had moderate to severe mental health conditions. Girio-Herrera et al. (2015) examined kindergarteners and their parent and teacher rating for risk of developing emotional, behavioral, social, and adaptive problems. The parents of children with low and high risk to developing mental health problems did not differ in their help-seeking behaviors (DeRigne et al., 2008). Causes of mental health issues, such as physical causes or trauma, have also been associated with future service use (Yeh et al., 2005).

Parental Characteristics/Beliefs Barriers

Of the articles selected for this review, all 10 articles (100%) identified barriers related to parent and caregiver characteristics and beliefs. Overall, parents perceived more barriers to mental health services for themselves than they did for their children (Thurston & Phares, 2008). In the study conducted by Thurston and Phares (2008), they compared parental-perceived barriers to mental health services for themselves to barriers to mental health services for their children. Results showed that gender of the parent was not related to identifying perceived barriers (Thurston & Phares, 2008). Furthermore, maternal education was examined in two articles that could contribute to potential barriers to children's mental health. A study by DeRigne et al. (2008) found that about half of the children with unmet mental health needs had mothers with a high school diploma. In the study by Fulda et al. (2009), they found that in the second highest SES category, mothers with a four-year degree were less likely to have their

children's mental health needs met compared to mothers with less education. The authors suggested that too little education may result in the mother not knowing enough about mental health to seek services. They also suggested that having higher education may result in having too high of expectations of mental health services (Fulda et al., 2009). The research suggests that other parental characteristics that may contribute to barriers to children's mental health include marital status, employment, and disability. In a study by Owens et al. (2002), they identified that parental divorce was statistically significant to the parents reporting barriers to children's mental health. This same study also found that those parents who were unemployed or disabled were more likely to report barriers to services than other parents (Owens et al., 2002). This may be because parents are overwhelmed with their own problems and therefore report more barriers to children's mental health services. Additionally, parents who had psychopathology were not more likely to seek services for their own children (Thurston & Phares, 2008). This implies that a parent's own mental health does not influence their decision to seek help for their child's mental health (Thurston & Phares, 2008).

Four of the 10 articles (40%) examined the relationship between race/ethnicity and the barriers they face meeting their children's mental health needs. The results in the study by Fulda et al. (2009), showed that in the lowest SES category, African Americans were less likely to receive services compared to Caucasians and Hispanics were more likely than Caucasians to receive needed mental health care. Thurston and Phares' (2008) study found that more Caucasians had more positive attitudes towards mental health. In addition, they found that African American parents perceived more barriers for themselves and their children. However, when controlling for SES, these patterns were not found (Thurston & Phares, 2008). Race and ethnicity were also proved to be significantly related to differences in perceived barriers and

parent belief of the causes of their child's mental health (Yeh et al., 2005; Young & Rabiner, 2015). In a study by Young and Rabiner (2015), Hispanic parents were more likely to rate wait-times and stigma related barriers as more inhibiting than Caucasian and African American parents. The authors of the study stated that this may be partially due to fact that many of the Hispanic participants were immigrants and may have a harder time navigating the systems. Asian-Pacific Islander American and Latino parents were found to be less likely than Caucasians to use mental health services at a two-year follow up in the study conducted by Yeh et al. (2005).

Stigma was identified as a barrier in five of the 10 articles (50%). Most often, stigma was identified by stating they feared others finding out that their child was receiving mental health services. Owens et al. (2002) and Bannon and McKay (2005), found that about three to eight percent of parents reported fearing what friend/family would think. Young and Rabiner (2015) also found that parents reported worrying about their child's school, teachers, friends, and family finding out that their child was receiving mental health services. These fears included fear their child would be teased at school, that it would reflect poorly on the parent, that they would be embarrassed to discuss concerns, and fear that friends and family would find out their child was receiving care (Young & Rabiner, 2015). According to their research study, these parents rated stigma as more inhibiting to mental health care than to medical care (Young & Rabiner, 2015). The authors suggest that this may be because there is less stigma in seeking medical care than there is to seeking mental health care. Furthermore, Hispanic parents rated these barriers as more likely to prevent them from seeking mental health services than did African American and Caucasian parents (Young & Rabiner, 2015). In a study by Turner et al. (2015), they surveyed 238 parents with children in head start programs in three southern U.S. states. The study found that African American parents reported significantly more stigma on a stigmatization scale as

compared to Hispanic and Caucasian parents (Turner et al., 2015). The authors stated that this finding is consistent with previous literature that African Americans tend to report more stigma to mental health services as compared to Caucasian parents (Turner et al., 2015).

According to the research literature, the ability of a parent to recognize mental health needs and the cause of mental illness is also a barrier in receiving child mental health services. Four articles (40%) addressed this specific barrier to mental health. In three studies, Bannon and McKay (2005), Girio-Herrera et al. (2015), and Owens et al. (2002) found that about 12 to 24 percent of parents did not believe their child's mental health needs were serious enough to warrant professional help. Owens et al. (2002) and Thurston and Phares (2008) also found that parents felt that they wanted to handle the problem on their own. How parents view the causes of mental health problems in their children can also affect their decision to seek professional help. Yeh et al. (2005), studied the relationship between parental beliefs about the causes of their child's mental health issues and the likelihood of using mental health services two years later. They found that biopsychosocial parental beliefs of the cause mental health issues in their children increased the likelihood that they would use mental health services two years later; specifically physical causes and traumatic causes of mental illness. This may be because physical causes and traumatic causes may be "less socially stigmatizing" than other causes of mental health issues (Yeh et al., 2005). However, if parents contributed their child's mental health to the influence of their friends and peers, then they were less likely to use services two years later (Yeh et al., 2005). The explanations that were insignificant included: personality factors, relational issues, family issues, American culture, prejudice, economics, spiritual issues, and nature disharmony (Yeh et al., 2005). At the two-year follow-up, the following four beliefs were associated with mental health service use: physical causes, relational issues, trauma, and

prejudice issues (Yeh et al., 2005). Examples of these four causes include a disability the child was born with, problems pertaining to the child's relationships, problems pertaining to the child suffering a traumatic event like abuse, and problems pertaining to racial discrimination. This study shows how parental beliefs about mental health can have a great impact on their decision to seek services for their child.

Parental beliefs about how well mental health services can help their child can also be a barrier to seeking services. Bannon and McKay (2005) found that about 23 percent of parents reported at least one barrier related to doubt, about 10 percent of parents did not believe therapy was necessary, and about 19 percent doubted it would work. Similarly, in the study by Owens et al. (2002), about 26 percent of parents reported a barrier related to their perception of mental health services. About 10 percent lacked confidence in their recommendation, nine percent had past negative experiences, five percent did not think it would help, 10 percent were advised not to seek help, and nine percent did not know who to trust (Owens et al., 2002). The authors suggest that more public education of mental health illnesses and services may be needed to better reach the children in need. In the study conducted by Thurston & Phares (2008), their findings showed that parents who perceived fewer barriers to mental health services for themselves and their children, had more positive attitudes toward mental health services and higher rates of using those services. Even when perceiving barriers for themselves and their children, it appeared that parents were able to overcome obstacles to seek services for their children (Thurston & Phares, 2008). Additionally, one of the most common reported barriers was fear that their child would be hospitalized against their will if they brought them in for mental health services (Thurston & Phares, 2008). The authors suggest that if parents do not have a positive view of services, then they will not seek services for their child. In the study African

Americans tended to perceive more barriers than Caucasians, and therefore, had less positive attitudes towards mental health services (Thurston & Phares, 2008). The study by Turner et al. (2015), found similar results, in that African American parents tended to have less positive attitude scores on the Parental Attitudes Toward Psychological Services Inventory than Caucasian and Hispanic parents. The study by Bannon and McKay (2005) also researched the relationship of service preference and attendance. They found that about 85 percent of parents had a preference in the type of services their child received. About 45 percent received their preferred service type and 55 percent did not. Parents and caregivers who received their preferred type of treatment attended about two more sessions than parents who did not (Bannon & McKay, 2005). The authors speculated that when parents did not receive the type of service for their child that they preferred, they tend to lose motivation in continuing their efforts to keep their child in treatment (Bannon & McKay, 2005).

Lastly, three studies (30%) identify other parental factors as a possible barrier to mental health. Bannon and McKay (2005) found that 20 percent of parents reported being too tired to attend services and 8% reported friend and family disapproval as stressful which they felt created an obstacle to services. Likewise, Owens et al. (2002) found that parents who reported structural barriers were significantly more likely to respond that they struggled with additional responsibilities and difficulties parenting. Difficulties parenting, parent stress, parental unemployment, or disability were significantly associated with barriers relating to perceptions of mental health problems (Owens et al., 2002). Additionally, difficulties parenting and divorce were significantly associated with barriers relating to perceptions of mental health services (Owens et al., 2002). The authors suggest that this may be because divorce causes added stress in a parent's life and places all of the caregiving responsibilities onto them. Smith et al. (2005)

found that a few of the most commonly reported barriers by parents was stress level while participating in treatment and family disagreements and crisis. The authors suggested that when parents are stressed and overwhelmed in their own lives, it may be difficult for them to attend to their child's additional mental health needs.

Discussion

The purpose of this study was to identify the barriers that parents and caregivers encounter in seeking mental health services for their children's mental health. Much of the available literature on children's mental health does not pertain to barriers to mental health. In addition, much of the literature that does address this topic relates to adult mental health or barriers to medical care. Only 10 articles were identified and included in this systematic review based on meeting inclusion and exclusion criteria as well as a quality assessment. Through a review of the 10 articles, barriers that parents and caregivers face in meeting their children's mental health needs were identified. The obstacles identified from the articles were categorized into four groups: logistic barriers, financials barriers, child characteristics, and parental characteristics and beliefs.

Five articles identified logistic barriers that parents and caregivers identified as an obstacle to care. About 20 to 55 percent of parents reported facing a logistic barrier to treatment (Bannon & McKay, 2005; Owens et al., 2012). Some of the most commonly reported logistic barriers included time, appointment times, waitlists, distance to series, and transportation (Bannon & McKay, 2005; Smith et al., 2015; Owens et al., 2012; Young & Rabiner, 2015). Other logistic barriers that were identified were number of children, child care, lack of knowledge, and lack of access (Bannon & McKay, 2005; Fulda et al., 2009; Smilth et al., 2005). How easily accessible services are to parents can greatly hinder their ability to meet their child's mental health needs. These barriers are consistent with previous literature, in that parents face external barriers to treatment. Receiving mental health treatment is a time commitment for both the parent and the child. If a parent is dealing with inconvenient appointment times, difficulty

managing work schedules, difficulty finding transportation, long travel times to agencies, etc., participating in treatment may not be feasible.

Seven articles identified financial barriers to mental health treatment. Cost and budget issues, as well as insurance coverage were the most common financial barriers stated. (DeRigne et al., 2008; Fulda et al., 2009; Girio-Herrera et al., 2015; Owens et al., 2012; Thurston & Phares, 2008; Yeh et al., 2005; Young & Rabiner, 2015). The type of insurance a parent has can greatly affect the coverage they receive for mental health treatment and whether there are any out-of-pocket costs. If a parent does not have sufficient insurance, then mental health treatment for his/her child may not be an option. In addition, parents may be on a restricted budget that makes situations, such as taking time off work to attend an appointment, unrealistic.

The third category, child characteristics, was identified in seven articles. The most common barriers related to child characteristics included gender, age problem type, and problem severity (DeRigne et al., 2008; Girio-Herrera et al., 2015; Fulda et al., 2009; Owens et al., 2002; Smith et al., 2005; Thurston & Phares, 2008; Yeh et al., 2005). These characteristics have been found to increase or decrease the likelihood that a child will have unmet mental health needs. However, some of the data is inconsistent. For example, one study found that boys were more likely than girls to receive services, and another study found no significant differences in gender (DeRigne et al., 2008; Fulda et al., 2009; Thurston & Phares, 2008; Owens et al., 2002). The way in which a mental health problem is shown externally can hinder mental health services because problems may go undetected. For example, if a child has more internalized mental health problems, is not disruptive to daily functioning, or is not severe, then his/her mental health needs may go unnoticed. As was previously stated, having unmet mental health needs may put a child at risk for having problems later in life.

The final and most extensive category of barriers to child mental health is parent characteristics and beliefs. All 10 articles identified barriers to children's mental health treatment that was related to the parent. These barriers include maternal education, marital status, employment status, parent disability and psychopathology, race/ethnicity, stigma, problem recognition, perception of mental health services, treatment preference, and parental stress (Bannon & McKay, 2005; DeRigne et al., 2008; Fulda et al., 2009; Girio-Herrera et al., 2015; Owens et al., 2012; Smith et al., 2015; Thurston & Phares, 2008; Turner et al., 2015; Yeh et al., 2005; Young & Rabiner, 2015). The variables that go on in a parent's life affect his/her ability and time available to take his/her child to mental health treatment. A parent's own needs and abilities will affect how he/she is able to meet the child's mental health needs. These differences in parent characteristics can affect the barriers they face. For example, parents who are unemployed are more likely to report barriers to treatment, which may include limited funds and insurance coverage, thereby making mental health services financially difficult (Owens et al., 2002). A potentially large barrier for children's mental health needs is the parent's perceptions. First, if a parent is unable to recognize a mental health problem or recognize that professional help is needed, then they will not seek out the necessary services for their child. If they do recognize a need but face stigma-related barriers or have a negative view of mental health services, then they too will not seek out help. This places children in a difficult situation where they are reliant on parents to help them get mental health services and thus places an additional barrier on children.

Limitations

Although this study provided an overview of the literature on barrier to children's mental health, this study has limitations that are important to mention. First, due to limited time and

access, there is the possibility that not all potential research studies were identified. This may have restricted the thoroughness of the findings in this review. Second, only 10 articles met all of the inclusion and exclusion criteria. Third, the 10 studies found had differing populations, design methods, and sample sizes. This creates limitations in the generalizability of the studies, and consequently, may have affected the systematic review.

Contributions to Social Work Practice

The findings from this systematic review have multiple implications for policy, practice, and future research. As stated previously, about 20 percent of the children in the United States today have a mental health problem, yet only a fraction of the children receive treatment. In the United States, about 20 percent of children suffer from a diagnosable mental disorder (Child Mind Institute Speak Up for Kids, 2015; FFCMH, 2008; Glied, & Cuellar, 2003; Holm-Hansen, 2006; Merikangas, 2010; Nanninga et al., 2015; NAMI, n.d; Perou et al., 2013; Power et al., 2005; Shatkin, & Belfer, 2004). This means that every day there are millions of children in our country who are suffering from mental health without the support they desperately need. It is vital to understand why these children's mental health needs are going untreated. The findings from this systematic review can provide some of the insights needed to make changes to our policies and practice to better serve these children.

At an agency level, we need to create practices and policies that decrease some of the known barriers parents and caregivers face. For example, an agency can address scheduling issues by making available appointment times at a more convenient hour for parents. Agencies can also work to expand and hire more professionals to decrease the time clients may spend on a waitlist. At a practice level, mental health professionals should engage with their clients and learn about the struggles they face. By having open discussions with clients, the clients can feel

more supported, and the mental health professional can make the necessary accommodations.

Creating culturally sensitive practices is also necessary to ensure families do not face discrimination or racial biases when seeking or receiving services. Policies at a national level are also implicated from these findings. As was stated earlier, there is no policy that directly addresses and mandates the mental health needs of children (Lourie & Hernandez, 2003). The present findings demonstrate that millions of children in this country greatly need mental health services, but face complications in receiving it. One way that policies can address children's mental health is to implement more funding specifically dedicated to the creation and maintenance of children's mental health services.

Implications for Future Research

These findings also have important implications for future research. Much of the current literature on barriers to mental health was not conducted on the unique obstacles children face. One such obstacle is how parents play an important role in their children's mental health needs. Further research should be conducted to better understand how parents play a role. Because much of the literature had low generalizability, more research should be conducted about the barriers children and their parents face in accessing mental health services in order to strengthen the findings.

In conclusion, the large gap between children who receive mental health services and those who do not should be of great concern to the mental health community. If these children continue to have unmet mental health needs, they will face serious difficulties later in life. Understanding why these children are not accessing services and the unique obstacles they face is vital. By addressing these obstacles, we can begin to analyze our policies at both a clinical and national level and make the required changes to better serve our nation's children in need.

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