Received: 19 June 2024 | Accepted: 14 February 2025

DOI: 10.1111/jora.70013

JOURNAL OF Research on Adolescence

EMPIRICAL ARTICLE

"My family won't let me." Adolescent-reported barriers to accessing mental health care

Chantelle A. Roulston[1] | **Isaac Ahuvia**[2] | **Sharon Chen**[3] | **Julia Fassler**[4] | **Kathryn Fox**[5] | **Jessica L. Schleider**[1]

[1]Department of Medical Social Sciences, Northwestern University, Chicago, Illinois, USA

[2]Department of Psychology, Stony Brook University, Stony Brook, New York, USA

[3]Department of Psychology, University of Kentucky, Lexington, Kentucky, USA

[4]Lincoln Square Psychotherapy, New York, New York, USA

[5]Department of Psychology, University of Denver, Denver, Colorado, USA

Correspondence
Chantelle A. Roulston, Department of Medical Social Sciences, Northwestern University, Chicago, IL, USA.
Email: chantelle.roulston@northwestern.edu

Funding information
Office of the Director, National Institutes of Health

Abstract

Depression is the leading cause of disability among adolescents. Fewer than 50% of youth with depression access mental healthcare services. Leveraging a mixed-methods approach, this pre-registered study characterized youths' self-reported barriers to accessing mental healthcare in a socio-demographically diverse sample of 123 United States adolescents (ages 13–16, identifying as Asian ($n = 19$), Hispanic ($n = 23$), Black ($n = 7$), White ($n = 65$), or other race ($n = 9$); man ($n = 9$), woman ($n = 58$), or gender minority ($n = 56$); heterosexual ($n = 19$) or sexual orientation minority ($n = 104$)). All participants were experiencing elevated depression symptoms (Patient Health Questionnaire-2 score of ≥2) and endorsed wanting mental health support but being unable to access it. We asked participants an open-ended question gauging perceived barriers to accessing care ("what has kept you from getting support when you wanted it?"), and a binary item gauging perceived current need for mental health support ("*right now*, do you feel that you *need* support for emotional or mental health problems?"). Via thematic analysis of responses to the perceived barriers question, we identified a total of 13 categories of barriers. Across all participants, 42.48% ($n = 52$) endorsed family-related barriers and 31.71% ($n = 39$) endorsed financerelated concerns. We conducted Chi-square analyses, examining rates of endorsing specific barriers as a function of (a) perceived current support need and (b) demographic variables (e.g. race/ethnicity, gender). In the current study, all adolescents endorsed similar categories of treatment access barriers, regardless of race/ethnicity, gender, sexual orientation, and level of depression. Implications for increasing mental healthcare access for adolescents with elevated depression symptoms are discussed.

KEYWORDS
mental healthcare access, mixed-methods analysis, youth-reported barriers to care

INTRODUCTION

Mental health-care access among adolescents

Depression is one of the most common diagnoses and is the leading cause of disability among adolescents, yet fewer than 50% of youth with depression access mental health-care services (Avenevoli et al., 2015; Michaud & Fombonne, 2005; Whiteford et al., 2013). Depression in adolescents often causes significant suffering and impaired functioning and is often life-threatening, as many adolescents experiencing depression attempt or die by suicide (American Health Rankings, 2020–2022; Kalin, 2021). It is imperative that youth are able to access care when needed in order to mitigate a variety of adverse physical, mental health, and functional outcomes that can arise from depression, including, but not limited to, poor attendance and performance in school, risky use of drugs and alcohol, and binge eating (Aguirre Velasco et al., 2020; Glied & Pine, 2002). Many adolescents experience barriers to accessing mental health support when they

need it. Some of the barriers to accessing support for broad mental health problems identified through various studies of professional organizations', youths', and family perspectives include unaffordable care, limited mental health providers, unpredictable insurance coverage, and wait times up to weeks or months in length (Findling & Stepanova, 2018; Radez et al., 2021; Waid & Kelly, 2020).

Understanding the barriers adolescents face to accessing mental health care is the first step in working towards increasing access to care. Youths' perspectives are a powerful tool in understanding the barriers to mental health care they face when trying to access support. Exploring adolescents' experiences, as described in their own words, offers unique insight into the problems *they* feel hinder their ability to access help. Furthermore, youth with different identities (e.g., diverse racial, ethnic, and gender identities) may face unique stressors, challenges, and barriers when seeking out mental health treatment, such as cultural stigma (Roulston et al., 2023). Thus, it is valuable to explore a variety of first-hand perspectives from youth with diverse identities. Accordingly, the current study employed a mix of quantitative and qualitative methods to better understand diverse youths' perspectives on the barriers they have faced to accessing mental health care.

The importance of centering Adolescents' perspectives in exploring barriers to care

Much of the available research on youth mental health access barriers has focused on information provided by caregivers (Children's Defense Fund, 2009; United States General Accounting Office, 2003; Reardon et al., 2017). Caregivers have cited logistical concerns as a barrier to youth accessing care; this includes lack of access to childcare and transportation, limited availability, and family circumstances (Reardon et al., 2017). Additionally, in a 2017 systematic review, "understanding of the help seeking process" was among the most common barriers to mental health-care access cited by caregivers (Reardon et al., 2017). In contrast, in a 2021 systematic review of adolescents' perceptions of barriers to mental health-care access, concerns about the therapeutic relationship, including trust and confidentiality, concerns were among the most frequently reported barriers (Radez et al., 2021). This discrepancy indicates that adolescent and caregiver perspectives are likely distinct from one another, and efforts to dismantle access barriers for adolescents require explicit centering of adolescents' lived experiences. While there is certainly value in understanding caregivers' perspectives on seeking mental health treatment for the adolescents they care for, oftentimes caregivers may not have a full sense of their teen's perceived treatment access barriers; indeed, in many cases, caregivers may be unaware that their adolescent is experiencing mental health symptoms at all (Klaus et al., 2009). Thus, it is critical to deeply examine youth-reported barriers to care in order to better understand the perspectives of the individuals we are aiming to help.

Several studies have found that social and emotional barriers deter youth from accessing support as well (Aguirre Velasco et al., 2020; Radez et al., 2021). Specifically, one systematic review examining 53 studies of youth perspectives found that shame and perceived social stigma surrounding mental health and help seeking were rated as some of the most critical barriers to accessing mental health support (Radez et al., 2021). A 2023 study centering adolescent perspectives noted financial and family concerns among the most common barriers to mental health-care access (Mora Ringle et al., 2024). Despite these advances in knowledge, our understanding of barriers to mental health-care access among adolescents remains limited. Exemplifying this point, among the few studies that have examined youth perspectives of barriers to mental health-care access, many have not evaluated potential differences in the types of barriers youth across racial, ethnic, or sexual minority groups face. Commonly, their samples are largely comprised of white, non-Hispanic youth and do not assess sexual orientation at all, making assessing disparities impossible (Aguirre Velasco et al., 2020; Radez et al., 2021). In contrast, the majority of the current study sample overrepresents participants with sexual minority identities, which enables a deeper understanding of potentially unique barriers faced by this population. Studies have shown that sexual and gender minority youth report higher rates of unmet mental health needs than cisgender, heterosexual youth; however, a deeper understanding of the specific barriers sexual and gender minority youth face to accessing mental health care is required to ameliorate this disparity (Williams & Chapman, 2011).

Although there are existing studies that examined youth perspectives, many of these studies require parental consent for participation, which is an identified barrier to accessing mental health care among youth (Aguirre Velasco et al., 2020; Mora Ringle et al., 2024; Radez et al., 2021). Youth may be more likely to share their sincere thoughts and personal experiences if they are asked directly and privately. This may provide researchers with a better understanding of the barriers youth face and, in turn, a clearer path toward solutions. Furthermore, focusing solely on the perspectives of youth whose caregivers are actively involved in their children's mental health journey such that they are able and willing to provide consent for participation in mental health research might limit our understanding of the barriers faced by adolescents with less supportive families. To this end, the present study offered youth the opportunity to anonymously share their experiences and thoughts through an online survey with a waived parental consent requirement.

Moreover, among the studies that have examined adolescent-reported barriers to mental health support access, no studies to our knowledge have exclusively sought the perspectives of youth who are actively struggling with depression but have been unable to access needed care (Aguirre Velasco et al., 2020; Reardon et al., 2017). As a result, there may be a gap in our understanding of the experiences of youth who may need the most help: individuals who are actively struggling and have not been able to access desired

care. Thus, it may be important to seek the perspectives of youth who are experiencing depression symptoms but are not in treatment, and notably, youth who currently *perceive a need* for treatment.

Exclusive focus on quantitative analyses may limit understanding of barriers

One limitation of the existing literature includes a focus on large-scale, quantitative surveys with forced-choice responses and limited options for youth to detail personal experiences. Many studies in this domain have failed to employ qualitative or mixed methods, which tend to have more flexibility to precisely capture the unique and descriptive nature of access barriers reported by youth (Mora Ringle et al., 2024). Survey-based studies with closed-ended items do not leave space for youth to share their experiences in their own words, instead limiting observable barriers to those that researchers (rather than young people) think to identify. Methodologies that allow youth the space to directly report the barriers to care they have faced, such as qualitative approaches, may be better able to reveal the full diversity of youths' own experiences.

Employing qualitative, open-ended approaches to studying youths' perceived barriers may be especially crucial for minoritized youth, given the complex and disproportionate barriers they face in accessing mental health treatments (Anderson & Mayes, 2010; Crenshaw, 1989; Macapagal et al., 2016; Price, 2018; Roulston et al., 2023). A recent study examining structural predictors of mental health-care access among sexual minority youth of Color with elevated depressive symptoms found that 83.8% of participants were "only sometimes" or "never" able to access mental health support when they wanted it (Roulston et al., 2023). Youth living in states with average or high levels of either anti-Black racism or homophobia were less likely to "always" access needed mental health support, indicating that sociocultural factors and structural stigma may serve as barriers to care for these adolescents (Roulston et al., 2023). Thus, leveraging qualitative approaches may be especially important to capture any unique, potentially identity-related treatment access challenges specific to multiply marginalized youth.

Present study

The present study aims to fill gaps in knowledge of adolescent-reported barriers to accessing mental health support. Using a mixed-methods approach in a large, socio-demographically diverse sample of adolescents experiencing elevated depression symptoms, we sought to characterize teens' self-reported barriers to accessing mental health care. The sample consists of 123 US adolescents ages 13–16 years old with elevated depression symptoms. This exploratory study utilizes data from a subset of participants in a randomized trial of online, single-session interventions (https://osf.io/kumdv). The current study aimed to answer the following research questions: (1) What barriers do adolescents reporting elevated depressive symptoms believe keep them from accessing treatment? (2) How do these barriers relate to demographic and symptomatology-related variables (symptom severity)? and (3) How do these barriers relate to current perceived need for mental health treatment? We examined youth qualitative responses to the following open-ended survey question: What has kept you from getting support when you wanted it?

METHODS

Procedures

All procedures, measures, and analytic methods used in this study were approved by the University of Denver Institutional Review Board and pre-registered at https://osf.io/5e6qz. Participants in this sample were recruited from the participant pool of a study conducted 6 months prior (original study $N = 2452$) (Schleider et al., 2021). All participants in the original study were 13–16 years old, fluent in English, and reported elevated symptoms of depression during the recruitment period (defined as a score of ≥2 on the Patient Health Questionnaire-2; Richardson et al., 2010). Original study participants were recruited via online advertisements posted to Instagram to participate in a randomized trial of online, single-session interventions (Schleider et al., 2021). Notably, a large majority of participants in the original study held sexual and gender minority identities, despite the original study not specifically recruiting for these groups. The sample of the present study, which was randomly selected from the original study, includes a similar proportion of sexual and gender minority adolescents. Participants in the current study were randomly selected from the original study pool and invited via email to answer additional research questions via a 30-min follow-up survey.

Recruitment for the current study took place over 4 weeks in the summer of 2021. A total of 281 participants were recruited for the follow-up study, participated in the survey, and received one $10 Amazon gift card each as compensation. Of these 281 respondents, the current study includes $n = 123$ respondents who had encountered barriers that prevented them from receiving support for mental health problems and shared these barriers with us. Specifically, participants had to meet the following three criteria:

> Criterion 1: Participants must want, or have wanted, support for mental health problems, as indicated by responding to the question "Have you ever wanted support for emotional or mental health problems before? By 'support', we mean professional therapy, seeing a counselor,

or seeing a doctor for any of these problems," by selecting, "Yes, I want support now" or "Yes, I have wanted support in the past (but I don't want support now)," but not "No, I have never wanted support" (277 of the original 281 participants met this criterion).

Criterion 2: Participants must not have received support for mental health problems, as indicated by responding to the question "Have you ever received support for emotional or mental health problems before?" by selecting "No, I have never gotten support," rather than "Yes, I am receiving support now" or "Yes, I have received support in the past (but I'm not receiving support now)" (135 of the 277 Criterion 1 participants met this criterion).

Criterion 3: Participants must have provided a written response to the question: "What has kept you from getting support when you wanted it?" (123 of the 135 Criterion 2 participants met this criterion).

Responses to the following survey questions were analyzed for the present study: (1) "Have you ever **wanted** support for emotional or mental health problems before? By 'support,' we mean professional therapy, seeing a counselor, or seeing a doctor for any of these problems. (2) Right now, do you feel that you **need** support for emotional or mental health problems? and (3) What has kept you from getting support when you wanted it?" Question 1 response options included: "Yes, I want support now"; "Yes, I have wanted support in the past (but I don't want support now)"; and "No, I have never wanted support." Question 2 response options included: "Yes" and "No." Question 3 was an open-ended question; participants typed their responses directly into the text box.

Qualitative coding

We conducted a thematic analysis (Riessman, 1993) on responses to the open-ended question, "What has kept you from getting support when you wanted it?" Specifically, we employed a coding reliability approach, sometimes referred to as "content analysis" (Braun et al., 2019; Kidder & Fine, 1987). All responses were coded using one codebook developed collaboratively among the authors (available at: https://osf.io/8hgye). To identify youth-reported barriers to accessing desired mental health care, we employed the following steps. First, each coder (CR, SC, and JF) independently read and developed initial coding categories from a random subset of 30 responses. Next, the coders met to review the responses and the individually-identified categories together to collaboratively develop a preliminary codebook. Coders then used the preliminary codebook to independently code an additional random subset of 30 responses. The coders met again to compare coded responses, discuss any discrepancies, and to revise and develop the final codebook. Using the final codebook, the coders individually coded another 30 randomly selected responses. The lead coder (CR) then conducted reliability analyses on the coded responses. Codes with reliability estimates of $k = 0.8$ or higher were kept in the final codebook (McHugh, 2012). Codes with reliability estimates of $k < 0.8$ were discussed and revised as a group. Lastly, the coders individually coded all responses ($N = 123$ responses) using the finalized codebook. The coders ultimately settled on a total of 13 codes. Several responses included multiple barriers to care and thus required multiple codes to fully capture all barriers reported in the response. Thus, several responses were double/multiply coded. All disagreements were resolved via discussion until a consensus was achieved for each response and code. Reliability analyses were conducted across the final set of coding and each code had a reliability estimate of $k \geq 0.8$. The complete codebook and study pre-registration are available at: https://osf.io/8hgye (codebook) and https://osf.io/5e6qz (pre-registration).

Measures

Multiple-choice questions

We recorded the following demographic information from each participant via multiple-choice survey questions: age, sexual orientation, gender, and race/ethnicity. Sexual orientation was coded dichotomously as sexual minority or heterosexual. Gender was coded in three groups: cisgender male, cisgender female, and gender minority. Lastly, race/ethnicity was coded as follows: White non-Hispanic, Black or African American non-Hispanic, Asian non-Hispanic, other non-Hispanic, and Hispanic.

We used a single-variable approach to assess race and ethnicity, rather than separating "race" and "ethnicity" into two distinct variables. We took this approach in order to avoid conflating responses from White non-Hispanic respondents and Hispanic respondents who do not belong to a second community of Color (as would be done within analyses examining *race*, but not ethnicity) and to avoid conflating responses from White non-Hispanic respondents and non-Hispanic respondents of Color (as would be done within analyses examining *ethnicity*, but not race).

Children's depression inventory 2nd edition short form (CDI-2-SF)

All participants in this study reported elevated depression symptoms, as this was an inclusion criterion of the original study. We measured depression symptom *severity* among this sample via the CDI-2-SF, which is a reliable and valid measure of adolescent depression symptoms (Allgaier et al., 2012; Kovacs, 2011). Depression symptom severity was coded dichotomously as clinically elevated (operationalized as a score of 10 or more on the CDI-2-SF) and subclinical (operationalized as a score of 9 or less on the CDI-2-SF; Allgaier et al., 2012; Kovacs, 2011). Cronbach's alpha for the CDI-2-SF of this sample was $\alpha = 0.85$, which is statistically acceptable.

Data analytic plan

All data processing and analysis was conducted in R (R Core Team, 2019), and code is available along with the study's pre-registration at https://osf.io/5e6qz. All analyses included in the study were restricted to complete cases; only individuals who provided a response to the qualitative question, "What has kept you from accessing support when you wanted it?" were included.

Research question 1: What barriers do adolescents reporting elevated depressive symptoms believe keep them from accessing treatment?

Once the barriers were qualitatively identified through thematic analysis, we evaluated and reported the frequencies of each barrier for the entire sample.

Research question 2: How do these barriers relate to demographic and symptomatology-related variables (symptom severity)?

We compared the prevalence of each barrier across participant groups (race/ethnicity, gender, sexual orientation, and depression symptom severity) using Chi-square tests. Two factors limited the number of comparisons that we could examine. First, per our pre-registration, we did not conduct any comparisons with groups smaller than $n = 25$; this cut-off was selected in order to ensure that our estimates were sufficiently reliable. Second, per recommendations for Chi-square analyses (McHugh, 2013), we did not conduct any tests where the expected number of participants (under the null hypothesis) in a cell of the contingency table was fewer than 5; this recommendation similarly exists to ensure that Chi-square results are valid and reliable.

Ultimately, then, comparisons were made between subgroups with at least 25 participants and for codes that were sufficiently prevalent to clear the Chi-square guideline of five expected participants per cell. This means that we did not conduct comparisons across race/ethnicity (as the only sufficiently large group was White non-Hispanic) or sexual orientation (the only sufficiently large group was sexual minority). Instead, we compared cisgender female participants to gender minority participants (Table 3) and participants who were above versus below the clinical threshold for depressive symptom severity (Table 4).

In each comparison, we report the number and percent of participants who endorsed each code by group, along with the Chi-square statistic for the comparison, the p-values, and a corrected p-value that limits the false discovery rate for that family of tests to .05, which ensures that no more than 5% of statistically significant tests are false positives (Benjamini & Hochberg, 1995).

TABLE 1 Sample description.

Variable	*n*	Percent	Mean (SD)
Age	NA	NA	15.18 (0.86)
Race/Ethnicity			
Hispanic	23	18.7%	NA
Asian non-Hispanic	19	15.4%	NA
Black non-Hispanic	7	5.7%	NA
White non-Hispanic	65	52.8%	NA
Other non-Hispanic	9	7.3%	NA
Gender			
Cisgender girl/woman	58	47.2%	NA
Cisgender boy/man	9	7.3%	NA
Gender minority	56	45.5%	NA
Sexual Orientation			
Heterosexual	19	15.4%	NA
Sexual minority	104	84.6%	NA
Depression Symptom Severity (CDI-2-SF)			
Clinically elevated (sum score ≥ 10)	88	71.5%	NA
Subclinical (sum score ≤9)	35	28.5%	NA
Current perceived need			
Current perceived need	85	69.1%	NA
No current perceived need	38	30.9%	NA

Research question 3: How do these barriers relate to the current perceived need for mental health treatment?

Research Question 3 was answered using the same methods as Research Question 2 and is presented in Table 5.

RESULTS

Descriptive statistics

There were a total of 123 participants in this study, all of whom were ages 13–16 years old. Participants identified as 5.7% Black non-Hispanic ($n = 7$), 18.7% Hispanic ($n = 23$), 52.9% White non-Hispanic ($n = 65$), 15.5% Asian non-Hispanic ($n = 19$), and 7.3% identifying as 'Other' ($n = 9$). Participants also identified as 47.2% cisgender female ($n = 58$), 45.5% gender minority ($n = 56$), and 7.3% cisgender male ($n = 9$). The vast majority (84.6%) of participants identified as sexual minority individuals ($n = 104$) and 15.5% of participants identified as heterosexual individuals ($n = 19$). A majority ($n = 85$, 69.1%) of participants reported clinically significant depression symptoms at the time of the survey, and a majority ($n = 85$, 69.1%) also reported a current unmet need for mental health services. A full description of the sample is presented in Table 1.

TABLE 2 Code descriptions.

Code/barrier	Percent endorsed (Total sample *N* = 123)	Definition	Examples from the data
Financial concerns	34 (27.6%)	Captures various finance issues or concerns, including not having enough money for adequate treatment, being concerned about paying for treatment, or any nonspecific money-related response	"Money" "Financial/insurance restrictions" "Financial situation"
General issues with family	30 (24.4%)	Any responses about parents or family in general that are nonspecific or do not fit with a more specific code	"Family" "Personal family matters" "Family not understanding me"
Lack of family support	22 (17.9%)	Any responses noting specifically not receiving some sort of help (treatment seeking or emotional support) from the child's family	"Parents didn't sign up for therapist" "Unsupportive family" "My family won't let me"
Discomfort sharing	15 (12.2%)	Any responses which endorse being uncomfortable sharing information about themselves or their desire for mental health treatment that is not explained by any other code	"Fear of opening up myself to a person I don't know well." "Embarrassed to bring up my mental health" "Afraid to talk about it"
Logistic constraints	13 (10.6%)	Any mention of logistic barriers to accessing care, i.e. mention of time, geography, or transportation. Does not include financial or insurance constraints	"Lack of time, and little to no professional help in the area" "Accessibility" "A lack of personal ability to get to support centers"
Others' beliefs about mental health	12 (9.8%)	Any comments in which the participant listed someone else's opinion or beliefs about mental health or mental health services, including misinformation about mental health and mental health services as a barrier to them receiving mental health care	"My parents don't believe in medicine." "Parents believe that teenagers cannot have mental health problems and believe that it is just hormones, and nothing else" "My parents stigma around professional mental help"
Having your feelings invalidated	9 (7.3%)	Any responses describing or explicitly stating that others have invalidated the participants' feelings regarding mental health	"Being told that I'm just weak and that it's all in my head." "…calls me a hypochondriac when I try to describe to her what I feel is wrong with me." "[My parents] passed me off as 'being dramatic' when I was just expressing emotion and concern for myself"
Feelings of stigma	8 (6.5%)	Any responses where the participant states or describes feelings of shame or being treated differently because of their mental health	"The fear and stigma against getting support." "Stigma" "Being treated like I'm different"
Therapist fit	6 (4.9%)	Responses in which the participant describes not being able to find a therapist they feel is a good fit for them	"Unsupportive counselor" "We couldn't find better ones in my area" "No good therapies on my insurance"
Insurance	5 (4.1%)	Captures anything that specifically references any problems with insurance like not being able to find a good therapist due to limited options from one's insurance	"Financial/insurance restrictions" "Insurance won't cover it" "No insurance"
Lack of treatment seeking	3 (2.4%)	Any responses that can be interpreted as the *child* not seeking out treatment/not asking for help	"I haven't really sought it out" "Just the effort of trying to find support in the first place" "Just lack of effort on my part to do research into what kind of help would be best for me and where I could find that"
Waitlists	2 (1.6%)	Any mention of having to wait a long time to receive care	"Waiting lists" "…Even if you could afford it/get insurance coverage, the appointment is 6 months out"
Other	25 (20.3%)	Responses that are too specific to fit under any other code or are too specific to come up more than once	"I didn't want to go to the school because I didn't want it on my record" "My own skepticism"

TABLE 3 Chi-square tests of barrier frequency by gender.

Code/barrier	Cisgender woman/girl ($n = 58$)	Trans/gender diverse ($n = 56$)	Statistic	p	p_{adj}
Financial concerns	14 (24.1%)	18 (32.1%)	$X^2(1) = 0.55$	.458	.735
General issues with family	16 (27.6%)	12 (21.4%)	$X^2(1) = 0.30$	.585	.735
Lack of family support	6 (10.3%)	16 (28.6%)	$X^2(1) = 4.96$	.026	.181
Discomfort sharing	9 (15.5%)	6 (10.7%)	$X^2(1) = 0.23$	.630	.735
Logistic constraints	5 (8.6%)	8 (14.3%)	$X^2(1) = 0.43$	.511	.735
Others' beliefs about mental health	8 (13.8%)	4 (7.1%)	$X^2(1) = 0.72$	.395	.735
Other	12 (20.7%)	10 (17.9%)	$X^2(1) = 0.02$	.884	.884

TABLE 4 Chi-square tests of barrier frequency by depression symptom severity.

Code/barrier	Below threshold ($n = 35$)	Above threshold ($n = 88$)	Statistic	p	p_{adj}
Financial concerns	7 (20.0%)	27 (30.7%)	$X^2(1) = 0.94$	.331	.662
General issues with family	4 (11.4%)	26 (29.5%)	$X^2(1) = 3.53$	.060	.241
Lack of family support	6 (17.1%)	16 (18.2%)	$X^2(1) = 0.00$	>.999	>.999
Other	7 (20.0%)	18 (20.5%)	$X^2(1) = 0.00$	>.999	>.999

Research question 1: What barriers do adolescents reporting elevated depressive symptoms believe keep them from accessing treatment?

The primary aim of this study was to better understand youths' self-reported barriers to accessing mental health care when they want it. A total of 13 codes (barriers) emerged during the qualitative coding process outlined in the Method section. Of the 13 barriers identified via our coding process, adolescents in our sample who desired mental health treatment endorsed *financial concerns* (27.6%), *general issues with family* (24.4%), *other* (20.3%), and *lack of family support* (17.9%) as the most frequent barriers to accessing mental health support. Table 2 provides a comprehensive overview of the barriers that youth reported kept them from accessing desired mental health treatment (codes by frequency with definitions and examples). The majority of youth reported one barrier to accessing mental health care (61.0%), while 31.7% reported two, and 7.3% reported three or more.

Research question 2: How do these barriers relate to demographic and symptomatology-related variables (symptom severity)?

Comparisons of barriers by gender (cisgender female versus gender minority) are presented in Table 3. Cisgender male participants were excluded from this analysis due to a small sample size. In addition, some codes were not tested because they were too infrequent for the Chi-square test to be valid and reliable (i.e., expected values were below 5). Cisgender female and gender minority participants did not differ on their endorsement of financial concerns, general issues with family, discomfort sharing, logistical constraints, others' beliefs about mental health, or the "other" code. Gender minority participants were more likely to endorse lack of family support as a barrier to care (28.6% vs. 10.3%, $X^2(1) = 4.9$, $p = .026$), however, this effect was no longer statistically significant after p-value correction ($p_{adj} = .181$).

Comparisons of barriers by symptom severity (above vs. below threshold) are presented in Table 4. Participants did not differ in the barriers they endorsed by depressive symptom severity (all $ps > .05$).

Research question 3: How do these barriers relate to the current perceived need for mental health treatment?

Comparisons of barriers by current unmet need are presented in Table 5. Participants did not differ in the barriers they endorsed by current unmet need (all $ps > .05$).

DISCUSSION

This study explored self-reported barriers to accessing mental health care from 123 US adolescents (ages 13–16) with elevated depression symptoms. A total of 13 barriers emerged from a thematic analysis of the qualitative data. Over one-third, 39.0%, of participants reported experiencing multiple barriers to accessing desired mental health care. The total number of barriers reported by all participants, along with the quantity of barriers that each individual reported facing,

TABLE 5 Chi-square tests of barrier frequency by current need.

Code/barrier	No current need ($n = 38$)	Current need ($n = 85$)	Statistic	p	p_{adj}
Financial concerns	9 (23.7%)	25 (29.4%)	$X^2(1) = 0.19$	.661	>.999
General issues with family	6 (15.8%)	24 (28.2%)	$X^2(1) = 1.58$	.208	.834
Lack of family support	6 (15.8%)	16 (18.8%)	$X^2(1) = 0.02$	.880	>.999
Other	8 (21.1%)	17 (20.0%)	$X^2(1) = 0.00$	>.999	>.999

illustrates how complex barriers to accessing mental health care are. Past research on accessing mental health care has often focused on only one barrier to mental health care access, for example, self-reliance or stigma; however, this study's findings imply that focusing on only one barrier may leave important information out (Labouliere et al., 2015; Tharaldsen et al., 2017). Incorporating teens' perspectives and experiences strengthens our understanding, which allows us to target the barriers that are truly important to teens.

Financial concerns and family-related issues emerged as the most prevalent barriers for participants, as the following barriers were reported most frequently: *financial concerns*, *general issues with family*, and *lack of family support*; this finding aligns with similar existing literature (e.g., Mora Ringle et al., 2024). Across all participants, 31.7% ($n = 39$) endorsed money-related concerns (*financial concerns* and *insurance*) as a reason they have not been able to access mental health care when they wanted it. Several participants discussed that they do not want to add any financial stress to their parents, and several participants pointed to insurance restrictions as barriers. It appears that many adolescents view mental health treatment as a financial burden. While past research on barriers to accessing mental health care has had similar findings—that money is a concern, stressor, and barrier when it comes to accessing mental health care (Aguirre Velasco et al., 2020; Radez et al., 2021)—the present study identified slightly different versions of financial concerns than are often noted. Specifically, teens are expressly worried about burdening their family finances. Our findings suggest that making *free* mental health support available for teens may help alleviate this common barrier for many (Schleider et al., 2020, 2021). Additionally, it is important to share these free supports broadly and to increase awareness of their existence by informing adolescents directly; this way, youth in need are able to access them and understand that they incur no cost.

Notably, family-related barriers emerged as especially prevalent in this sample, as 42.5% ($n = 52$) of participants reported family-related barriers (*general issues with family* and *lack of family support*). One's family appears to be incredibly influential for high symptom adolescents seeking mental health treatments/supports. Several participants spoke of being discouraged by family members' negative beliefs about mental health, of not having the support of their family, and of having their feelings invalidated by family members. These findings are in line with prior research on the same topic; family members' views on mental health and mental health related topics can be a deterrent for individuals who desire professional help (Radez et al., 2021; Zullo et al., 2021). Thus, ensuring mental health supports are directly accessible by teens, without requiring parental or familial support, may help teens overcome this barrier (Mora Ringle et al., 2024). Exemplifying this point, a prior study offering free mental health activities to adolescents ages 13–16, which employed a parental consent waiver, yielded >80% activity completion rates; it is likely that this waiver positively impacted how many adolescents were able to participate (Schleider et al., 2021). Furthermore, parent and family psychoeducation regarding mental health concerns, such as depression, and mental health treatment may help to alleviate impacts from barriers such as "others' beliefs about mental health" and "having your feelings invalidated," as these are barriers that several participants endorsed in addition to family-specific barriers. Additionally, making supports available to *all* family members, such as parents and other caregivers in addition to adolescent children, may prove helpful. Framing this support differently, for example as "activities to increase communication and understanding within families," rather than as mental health support may be helpful, as several participants who reported family-related barriers indicated that their family does not regard mental health supports positively.

Notably, state differences regarding age to consent to mental health treatment without parental permission may impact barriers to care for youth. There are highly variable legal standards across the United States regarding adolescent consent to mental health treatment and confidentiality, which often suppress treatment accessibility (Rowan, 2023). Specifically, one-third of US states have mandated caregiver consent for youth to access mental health treatment, and treatment use among adolescents who recently experienced major depression was significantly lower in these states, which prohibit them from independently consenting to mental health treatment (Schleider et al., 2025). As this study presents perspective from youth as young as 13 years old, it is worth noting that family-related barriers were endorsed at higher rates compared to other barriers. This highlights the importance of teens being able to access support on their own and the impact of teens not having this ability (e.g., a decreased ability to access mental health care).

The barriers to accessing mental health care that emerged in this study were endorsed similarly across groups. Results indicated that participants agree upon the top barriers, regardless of identity. Participants across all

genders (gender minority individuals, women, and men) endorsed having their feelings invalidated and experiencing feelings of stigmatization, which are keeping them from accessing needed treatment. This suggests that, regardless of gender identity, participants are hindered by others' opinions, whether they're personal (*having your feelings invalidated; feelings of stigma* as it pertains to internalized stigma) or societal (*feelings of stigma*). Previous literature in this domain has yielded similar findings. Specifically, studies have shown that stigma-related factors are often cited by adolescents as a reason they do not seek mental health-care services (Aguirre Velasco et al., 2020; Rickwood et al., 2005; Tharaldsen et al., 2017). Seeking mental health support has been described as "taboo" by participants in Tharaldsen et al.'s (2017) study examining barriers to care. This information, coupled with this study's findings, highlights the importance of breaking down mental health stigmas and indicates that, although there has been considerable progress in this domain, more work is needed.

Many participants ($n = 25$, 20.3%) endorsed unique barriers which could neither accurately be captured by any identified codes nor combined into additional codes and thus were coded as "*other*." Therefore, in addition to the 13 identified barriers, youth reported 25 unique barriers they have experienced to accessing desired mental health care. This finding provides further support for the idea that barriers to accessing care can be extensive, unique, and complex. There were no statistically significant differences in the endorsement of each barrier across groups.

Chi-square results showed no statistically significant difference between endorsements of barriers by gender, symptom severity, or current perceived need for treatment. The barriers identified in this study are similar for all participants. *Financial concerns, general issues with family, and others* were endorsed nearly equally across groups; these barriers are the top three most endorsed barriers for each group, regardless of identity, severity of depression symptoms, and whether participants felt they needed treatment at the time they participated in this study.

This study has several strengths. This study involves a diverse sample, particularly of sexual minority individuals, which allows for diversity in perspective. Additionally, the qualitative nature of this project allows great insight into the complex nature of youths' experiences of barriers to care, as they provided detailed information that enabled us to understand what is truly important to youth. Thematic analysis allows us to identify commonalities among youths' individual, subjective experiences while also appreciating the diversity between and within these themes. For example, while 42.5% of youth in this sample endorsed family-related barriers to care, there were a range of concerns within this theme, as one individual reported that their family is unsupportive ("unsupportive family") while a different individual reported their family does not understand them ("family not understanding me"). Few studies have leveraged qualitative methods to address the goals of this study.

This study also has limitations. One limitation of this study is that there was inadequate representation among several groups (e.g., boys, racial minority groups). The small number of participants from these groups limits the generalizability of our findings to these populations; it also limited our ability to test differences in barriers faced across these groups. Moreover, even when across-group comparisons were possible, small sample sizes limited our ability to detect small differences between groups. Future studies should make efforts to have adequate, equal representation among groups to strengthen results. An additional limitation to take into consideration relates to regional considerations. We were unable to explore regional differences in our sample, which is a limitation, as different regions have different concerns; for example, varying levels of provider shortages and varying laws regarding adolescents' ability to consent for mental health treatment independently. Future studies may take regional considerations, socioeconomic status, cultural background, and religious background into account for each participant, as it may offer new insights into future findings.

CONCLUSION

This study explored youth-reported barriers to accessing desired mental health care from 123 US adolescents (ages 13–16) with elevated depression symptoms. More than one-third (39.0%) of participants reported encountering multiple barriers to accessing desired mental health care. Overall, 13 barriers were identified through thematic analysis, and youth reported an additional 25 unique barriers best described as "other," which highlights the complex nature of adolescents' challenges to accessing mental health support. Among the barriers endorsed, financial concerns and family-related issues emerged as the most prevalent, as *financial concerns*, *general issues with family*, and *lack of family support* were the most frequently reported barriers. Specifically, across all participants, 31.7% ($n = 39$) endorsed money-related concerns (*financial concerns* and *insurance*) and 42.5% ($n = 52$) of participants reported family-related barriers (*general issues with family* and *lack of family support*). Chi-square results indicated that the barriers to accessing mental health care that emerged in this study were endorsed similarly across groups. Results indicated that participants agreed upon the top barriers, regardless of identity, depression symptom severity, and perceived current need for treatment.

Adolescents continue to face numerous barriers to accessing mental health care when they want it. This study highlights the need to amplify youths' voices to reduce barriers to care for adolescents who want it; namely, addressing financial concerns and family-related barriers may be particularly important.

ACKNOWLEDGMENTS

I am grateful to the participants of this study, who selflessly shared their experiences. I would also like to thank

my mentor, Dr. Jessica Schleider, for her encouragement and guidance throughout the entirety of this project.

FUNDING INFORMATION

This study was supported by the Office of the Director, National Institutes of Health under an Emergency COVID-19 Competitive Revision linked with award number DP5OD028123 (PI: Schleider).

CONFLICT OF INTEREST STATEMENT

Authors report no conflicts of interest to disclose.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are openly available in Open Science Framework at https://osf.io/k46xs.

PARTICIPANT CONSENT STATEMENT

All involved persons gave their informed, written consent prior to study inclusion.

ORCID

Chantelle A. Roulston https://orcid.org/0000-0001-6312-0171
Isaac Ahuvia https://orcid.org/0000-0003-4558-2123
Sharon Chen https://orcid.org/0000-0001-7670-0458
Julia Fassler https://orcid.org/0000-0002-9598-6348
Kathryn Fox https://orcid.org/0000-0002-6247-6210
Jessica L. Schleider https://orcid.org/0000-0003-2426-1953

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How to cite this article: Roulston, C. A., Ahuvia, I., Chen, S., Fassler, J., Fox, K., & Schleider, J. L. (2025). "My family won't let me." Adolescent-reported barriers to accessing mental health care. *Journal of Research on Adolescence*, *35*, e70013. https://doi.org/10.1111/jora.70013