



**An Exploration into the Barriers Faced by Parents in Accessing Mental Health Services
for their Children.**

Professional Master of Education

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Declaration

I hereby certify that this material, which I now submit for assessment on the programme leading to the award of the degree of Professional Master of Education, is entirely my own work and has not been taken from the work of others, save to the extent that such work has been cited and acknowledged within the text of my work. I further declare that this dissertation has not been submitted as an exercise for a degree at this Institute and any other Institution or University. I agree that the Marino Institute of Education library may lend or copy the thesis, in hard or soft copy, upon request.

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Abstract

This study explores the barriers faced by parents in accessing mental health services for children from the perspective of mental health care professionals. The research took a qualitative approach using semi-structured interviews with seven mental health care professionals. Data was analysed thematically. Parental fear of being judged as a failure, fear of being seen attending services and the prospect of a child being labelled with a diagnosis were identified as key deterrents. Systemic issues which were highlighted as significant barriers included deficiencies in the referral process and inadequate communication between services. Resource issues were also flagged as hindrances to parents accessing mental health services for their children. The findings point to the ongoing need for investment in community-based psychology services and the need to explore alternative avenues for service delivery online or by phone. Efforts to improve the referral process and mental health education and awareness remain key elements in increasing uptake of mental health services for children.

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Chapter One: Introduction

While the number of young Irish people experiencing mental ill-health at any given time is high, many of those young people do not seek help (Cannon, Coughlan, Clarke, Harley, & Kelleher, 2013). For most children, parents play a pivotal role in accessing services, therefore understanding the barriers which hinder help-seeking in parents may provide a useful starting point for exploring uptake of mental health services for children and adolescents. Increasing emphasis has been placed on understanding these barriers over the last couple of decades in the international literature, however there is a dearth of research from an Irish context.

The purpose of this study was to understand the barriers faced by parents in accessing mental health services using the perspective of mental health care professionals. Adopting a qualitative methodology, semi-structured interviews were carried out with mental health care professionals to gain an insight into the barriers to parental help-seeking.

The study is comprised of four chapters. Chapter two will present the literature on parental help-seeking, from both an Irish context and an international perspective. Chapter three outlines the methodology used in the study: the research design, research method, sampling strategy, ethical considerations, and limitations of the research. Chapter four presents the findings of the study and discusses them in relation to the literature. Chapter five concludes the findings and provides recommendations for future research in the field and suggestions for improving parental help-seeking in Ireland.

Chapter Two: Literature Review

Mental Health and Children

According to the World Health Organisation (WHO, 2004), mental health is a state of physical, mental, and social well-being, in which the individual can deal with life's stressors, realise their own abilities, and operate productively. Mental health can be influenced by various factors including life circumstances, genetics, and developmental stages (WHO, 2004). Mental ill health has a significant impact on societies worldwide, costing more than 4% of GDP in member EU states (OECD, 2018) and costing the Irish economy an estimated €11 billion per annum (Health Service Executive [HSE], 2013). According to a report by the Royal College of Surgeons Ireland (RCSI), 1 in 3 young people in Ireland will have experienced a mental health problem by the age of thirteen, a rate which will increase to 1 in 2 by the age of 24 years (Cannon et al., 2013). This report also identified the most common mental health disorders in children aged 11-13 years: anxiety disorders and behavioural disorders, such as ADHD; followed by mood disorders, such as depression (Cannon et al., 2013). A large-scale study in Tipperary, estimated that approximately 15% of children under 5 years and 18.5% of children between the ages of 6-11 meet the criteria for at least one psychological disorder (Martin, Carr, Burke, Carroll, & Byrne, 2005).

The Service Gap

Despite the high prevalence of mental health disorders in children, many children do not receive adequate help or seek mental health services (Cannon et al., 2013; Martin et al., 2005). The discrepancy between those who need mental health services and those who use them has been coined the “service gap” (Stefl & Prosperi, 1985). Although recent years have seen a sharp increase in evidence-based treatments for mental health disorders, the uptake of treatment continues to be low (Reardon, Harvey, Baranowska, O'Brien, Smith, & Creswell,

2017). Given the rates of mental health disorders in children, it is of the utmost importance that mental health services identify the most effective means of detecting mental health problems and delivering services which meet the mental health needs of the child population (Kerin, 2014).

International research shows that the onset of mental health problems peaks during adolescence and young adult years (Kessler et al, 2005). The long-term consequences of untreated mental health disorders in childhood can be costly, for the individual and for the economy (Satcher, 2001). Experiencing poor mental health during these years has been linked to poor mental health in adulthood, substance misuse and unemployment (Cannon et al., 2013). The earlier that problems are identified and treated, the more amenable they are to treatment (Dempster, Wildman & Keating, 2013), thus identifying ways to lessen the “service gap” may be vital for reducing the negative outcomes which stem from untreated mental health disorders.

Mental health services for children and adolescents in Ireland

For children and adolescents with mental health difficulties in Ireland, the first point of contact is generally their General Practitioner (GP) or the Health Service Executive (HSE) Primary Care services. Primary Care services include medical practitioners, public health nurses, occupational therapists, speech and language therapists, social workers, counsellors, and community psychologists (Health Service Executive [HSE], 2018). The role of the GP or Primary Care service is to establish if the individual needs more specialist mental health care. The HSE Child and Adolescent Mental Health Services (CAMHS) “provide mental health services to those up to the age of 18 years, who have moderate to severe mental disorders” (Health Service Executive [HSE], 2019, p. 2). Referrals into CAMHS are made by the GP, or by other referral agents (e.g. paediatrician, consultant psychiatrists, community-based

clinicians) in collaboration with the GP. Deciding whether the child/adolescent meets the moderate to severe threshold for CAMHS falls to CAMHS staff (HSE, 2019). The CAMHS operational guidelines anticipate that approximately 90% of child and adolescent mental health needs can be treated within Primary Care, with the remaining 10% being referred to and treated in CAMHS. Other mental health services in Ireland include private clinicians, National Education Psychological Services (NEPS), and Pieta House.

Parents as the gatekeepers

Parents are generally the gatekeepers to children accessing mental health services, requiring them to recognise a problem and seek help if it is needed (Reardon et al., 2017). Given the importance of parents as mediators between children and service utilisation, it is important to understand the factors which underpin parental help-seeking and the barriers which hinder it. A HSE report in 2007, *Mental Health in Ireland: Awareness and Attitudes*, examined people's attitudes towards and knowledge of mental health: the report established that while Irish people had a relatively good understanding of mental health, they significantly underestimated the prevalence of mental ill health. Furthermore, the report further identified stigmatising attitudes as a barrier to help-seeking. This is borne out by the literature wherein some of the most common barriers to parental help-seeking include attitudinal barriers and poor mental health literacy. Additionally, studies have identified other factors which inhibit parents seeking help, namely systemic-structural barriers, and individual-level barriers, which will be discussed further below.

Attitudinal barriers

Parental attitudes towards mental health and mental health services have been found to influence help-seeking behaviour in Ireland and across the globe (Coyne et al. 2015;

Dempster et al., 2013; Dempster, Davis, Jones, Keating, & Wildman, 2015; Ohan, Seward, Stallman, Bayliss, & Sanders, 2015; Raviv et al., 2008; Reardon et al., 2017). According to a systematic review of the literature on parental help-seeking by Reardon et al. (2017), attitudinal barriers to help-seeking included (1) fear of stigma, (2) feeling dismissed by service provider, (3) negative associations with a diagnostic label, and (4) a lack of a trust.

Stigma

The stigma associated with seeking mental health services has been identified as a major barrier to help-seeking and can be classified into two subgroups: public-stigma and self-stigma (Corrigan, 2004). In the context of this study, public stigma refers to a parent's perception that they will be negatively judged by others for seeking treatment for their child (Dempster et al., 2013). It also extends to the fear that their child's mental health disorder will be stigmatised (i.e., deemed socially unacceptable) by others. On the other hand, self-stigma refers to the parent's reduction of their own self-worth because their child is engaging with mental health services (Corrigan, 2004).

A fear of being negatively judged and deemed a "bad parent" by others for seeking help emerged as a barrier to help-seeking in a qualitative study carried out by Sayal et al. (2010). Buckley, Gavin, Noctor, Devitt, and Guerin (2012), also identified stigma as a major barrier to accessing mental health services in Ireland, and outlined efforts made by parents and children to ensure their availing of services was not public knowledge. Trepidation surrounding diagnostic labels has been expressed by both professionals and the public and underpins many anti-psychiatry movements (Corrigan, 2004). In an exploration of the barriers to utilising school psychology services, a third of the parents voiced a concern that their child would be diagnostically labelled and that this label would follow them through school and beyond, tainting their educational future (Ohan et al., 2015).

Parental help-seeking can pose a threat to the individual's self-esteem in the fulfilment of their role as parent (Raviv et al., 2008), whereby parents may feel they have failed if they cannot fix the problem on their own (Moses, 2010). A study by Eaton, Ohan, Stritzke, and Corrigan (2016) showed that parents of children with mental health disorders experience self-stigma, leading to a diminished sense of being a good parent. Regarding help-seeking, Dempster et al. (2015) reported that parents who had higher levels of self-stigma, were less likely to seek help for a child's behavioural problem.

Coyne et al. (2015) found that the stigma attached to mental health problems made parents and adolescents more reluctant to engage with CAMHS. The same study also reported that some parents concealed the fact their child was attending CAMHS from friends and family (Coyne et al., 2015). Since the development of Ireland's national mental health policy, *A Vision for Change*, the HSE have issued a number of reports on mental health in Ireland: In 2007, the report *Mental Health in Ireland: Awareness and Attitudes* (HSE, 2007), found stigmatising attitudes to be a barrier to help-seeking. Although efforts have been made to reduce stigma by organisations such as Mental Health Ireland and the HSE's Green Ribbon Campaign (Health Service Executive, 2017) stigma continues to hinder help-seeking.

Negative perceptions of mental health services.

Negative perceptions of mental health services have been identified as a barrier to parental help-seeking (Reardon et al., 2017). In a study assessing the barriers to children accessing mental health services, Owens et al. (2002) reported that perceptions about mental health services, namely a lack of trust in or negative experiences with mental health services, could present as a barrier to parents accessing mental health services. Similarly, Coyne et al. (2015) identified the importance of building a therapeutic alliance for adolescents and parents in CAMHS; he reported that high staff turnover negatively impacted their experiences and

hindered development of trust. Participants reported feeling exposed having to retell their story to a stranger. A mistrust and lack of confidence in mental health services was also identified as a barrier to accessing services, for individuals from ethnic minority groups and for members of the travelling community (Mental Health Reform, 2016; Quirke, 2010).

Systemic-structural barriers in Ireland

Lack of coordination and communication

Despite being a key principle in Ireland's national mental health policy, *A Vision for Change* (HSE, 2006), the integration and co-ordination between services in Ireland is inadequate (HSE, 2012; Coyne et al., 2014; Illback & Byrnes, 2011; Kerins, 2014; McHugh & Byrne, 2013). Poor interagency liaison between mental health teams and Primary Care was also revealed in a 2013 report, *Profile of the shared care activities of mental health teams in Ireland*, which revealed that "only 58% of respondent Primary Care teams had formal referral procedures with mental health teams" (McHugh & Byrne, 2013, p. 3).

Role of the GP in the referral process

The role of the GP is paramount in the initial stages of a mental health problem, they are often the first line of response for parents of children and adolescents with a mental health concern (HSE, 2007) and are generally required for making a referral into CAMHS. However, according to Kerin (2014), this referral requirement can be problematic, particularly for young adolescents. According to Irish research, young people in Ireland do not/would not seek help from their GP for a mental health problem (Buckley et al., 2012; Cannon et al., 2013). A review of *A Vision for Change* indicated service users' dissatisfaction with the level of mental health knowledge of GPs (Mental Health Reform, 2015). Copty (2004) reported that 68% of GPs had not received specific training in mental health and that

Ireland has no national training programme for GPs to ensure adequate knowledge of mental health and mental health services (Mental Health Reform, 2015). A lack of reimbursement for GPs' participation in the current mental health system has also been highlighted as a fundamental barrier to the delivery of efficient mental health services (O' Riordan, 2011).

Restrictive referral criteria into CAMHS

The restrictive referral criteria into CAMHS has also been reported as a barrier to accessing services (Coyne et al., 2015). The literature highlights a pressing need for clear pathways of collaboration and referral between mental health services (Houses of Oireachtas [HOI], 2017; Kerin, 2014). As mentioned above, CAMHS workers must decide if a child's mental health disorder reaches the threshold criteria for 'moderate to severe' (HSE, 2019). If they determine that a child does not meet the threshold, the child is referred into Primary Care, which has an average wait time of 18 months (HOI, 2017).

CAMHS generally does not treat young people with dual diagnosis of a mental health disorder and an intellectual disability. A Seanad report on children's mental health services found that parents often felt that the disability services and CAMHS did not work collaboratively, but rather used the excuse of a dual diagnosis to exclude a child from the service and transfer them to another waiting list (HOI, 2017). As such, there is a pressing need for the development of a clear framework between services for collaboration and referrals (Kerin, 2014).

Long wait lists

Kerin's (2014) review of national and international good practice in the child and adolescent mental health sector, found that many families struggled to access CAMHS due to long waiting periods. This is highlighted by Coyne et al. (2015) who reported that many

parents struggled with the long wait times for CAMHS, which could sometimes be up to 18 months. Figures show that 2,526 individuals were waiting to be seen by CAMHS in 2018 and 6,811 children and adolescents were on the Primary Care wait list in 2017 (Ombudsman for Children's Office, 2018). These wait lists are unsurprising due to Primary Care services being very under resourced (HOI, 2017) and CAMHS operating on 44.6% capacity of what was suggested in *A Vision for Change* (Kerin, 2014). According to Schraeder and Reid (2014), placement on a wait list may lead parents to seek help elsewhere. In this case, long wait lists in public services like CAMHS or Primary Care may cause parents to seek help from private practitioners.

Individual-Level Barriers

Individual-level barriers refer to the barriers specific to an individual's circumstance which may hinder help-seeking behaviour. These include a lack of knowledge about mental health problems and services; the direct and indirect cost of services; location of service and language barriers.

Poor mental health literacy

A lack of knowledge about mental health problems and mental health services has been identified as a major barrier to help-seeking (Boydell et al., 2006; Coyne et al., 2015; Hurley, Swann, Allen, Ferguson, & Vella, 2020; Sayal et al., 2010; Zachrisson, Rödje, & Mykletun, 2006). The term 'mental health literacy' was first conceptualised by Jorm and his colleagues in 1997. It refers to the knowledge and recognition of mental health problems, as well as knowing how and where to seek help. Good mental health literacy results in "mental health action," "an action that individuals take to benefit their own mental health or that of others" (Jorm, 2020, p. 1). As it is generally up to the parent to initially recognise a mental

health problem in their child and actively seek help for it (Boulter & Rickwood, 2013), the inability to recognise symptoms and relay them to a GP may result in problems going untreated (Jorm, 2000). A systematic review of the literature, pertaining to parental mental health literacy and help seeking, revealed that inadequate mental health knowledge was one of the most prominent barriers to help-seeking across the studies (Hurley et al., 2020). In an Irish study assessing parents' and adolescents' perceptions of CAMHS, a lack of information on the services available was cited by parents as a barrier to help-seeking (Coyne et al., 2015). This is also congruent with Jorm's (2012) idea of mental health literacy, which contends that effective mental health action requires knowledge about the services and treatments available.

Financial barriers

The cost of a GP in Ireland was highlighted as a barrier to people accessing mental health services in Ireland; people with mental health concerns may be hesitant to seek help through a GP due to the cost of an assessment (Mc Daid, 2013). The international literature found both direct and indirect costs to hinder help-seeking, these include the cost of treatment itself and the indirect cost due to loss of wages and travel costs (Thurston & Phares, 2008; Girio-Herrera et al., 2013). Although poverty is a major risk factor for poor mental health (World Health Organisation, 2003), parents from lower socio-economic backgrounds were found to be less likely to seek help for their children (Bussing, Zima, Gary, & Wilson Garvan, 2003).

Urban/rural divide in access to mental health services

As the distribution of CAMHS is population-based, with one team per 50,000 of the population (Irish College of General Practitioners, 2018), it leaves less densely populated

areas at a disadvantage, with clients having to travel long distances to access a service within their catchment area. Rural disadvantage is also cited in an international systemic review on the barriers to help-seeking (Gulliver, Griffiths & Christensen, 2010).

Language Barriers

Children and adolescents from ethnic minority groups in Ireland appear to utilise mental health services less than would be expected based on their presence in the population (Mental Health Reform, 2016). A national report, *Ethnic Minorities and Mental Health*, identified language and communication difficulties and a lack of experienced interpreters as barriers to help-seeking from ethnic minority groups (Mental Health Reform, 2016).

The present study

The purpose of this study is to explore the barriers experienced by parents in seeking mental health services for their children in Ireland. The existing literature from both national and international sources has indicated that there are various factors which deter parents from accessing services for their children. The present study sought to explore the presence and nature of these barriers from the perspective of mental health care professionals.

Chapter 3: Methodology

Introduction

This chapter outlines the methodological approach used to elicit the views of mental health care professionals on the barriers experienced by parents in accessing mental health services for their children. The purpose of this study was to gain an insight into these barriers using the perspective of mental health care professionals. Each stage of the research process is discussed in this chapter, including the research approach and design, sampling strategy, and data collection and analysis. The rationale for the research approach and choice of design is considered in relation to the research question and the ethical implications and the role of the researcher are outlined. Lastly, the limitations and efforts to mitigate their effect are presented and discussed.

Aim of the research

This study was exploratory in nature, it sought to gain insight into the barriers faced by parents in accessing mental health services for their children in Ireland, as identified by mental health care professionals. This study aims to provide additional information on what deters parents from engaging with mental health services and hopefully identify areas which can be improved in the future.

Positionality of researcher

In qualitative research, the researcher is not a blank slate; the position of the researcher, their biases, background, and values, influence every element of the research, from the construction of the research question to the interpretation of findings (Creswell, 2009). The researcher's position will also determine which outcomes are disseminated and whose voices will prevail (Coghlan & Brydon-Miller, 2014).

The concept of what motivates and deters people from using mental health services has been of interest to me since my undergraduate studies in psychology and was the topic of my previous dissertation. The prevalence of mental health problems presenting in Irish children is steadily increasing, however help-seeking in children and adolescents is mediated almost entirely by their parents. Understanding what deters parents from accessing the necessary treatment is an area of research that I am very interested in and one which I think will provide me with useful information as I teach.

Research approach

This research is explored through a qualitative lens. Qualitative research can be located within the interpretivist paradigm. According to Meriam and Tisdell (2016), interpretive research “assumes that reality is socially constructed; that is, there is no single, observable reality. Rather, there are multiple realities, or interpretations, of a single event. Researchers do not ‘find’ knowledge; they construct it” (p. 9)

Qualitative research is exploratory and descriptive by nature (Ferreirra, Mouton, Puth, Schurink & Schurink, 1998). It is typically associated with using words as the unit of analysis (Denscombe, 2014) to explore the meaning “individuals or a group of individuals ascribe to a social or human problem” (Creswell, 2009, p. 3). By contrast, quantitative research is associated with analysis rather than description, transforming what is reported or observed into quantifiable units. While quantitative methodology seeks to generate generalisable data under controlled research environments, qualitative methodology uses thick description to describe and interpret the experiences of people in the context of their natural environment (Denzin & Lincoln, 2000).

This study adopted a qualitative research approach to explore the barriers faced by parents in accessing mental health services for their children. This study did not seek to test a theory or to determine cause and effect, it was interested in understanding the barriers to parental help-seeking. Qualitative research allowed greater capacity for depth of understanding and insight (Merriam & Tisdell, 2016), and the complexity of participants views could be faithfully communicated through rich description and quotation (Creswell, 2009).

Research design and pilot study

A qualitative methodology employing semi-structured interviews was used to carry out this research. Interviews are a “powerful implement for researchers” (Cohen, Manion, & Morrison, 2011, p. 409). They to allow us to “enter into the other person’s perspective” (Patton, 2014, p. 426) and obtain information on things we have not or could not have observed.

According to Cohen et al. (2011), semi-structured interviews are the most appropriate form of interview to yield unique and personalised data. They use participants’ self-reports as the source of data for the research, giving them the flexibility to share their own experiences and understanding of the topic (Willig, 2001). Semi-structured interviews also allow a certain amount of variance between interviews, while providing the researcher with a clear list of issues to be addressed.

Interview Schedule

An interview schedule was prepared in advance to guide the interview, this ensured that the topics covered related to the research question. The questions were guided by three key areas of inquiry that linked to the overall research aim; attitudinal barriers; systemic-

structural barriers; and the influence of demographics. The interview schedule focused on exploring these barriers through open-ended questioning. This method of questioning was used to yield responses which reflected the “richness and complexity” of the views of each participant (Denscombe, 2014, p. 166).

Pilot Study

Prior to conducting the interviews, a pilot study was conducted. This provided an opportunity to pre-test the interview-schedule in advance. The interview schedule was tested with two people. This gave a good indication of how the questions would work in practice and highlighted any areas for improvement (Denscombe, 2007). Following this, questions were amended to ensure they used simple and clear language and were open-ended in nature.

Participants

The current study used purposeful sampling, meaning the sample was “hand-picked” for the research (Denscombe, 2007, p. 17). According to Merriam and Tisdell (2016), purposeful sampling “is based on the assumption that the investigator wants to discover, understand and gain insight and therefore must select a sample from which the most can be learned” (p. 96). In line with this method of sampling, participants were recruited based on the characteristic that they are mental health care professionals working with children. As they have experience engaging with many parents seeking help for their children, they were thought to produce the most “relevant and plentiful data” for the study (Yin, 2015, p. 93). In the current study, the participants consisted of seven mental health care professionals who work with children, five females and two males. Participants resided in the west, east and south of Ireland. To yield a wide range of perspectives on the topic, a researcher should interview people who may hold different views on the subject (Yin, 2015). This aspect of

purposeful sampling was taken into consideration and participants were recruited from both public and private mental health care services for maximum variation.

All participants were recruited via an email outlining the purpose of the study, its aims, and my contact information. Participants were then sent a follow-up email with the consent form (see Appendix A). Participants were asked to identify their preferred method of contact (by phone or via 'Zoom') and a suitable time and date for the interview was scheduled.

Ethical considerations

There are various ethical issues which must be considered prior to and while carrying out research. Prior to conducting this research, ethical approval was granted by the Ethics Committee at Marino Institute of Education. Before each interview, participants were given a consent form with details of the research, the risks involved and their entitlements as participants. Although the risks were minimal, participants were encouraged to consider their participation if they felt as though the study may cause them distress. Participants were reminded that they were not obliged to answer all questions and had the right to discontinue their participation before, during or after the interview; and they had the right to ask for their data to be removed. Measures were taken to ensure anonymity of all participants, for example participants were referred to under pseudonyms; no identifying information was disclosed; and all transcripts and recordings from interviews were kept on a password encrypted computer for eleven months. This was all outlined in the consent form (see Appendix 1) so participants were aware all ethical issues had been taken into consideration.

Data collection

Data was collected through one-to-one, semi-structured interviews. The semi-structured nature of the interview allowed for participants' responses to be probed, checked for meaning and for new lines of enquiry to be followed up. The questions were open-ended in nature and focused on exploring the participant's perception of the barriers faced by parents in accessing mental health services for their children.

All the interviews took place in February, March, and April. Interviews were conducted as face-to-face interviews in Galway (1); via webcam using the computer software 'Zoom' (4) and by phone (2). Each interview lasted between 20-30 minutes. The webcam meetings were recorded using the Zoom software and a Dictaphone was used for the face-to-face interview and phone calls. Recordings were then transcribed verbatim.

Data analysis

Data analysis is a process of "consolidating, reducing, and interpreting" what participants have said and what the researcher has heard and read (Merriam & Tisdell, 2016, p. 202). It aims to make meaning from the data to answer the research question.

An inductive thematic analysis was used to analyse the data, using Terry, Hayfield, Clarke, and Braun's (2017) analytic process. The data was used as a starting point and it formed the basis for the development of codes and themes (Terry, et al., 2013). Becoming familiar with the data provides a solid entry point into analysis. Therefore, I familiarised myself with the data during the interviews, transcriptions, and subsequent re-reading of the dataset. From there, I began to sort through the data, taking note of patterns and themes. I then began the generation of codes; a systematic process whereby segments of the data

relevant to the research question were tagged with a code. Coding reduced the data into specific topics and emerging patterns became visible.

Lastly, I began the process of theme development. This is guided by the research question as it helps establish which coded segments are, and are not, relevant to clusters of meaningful patterns. These clusters of codes were then developed into a possible category or theme. Potential themes were then reviewed, re-checked, and clarified. The title of each theme was altered to ensure it represented a distinguishable finding and captured the meaning of the coded data and dataset.

Reliability and validity

According to Yin (2015), a valid study is one that has “properly interpreted its data, so that the conclusions accurately reflect and represent the real world that was studied” (p. 88). Attaining complete validity is not possible for a study, however a study’s validity can be fortified by addressing certain concerns or challenges.

Lincoln and Guba (1985) put forward an alternative means to reflect the concepts of validity and reliability: *trustworthiness*. The trustworthiness of a study relies on four components: credibility, transferability, dependability, and conformability. The current study adopted techniques to build the trustworthiness of the research, inspired by the work of Lincoln and Guba (1985).

To achieve credibility, sufficient time was spent talking to each participant, allowing a good rapport to be built with them and time to understand their perspective on the topic. To allow the voice of the participant to speak for themselves, quotes from the interviews were included in the findings. While transferability of findings in qualitative studies is limited, rich detail of the sample, data collection and researcher’s positionality, may help readers to

understand the findings in other settings and make decisions about transferability. To achieve a degree of dependability, the transcripts, codes, and results were available for peer inspection. This study used a critical and ethical method of data analysis and sought to fairly represent and communicate the data. Furthermore, the coded data was reviewed many times over to ensure correct codes had been tagged on specific data segments.

Limitations of the study

This section outlines the weaknesses of the current study. These limitations include small samples size, bias, second-hand perspective, and internal reliability.

One of the limitations of the current study was the small sample size (7). A larger pool of participants may have yielded additional or different themes and/or a more comprehensive analysis of the research aim.

A clear limitation of this study is the use of a second hand-perspective where mental health care professionals are reporting on the barriers faced by parents. The perspectives of mental health care professionals are largely formed by feedback they receive from parents who do come in, rather than those who do not. Perhaps, understanding the barriers from the parents' perspectives may have yielded more accurate and trustworthy results.

As mentioned above, a limitation of the study involves the risk of researcher bias. Although I sought to be vigilant of this risk and took measures to avoid clouding data analysis and collection, it is very likely that my own subjectivity interacted with the research process along the way. Using an approach suggested by Corbin and Strauss (2015) to minimise the intrusion of biases and assumptions from the research process, I made constant comparisons within the dataset, checking and rechecking the meaning and codes that had been assigned to the data.

A third limitation centred around the idea of credibility. The credibility of results could have been increased if participants were asked to verify the accuracy of the data analysis and transcripts. This process could have strengthened the trustworthiness of the findings.

Conclusion

This research employed a qualitative approach using semi-structured interviews. This chapter outlines why this approach and design was deemed the most appropriate for the current study. The chapter describes the process of sampling, data collection and data analysis. Efforts to enhance the trustworthiness of the findings are presented and the ethical considerations and limitations of the study are identified.

The methodology and procedures were designed to explore the barriers faced by parents in accessing mental health services, using the perspectives of mental health care professionals. The following chapter details the key findings of the study.

Chapter Four: Findings and Discussion

Chapter four presents the findings and discussion. The findings are presented within the context of the literature and the research aim: to explore the barriers faced by parents in accessing mental health services for their children. Eight themes emerged from the data, these include (1) The prospect of being judged a failure as a parent deters parents from seeking help, (2) The fear of being seen attending a mental health service is a concern for parents of service users, (3) Severity of the problem and difficulty accessing services mediates stigma, (4) Diagnosis as a mediator of help-seeking, (5) Negative perceptions of mental health services as a barrier to help-seeking, (6) Deficiencies in CAMHS referral process, (7) Inadequate resourcing and inter-agency communication impedes access to services, and (8) Availability of parental resources is a key determinant of help-seeking.

Theme 1: The prospect of being judged a failure as a parent deters parents from seeking help.

Parents' apprehension that they would be blamed for their children's mental health issues and perceived as a bad parent by others was identified by all participants as a deterrent to seeking help. One commented, "what stops parents is a feeling they will be blamed...people thinking that there's something bad about them and their parenting and they haven't done their job properly." This sense of being perceived by others as a failure was said to cause "reluctance and uncertainty" in the decision to seek help.

Five participants referred to a parents' own sense of blame and failure as a parent for their child engaging with mental health services. In contrast to the fear of other people judging them as failures, this reflects parents' own judgement of themselves as an "inadequate parent." As one participant called it, "a stigma that they turn towards themselves as opposed to it being from other people." She went on to say that "their own sense of shame

and fear” can be one of the biggest barriers to parental help-seeking. This sentiment was echoed by another participant, who said what he’d “noticed is this nearly like self-stigma,” a sense of the parent feeling “I didn’t do a good enough job, I’ve kind of done something to them.” Two participants described this self-stigma, judgement towards the self, to be more of an issue in relation to help-seeking, than the fear of judgement by others.

The negative judgement of others has been described in the literature as *public stigma*, whereas the judgement and blame placed on oneself has been referred to as *self-stigma* (Vogel, Wade, & Haake, 2006). The findings which emerged from this study in relation to both public stigma and self-stigma are broadly consistent with the findings of Sayal et al. (2010), a qualitative study which reported that parents’ perceived consequences of help-seeking included feeling blamed for their child’s mental health difficulty. The findings are also congruent with the work of Eaton et al. (2016), who showed that parents of children with mental health disorders experience self-stigma leading to a diminished sense of being a good parent.

Theme 2: The fear of being seen attending a mental health service is a concern for parents of service users.

The fear of being seen going into a mental health service was emphasised particularly in relation to public mental health services. One participant noted, “I think sometimes they go, okay god, I don’t want have to go down to my local centre and be seen by everybody walking in.” Another participant reported that “some families will come in and they would be very, very worried about being seen in the building.” The fear of being recognised at a mental health service was also highlighted as an issue in smaller villages, whereby if parents “had to attend [services] in their local village, they’d probably be less likely to because they’d be

afraid other people would see them. They would be concerned about being seen at a mental health service.”

The fear of being recognised using a mental health service, highlights the stigma, (i.e., the negative perceptions), associated with mental health problems and the desire to keep them hidden from others. Although stigmatising attitudes may not be more prevalent in small communities, the likelihood of being recognised is greater, so individuals may be less likely to utilise services within the area. Buckely et al. (2012) identified stigma as a significant barrier to accessing services and support in Ireland. They described the fear of stigma and highlighted strategies used by parents and children to ensure that availing of services was not publicly known, this echoed the views of the participants in this study.

Theme 3: Severity of the problem and difficulty accessing services mediates stigma.

Two participants working in a private setting commented that difficulty in accessing services, lessened stigma acting as a barrier. They both reported that when parents are very actively seeking mental health services and are keen to get help for their child, they are not deterred by the prospect of public stigma. Additionally, a participant from CAMHS said that when children present in crisis, there is less stigma and they want to attend. However, “as time goes on, sometimes parents are kind of thinking, well, I want them out of the service now and I don’t want them attending long term I would see it [stigma] maybe in the middle and towards the end.” The notion that the severity of the presenting problem mediates stigma has emerged in the literature. Dempster et al (2013) found that the more severe the child’s problem was, the more likely the parents were to seek help, even those who believed they would be negatively judged, or *stigmatised*, for doing so. The authors suggested that parents who believe they will be stigmatised for accessing treatment may also perceive there to be greater stigma attached to having a child with behavioural problems. Thus, they must decide

which stigma would be greater: the stigma of attending treatment versus the stigma attached to their child's current behaviour. This may explain the finding of this study that the severity of the problem mediates stigma. Additionally, while parents are struggling to access a service, a mental health problem could become more pronounced and receiving treatment may be more of a concern than the prospect of stigma.

Theme 4: Diagnosis as a mediator of help-seeking.

According to participants, the prospect of a diagnostic label can present itself as both a barrier and an incentive to parental help-seeking.

Some parents were said to fear a diagnostic label as it may result in a child being stigmatised, pathologised and given medication, it may limit how people view a child and be used to define them for life. Two participants highlighted the fear of a diagnostic label as the biggest barrier in parental help seeking. Parents were said to be concerned that a label would "limit them [the child] in terms of how they're viewed." Another participant expressed it as "a real fear they are going to be labelled, and then they'll be stigmatised, and then they'll think that they are their label." The prospect of a diagnostic label becoming a matter of record was identified as propelling some parents away from CAMHS and into private services "outside the system," where the diagnosis would not be "public knowledge" or "end up on their educational records." The parents' concern for such labels may be well-founded, as one participant explained, a diagnostic label can sometimes define a teacher's response and treatment of a child, "as opposed to seeing the child as the child." However, one participant commented that she believed a lot of the stigma around children and diagnostic labels is no longer a big issue particularly for the more "socially acceptable" diagnoses like "ASD and ADHD."

The fear that a diagnostic label might lead to a child being prescribed medication was raised as a particular barrier in the case of CAMHS, due to its reputation as a mental health service “that pathologises a child.” Parents “had heard that the only response really in CAMHS when it comes to ADHD is medication and they didn’t want that.” The trepidation surrounding diagnostic labels echo the findings of Ohan et al. (2015) who found that parents’ fear of their child being labelled deterred them from accessing psychological help. The desire to keep a child’s mental health problem off their education record was also seen in Ohan et al.’s (2015) study: they reported that parents’ apprehension of stigma from a child’s teacher and a fear of the label following the child throughout school and tainting their education were major barriers to utilising the school psychology service.

Although the issue of diagnostic labels emerged as a barrier to help-seeking conversely, for a cohort of parents achieving a diagnosis may be an objective of accessing services. Three participants explained that some parents attend mental health services, hoping for a label or diagnosis to explain a behaviour, to provide a “framework to explain things.” The value of an explanation in relieving a parent’s sense of self-blame was mentioned by two participants, “there’s always a cohort of parents who quite like having a diagnosis... to hopefully be able to show it’s not their own fault.” The provision of resources that comes with a diagnosis, was also identified by two participants as an incentive for parents attending services, “a lot of parents will come to a service looking for a diagnosis that will support them in getting extra resources.”

Theme 5: Negative perceptions of mental health services as a barrier to help-seeking.

Negative perceptions of mental health services were influenced by people’s previous experiences and their level of trust in mental health services.

Six participants commented on the influence of previous experiences of mental health and mental health services on parents' willingness to seek help. Participants reported that bad experiences with mental health services in the past, can turn parents off. One participant reported, if parents' "have experiences of mental health services having let them down themselves, or maybe let family members down...they can be very, very slow in getting help."

When asked about help-seeking behaviour in individuals from minority groups or lower socio-economic backgrounds, a "sense of distrust" towards the services was highlighted by three participants. One participant commented that members of the travelling community can be reluctant to engage with the services as "it's been well documented that they don't trust the service." Another participant mentioned that individuals can be "more distrustful of any sort of system" if they are worried that information disclosed within a mental health service could be passed on to social welfare or other government agencies. This distrust was only identified as a barrier to accessing public services. These findings are in line with the large body of work on minority groups (ethnic minorities and the travelling community) and mental health, which reported mistrust in services presented a barrier to seeking mental health services (Mental Health Reform, 2016; Quirke, 2010).

Theme 6: Deficiencies in CAMHS referral process

The referral process for accessing public mental health services, was cited by all seven participants as a barrier to parents accessing the service for their child. Participants described accessing CAMHS as "difficult" and hard to get accepted into. The pivotal position of GPs in the process and the referral criteria both present obstacles to accessing the mental health services.

Role of the GP in the referral process

GPs are the key gatekeepers to the mental health services: the majority of referrals into CAMHS are made by, or in collaboration with, a GP. Four participants identified issues surrounding the role of the GP in the mental health system. Participant 2 noted that some GPs were not “fully up to speed with services that are available” and as a result couldn’t direct parents toward private practitioners if they requested it. The referral process in general was described as “inordinately frustrating” for GPs as the system seems to be “changed relatively quickly or frequently.” Another participant highlighted the importance of the referrer knowing the correct language to use for a referral to be accepted. This would suggest that a referral made by someone who did not have sufficient training in or knowledge of mental health, could result in a child’s referral being rejected. However, according to a review of *A Vision for Change*, Ireland’s national mental health policy from 2006, there has not been a national programme to ensure GPs have an adequate knowledge of and training in mental health in Primary Care. The same report also revealed that service users identified a lack of knowledge around mental health issues and support services among GPs (Mental Health Reform, 2015).

The idea that some people, particularly young adolescents, would not feel comfortable disclosing mental health problems to their family GP was highlighted by one participant in this study. Similarly, Canon et al. (2013) and Buckley et al. (2012) both reported that young people in Ireland were unlikely to or did not consult with a GP about a mental health difficulty. It is reasonable to conclude that particularly for parents of older adolescents, these views may deter them from seeking help from their GP.

Referral criteria

All participants who worked in public services (4) commented on the vague referral criteria as a barrier to accessing CAMHS. To be eligible for CAMHS, an individual must have a moderate to severe mental disorder (HSE, 2019). Despite efforts to define the threshold criteria, it remains a “bone of contention.” There is a perception from other services “that CAMHS can be strict enough in what we take and a bit arbitrary.” One participant commented that if a child with Autism Spectrum Disorder presents to CAMHS in crisis “sometimes we see them and sometimes we don’t.” Similarly, another participant highlighted that if a problem presented itself as ‘behavioural’, they might not be accepted into CAMHS, but she made the point that “everything can be done with behaviour, self-harm is behaviour, not eating is behaviour. Some behaviours get in and others don’t. That can create a real obstacle.”

Participant 6 mentioned that difficulty can arise when an individual is “in between two: not severe enough [for CAMHS], but then over the threshold for Primary Care.” A report on children’s mental health services referenced this “gap” and highlighted a need for a service for those children (HOI, 2017). Two participants referred to parents having to “fight” to be seen by CAMHS, “the parents who cry the loudest can get some resources.” This was in line with findings of Coyne et al. (2015), who reported that “parents felt that those who made a fuss often got an appointment faster than those who stayed silent” (p. 564).

These findings were consistent with national reports and studies on CAMHS and mental health in Ireland (Department of Health, 2017; Houses of Oireachtas, 2017; Illback & Bates, 2011; Kerin, 2014), many of which highlight the need for a review of the current referral process namely the referral criteria for CAMHS and the pathways to care (HOI, 2017).

Theme 7: Inadequate resourcing and inter-agency communication impedes access to services.

Under-resourcing of services

The under-resourcing of services presents significant barriers for service users, in the form of insufficient staff and longer wait times. The understaffing and lack of resources was mentioned by five participants, particularly in reference to Primary Care Psychology. According to one participant, Primary Care Psychology has approximately 40% to 60% empty posts. Understaffing in CAMHS was also highlighted as an issue by three participants, “most of the time the team is understaffed” and in the last two years, “post didn’t get filled.”

Participant 1 reported that fewer resources in Primary Care leads more people and GPs to try to “work the system.” A problem may need to be escalated or presented “really negatively to get into CAMHS,” if the wait list is too long or there is no psychologist in Primary Care. One participant said, “it’s ridiculous with Primary Care because if it was well enough resourced, far fewer people would end up having to go to CAMHS.” This goes back to the triage system, which envisions 90% of all mental health needs being met within Primary Care (HSE, 2019). However, to respond effectively to those children and adolescents, there is an urgent need to increase capacity of Primary Care services (Kerin, 2014)

Wait times in mental health services were identified as an obstacle to help-seeking by five participants. One participant described this experience as an “interminable waiting list with no particular contact from the service” and parents feeling like “they’re sitting in a vacuum just kind of waiting with no great help or offers.” This experience can lead parents down an avenue of hostility or feeling let down, believing that the services aren’t taking their

problem seriously enough: “They’re like, yeah I see you’re in distress, but I’ll see you in two years. Which is a horrible experience.” These views are similar to those expressed in the study by Coyne et al. (2015), where parents were critical of the long wait times in CAMHS, describing it as a stressful and challenging time. These findings are in line with figures from Ombudsman for Children’s Office, (2018) which reported that 6,811 children and young people were awaiting an appointment in July 2017 with an average wait time of 18 months (HOI, 2017).

Although wait times acted as a barrier to CAMHS and Primary Care services, two participants reported that the wait times for public services facilitated engagement with private practitioners. One participant said: “being in private practice is often a go to because of waiting lists.” The idea of parents seeking additional help while on a waiting list is supported by the research of Shraeder and Reid (2014), who found that within a month of waiting, 25% of the parents had sought help elsewhere.

Lack of communication and co-ordination between services

Difficulties in coordination and communication within and between services, was identified as an issue by six participants with one describing it as “notoriously poor,” making it “harder for parents to access the services.” Similarly, other participants referred to the systems as “silo,” and not “sufficiently coordinating with one another.” Despite the importance of “inter-agency” coordination (Department of Health, 2017), three participants mentioned families getting caught in “internal politics” due to stretched resources and the referral criteria of CAMHS. One participant described the referrals as causing “tension” between Primary Care and CAMHS workers: “Professionals are fighting...they’re saying no, no its not for CAMHS, there isn’t a mental health diagnosis, it’s for Primary Care.” This is congruent with results from a HSE survey on collaborative work between Primary Care and

mental health service practitioners; it found that the level of integration between the services was “inadequate in relation to what is necessary to best facilitate the patient’s journey and to support the professionals providing care for patients” (Health Service Executive, 2012, p. 6). Similarly, Kerin (2014) highlighted the need for improved coordination and communication between mental health services in Ireland. Improved communication between services in Ireland could increase the provision of accessible and high-quality mental health services.

Theme 8: Availability of parental resources is a key determinant of help-seeking.

The means available to individual parents emerged in the interviews as a significant factor. It emerged from the interviews, that the following resource issues posed barriers to help-seeking: (1) lack of knowledge, (2) cost, (3) geographical distance from service provider, (4) language.

Lack of knowledge about mental health and available services

Four of the participants mentioned that a parent’s failure to recognise a mental health problem in their child may result in parents not seeking help or not getting help until the problem is at a “crisis” level. Participant 3 stated that a big worry is “when the parents don’t notice” a mental health problem. One participant mentioned some parents tend to “over-normalise” certain behaviours and therefore not seek help when it may be needed. Conversely, another participant commented on people over-pathologising, and stressed the need for parents to recognise that everyone has their “ups-and-downs. It is not normal to be in good form all of the time.” This finding suggests while a lack of knowledge may cause problems being left untreated, it also could lead to some parents over-seeking help. The latter view was supported by the findings of Buckley et al. (2012) who discuss the over-

normalisation of mental health problems within society and the loose use of language around mental illnesses.

A lack of understanding of where and how to access help was also identified as a barrier to parents accessing mental health services by four of the participants. One participant commented on there not being any “clear line of resources until you actually go to a clinician or psychologist” and that “parents have to be told, look the GP is the gatekeeper, you go through them.” Not knowing “how to navigate the services” ultimately places parents at a disadvantage, according to one participant. This comment was supported by Participant 3 who said, “it’s not that they don’t want the service, they literally don’t know [where to access it].” Two participants noted a lack of knowledge about the services as a potential barrier for parents of a non-Irish origin; “I work with lots of nationalities and what they’ll often say is, well this is what happened at home, but I have no clue, there’s no information anywhere on how this actually happens in Ireland.” This is in line with Jorn’s (2012) work on mental health literacy. He states that a recognition of mental health problems may assist help-seeking, however the individual must have access to knowledge about the services and evidence-based treatments available (Jorn, 2012). A lack of knowledge of the mental health services available has been identified in the literature as a barrier to parental help-seeking (Boydell et al., 2006; Coyne et al., 2015; Hurley et al., 2019; Sayal et al., 2010).

However, a national increase in awareness and knowledge of mental health problems and services was mentioned by three participants. “I would love to think it’s [knowledge of therapy] less limited now... that it’s much more mainstream.” These findings indicate that although a lack of knowledge is still an issue in the realm of help-seeking, there have been improvements in awareness of mental health in Ireland.

Financial and personal cost of access

The direct and indirect cost associated with accessing a mental health service was identified as a barrier by four of the participants. For public services, one participant noted that the referral process into CAMHS was unintentionally set up “for people who have more means financially” because it generally requires a referral from the GP, costing people €50. “There has to be some other way of letting a GP know that you’ve come into a problem without having to pay that €50. But that’s the system that we’re in at the moment.” The cost of a GP assessment was also highlighted as a barrier by service users, according to a report on Primary Care services in Ireland (Mc Daid, 2013).

The indirect cost associated with attending services was mentioned by two participants. These costs involved parents having to take time off work to attend the service with their child and the cost of transport. One participant said, “There are people out there, kids out there, who are living in families where their parents are without means, without motivation or are too poor or distressed... So, a lot of those kids will never get to be seen by CAMHS, how could they?” This statement reflects two types of costs; firstly, the financial costs, but also the extra cost or burden in having to engage with mental health services. Accessing and attending a mental health service requires a caregiver who has the means, both financially and motivationally, to support this process.

Similarly, in private practice, financial cost was brought up as a barrier by two of the participants. One participant said “you get people who can afford to be coming, and so that’s [the cost] definitely going to be a barrier for some parents, they couldn’t necessarily choose to go privately because they just couldn’t afford it.” These findings are in line with the international literature which indicated that parental help-seeking was hindered due to the

direct cost of treatment and the indirect costs incurred due to loss of wages or travel costs (Thurstun & Phares, 2008; Girio-Herrera et al., 2013).

Proximity to services

The physical location of the service was another barrier identified in the study by four participants, particularly for those living rurally. Participants described parents having to travel 20 miles to the service, organising childcare for other children and having to take a day off work. One participant noted, “it’s so difficult for them to come into an appointment. Sometimes for an hour-long appointment, they’ve to take the day off to come in, it’s a huge barrier or obstacle.” This is consistent with the international research on help-seeking in adolescents, which reported that a paucity of mental health services in rural settings, made it difficult for individuals to source accessible help (Gulliver, Griffiths & Christensen, 2010).

Language barriers

Language barriers were only identified by two participants, whereby “language, understanding and communication gets lost.” Communication has been cited as a major barrier for individuals from an ethnic minority background for both seeking and remaining in mental health services in Ireland (Mental Health Reform, 2016). However, by and large, participants reported a good availability of interpreters for public service. This is not line with the Irish research which reports a lack of good quality interpreters and counsellors capable of working with interpreters (Mental Health Reform, 2012).

Conclusion:

This chapter outlined the eight themes which emerged from the data and presented them in the context of the literature and the research aim. The following chapter concludes the findings and provides recommendations for future research in the field and suggestions for improving parental help-seeking in Ireland

Chapter Four: Conclusions and Recommendations

This study describes the obstacles faced by parents in accessing and fully engaging with Irish mental health services. This is explored using the perspective of mental health professionals gleaned through semi-structured interviews. The insights offered by the participants provide indirect access to the experiences of the many parents and children with whom they have worked. This chapter presents a synopsis of the findings along with new avenues for research and recommendations.

Conclusions

The role of stigma as a key barrier, flagged in the literature from Ireland and across the globe, underpinned three of the themes which emerged. Parents of children with mental health issues are deterred by a fear of being blamed by others, some also experience a sense of failure for seeking treatment for their child. The fear of being recognised using a mental health service and the wish to avoid diagnostic labels are also manifestations of stigma as a barrier. However, there were indications that stigma is overcome when parents perceive an urgency, in terms of severity of a condition and difficulty accessing services. The study revealed that diagnostic labels, seen by some parents as potentially stigmatising, are seen by others as valuable, giving them an explanation for their child's condition, a clear line of enquiry for treatment options and access to resources.

The implications of negative perceptions about mental health services was borne out in the findings. Participants highlighted the reluctance of some parents to engage with services based on previous negative experiences encountered by themselves or others. Negative perceptions toward mental health care also presented as a 'distrust' in the services and a fear they would relay information to other government services.

Systemic barriers, particularly in accessing public services, were posed by deficiencies in the organisation of the mental health system, namely the referral process; inadequate interagency communication and coordination; under-resourcing; and wait times. Regarding the referral process, participants cited issues with the role of the GP as the primary referrer into CAMHS, specifically GPs' lack of knowledge around mental health issues and a reluctance to disclose mental health concerns to a family GP. Additionally, the referral criteria into CAMHS was termed "arbitrary," and unclear. The under-resourcing of services was also highlighted as a major impediment to accessing mental health services, this was particularly prevalent in Primary Care services, where long wait times can lead to parents feeling disempowered and seeking help elsewhere. A combination of inadequate interagency communication and coordination and the CAMHS' referral criteria were said to leave families caught up in the "internal politics," of the services.

Lastly, the resources available to a parent were found to be key determinant of help-seeking. The findings suggest that a parent's lack of knowledge around mental health may result in them failing to recognise a mental health problem in time. Lack of knowledge in terms of the services available was also identified as a hinderance to accessing care. The findings highlight the obstacles created by cost, namely the fee for the GP, cost of the service (private therapy) and the indirect cost associated with attending services such as transport and taking time off work. Interestingly, the cost of services extended to the personal cost or burden imposed on a parent when their child is regularly attending a mental health service. Language and the geographical distance between the service and a person's home emerged as barriers. For example, long distance travel for appointments posed a significant challenge for families living rurally.

This study approached its inquiry into the barriers faced by parents in accessing mental health services by ascertaining the perspectives of mental health professionals. Some of the findings echo themes which emerged in previous Irish studies involving parents and adolescents (Buckley et al., 2012; Coyne et al., 2015). The recurrence of these themes points to slow progress in implementing the objectives outlined in Ireland's national mental health policy, *A Vision for Change*, such as the development of clear links between CAMHS and Primary Care, having sufficiently resourced services and destigmatising mental health (HSE, 2006). Unfortunately, it appears that the gap identified by Coyne et al. (2015) between rhetoric and practice remains. The barriers to help-seeking are complex, and the impact of certain factors is not clear-cut. Destigmatising and normalising mental ill health would appear to be a key strategy in facilitating service access by parents. However, this needs to be matched by an accessible service which parents can navigate easily and which delivers timely help.

Recommendations

Further research into the barriers parents face when accessing mental health services would be beneficial. A larger-scale study using parents as participants could potentially yield more comprehensive and credible findings. Taking the small-scale nature and limitations of the study into consideration, the findings of the study would support the following recommendations:

1. Increasing funding into the mental health sector, particularly into Primary Care Psychology is essential if services are to meet the current demands. Both Primary Care and CAMHS should be staffed in accordance with the recommendations set out in *A Vision for Change* or in line with the increasing demand on services. This will ensure that children and adolescents have timely access to mental health services. If

Primary Care is equipped to detect and treat 90% of mental health difficulties as was planned, there would be less pressure on CAMHS and wait times would improve.

2. A fear of being seen attending a mental health service has been identified as a deterrent to help-seeking. Therefore, greater provision of community-based mental health services, in locations not solely associated with mental health provision, may improve parental access to mental health care.
3. Increasing investment in online and phone mental health supports, such as giving families the option to access CAMHS via webcam or by phone, may remove the barriers associated with the indirect cost of accessing treatment (e.g., transport, loss of wages, travel time). This would make services more accessible for individuals who currently commute long distances for an appointment and could also remove the fear associated with being seen at a mental health service.
4. There is a need to update aspects of the CAMHS referral process. Removing the €50 fee for an assessment and referral from a GP would open access to some families who may not be able to afford the extra cost. Furthermore, mainstreaming mental health training for GPs may also increase the delivery of effective and timely mental health care.
5. Investments should be made to improve awareness of mental health in Ireland. This could be achieved through social media campaigns or through programmes targeted at parents with a focus on destigmatising and improving knowledge of mental health and the services available. Educating and empowering parents to recognise mental health issues could facilitate early identification and limit the numbers of children presenting to CAMHS in crisis. Clear online guidelines on pathways to mental health care for children could be extremely useful for parents and equip them with a baseline knowledge of the services available.

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Appendices

Appendix A

Letter of Consent

My name is Róisín Quinn. I am a student in Marino College and as part of my Professional Masters in Education degree, I am conducting a research project.

The aim of this research is to explore the barriers faced by parents in seeking mental health services for their children. It seeks to elicit the perspectives of mental health professionals working with children as to what these barriers are. I hope that the study will assist in identifying what deters parents from engaging with mental health services. The concept of what motivates and deters people from using mental health services has been of interest to me since my undergraduate studies in psychology. Help-seeking in school-going children is mediated almost entirely by their parents and in an effort to explore uptake of mental health services by school-going children, barriers encountered by parents provides a useful starting point.

To obtain the data for my project, I will be interviewing mental health care professionals, who have experience working with children in that capacity. The interview will be a semi-structured one, lasting approximately 20-30 minutes. The questions will focus on exploring your perceptions of the barriers encountered by parents in seeking mental health services for their children.

The risks associated with participation are minimal. If you feel as though this study may cause you distress, you are encouraged to consider your participation. Your participation will remain strictly confidential and all participants involved will be referred to under pseudonyms (Participant 1, 2 etc). No identifying information will be included in the study.

You can decide to discontinue participation in the study at any time and are not obliged to answer all questions asked. You also have the right to withdraw from the study at any time and maintain the right to ask for your data to be removed. All transcripts and recordings will be stored on a password encrypted computer for eleven months. While there will be no direct benefit from participation, however studies like this can contribute to the understanding of the barriers experienced by parents in accessing mental health services for their children.

Your time and willingness to participate in this study is very much appreciated. If you consent to participate in the study, please confirm:

I have read the above consent form and I agree that my data may be used anonymously in the research described above.

YES _____

NO _____

PRINTED NAME: _____

SIGNATURE: _____

DATE: _____

