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Youth Mental Health in Canada: Barriers to Timely Access to Primary and Community-Based Care

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Abstract

Background: Youth mental health is an important and growing public health priority in Canada. Recent evidence indicates increasing mental health needs among adolescents and young adults, while many continue to experience delays, unmet needs, and difficulties navigating primary and community-based mental health services. Objective: This narrative literature review examines barriers to timely access to primary and community-based mental health care among youth aged 12 - 24 years in Canada and evaluates current health-system responses intended to improve timely and equitable access. Methods: A narrative literature review with a structured search approach was conducted using recent Canadian peer-reviewed literature and authoritative national data, with emphasis on evidence published between 2020 and 2026. PubMed/MEDLINE and Google Scholar were searched for literature addressing mental health service access, unmet needs, primary care, community services, help-seeking, wait times, service navigation, Integrated Youth Services, and health inequities. Relevant evidence was synthesized thematically. Findings: Barriers to timely care are cumulative and occur across the care pathway, from initial help-seeking to assessment, treatment, and continuity of care. Major barriers include long wait times and limited service capacity, mental health workforce shortages, inadequate access to primary care, fragmented referral and navigation pathways,

stigma, geographic disparities, and socioeconomic and cultural inequities. Canada has responded through the expansion of Integrated Youth Services, including ACCESS Open Minds and Youth Wellness Hubs Ontario, alongside greater primary-care integration, navigation strategies, virtual and hybrid care, school- and community-based approaches, and culturally responsive services. Integrated Youth Services provide the strongest emerging Canadian evidence for improving rapid entry into care, particularly through ACCESS Open Minds; however, evidence demonstrating population-level reductions in wait times and unmet need remains limited for many other approaches. Conclusion: Canada has made substantial progress in developing integrated and youth-centred models of mental health service delivery; however, significant gaps in timely and equitable access remain. Improving access requires attention to the entire care pathway rather than simply increasing the number of entry points or programs. Future policy should strengthen workforce and treatment capacity, improve coordination and continuity across services, expand effective approaches equitably, and embed standardized evaluation of waiting times, unmet need, engagement, outcomes, and equity. Progress should ultimately be measured by whether young people can obtain appropriate, timely, continuous, and effective care when they seek help.

Subject Areas

Psychiatry & Psychology

Keywords

Youth Mental Health, Mental Health Services, Access to Care, Primary Care, Community Mental Health, Integrated Youth Services, Health Inequities, Canada

1. Introduction

Mental health concerns among adolescents and young adults represent an increasingly important public health and health-system challenge in Canada. Adolescence and emerging adulthood are periods of substantial biological, psychological, educational, and social transition, during which mental health difficulties can interfere with academic achievement, relationships, employment, and longer-term functioning. Recent Canadian evidence suggests that the mental health of many young people has deteriorated and that increasing need has not been matched by equally timely access to appropriate care.

Longitudinal data from the 2023 Canadian Health Survey on Children and Youth (CHSCY) provide particularly important evidence of this trend. Among youth who were aged 12 - 17 years in 2019, 12% initially rated their mental health as "fair" or "poor." Four years later, 26% of the same cohort, then aged approximately 16 - 21 years, reported fair or poor mental health [1]. Moreover, among youth who had reported fair or poor mental health in 2019, 62% continued to

report low self-rated mental health in 2023, suggesting that poor mental health persisted for a substantial proportion of affected young people rather than representing a temporary deterioration [1].

National diagnostic data demonstrate a similar increase in common mental disorders. Analysis of the 2022 Mental Health and Access to Care Survey (MHACS) found that, among Canadians aged 15 years and older, the 12-month prevalence of a major depressive episode increased from 4.7% in 2012 to 7.6% in 2022, while generalized anxiety disorder doubled from 2.6% to 5.2% over the same period [2]. The burden was particularly pronounced among young women aged 15 - 24 years: in 2022, 18.4% met criteria for a major depressive episode, 11.9% for generalized anxiety disorder, and 24.7% for social phobia [2]. Although these estimates do not encompass every mental disorder affecting youth, they demonstrate the substantial burden of mood and anxiety disorders during adolescence and emerging adulthood.

Growing mental health needs are occurring alongside persistent difficulties obtaining care. In the 2022 MHACS, 36.6% of Canadians with a mood, anxiety, or substance-use disorder reported that their health or mental-health-care needs were partially or completely unmet, with counselling representing the most frequently unmet type of need at 30.5% [2]. More recent Canadian Institute for Health Information (CIHI) data demonstrate that access problems remain substantial. In 2024, 36% of Canadian children and youth aged 2 - 17 with a diagnosed mental health condition reported partially or completely unmet mental-health-care needs [3] [4]. Among adults, unmet need was particularly high among those aged 18 - 34 years, at 52%, demonstrating that access challenges extend into the young-adult years included within the population of interest for this review [3].

Timeliness is an additional concern. CIHI reported that wait times for community mental health counselling increased by 36% between 2020 and 2024 [4]. By 2024-2025, only approximately half of Canadians referred for community mental health counselling received care within 30 days of referral [4]. These findings are important because primary and community-based services are intended to provide early, accessible points of entry to the mental health system. Prolonged waits may leave young people relying on families, schools, primary-care providers, emergency departments, or informal support while awaiting specialized or community treatment.

Access to youth mental health care is not determined by waiting time alone. Canadian literature increasingly describes access as the product of interacting individual, community, provider, organizational, and structural barriers. At the individual level, young people may encounter stigma, uncertainty about whether their symptoms warrant professional help, concerns regarding confidentiality, and limited knowledge of available services. Sheikhan *et al.* [5], in a qualitative study of youth seeking mental health services in Ontario, found that stigma affected both help-seeking and young people's experiences after entering care. Participants described negotiating whether they were considered "sick enough" to

receive assistance, illustrating how perceived legitimacy of need can interact with service thresholds to delay intervention [5].

Community and geographic factors further shape access. In a 2024 Canadian study of 243 high-school students in rural Nova Scotia, adolescents identified inadequate mental health education, insufficient knowledge of available resources, shortages and turnover of qualified professionals, and poor communication between service providers as important barriers to obtaining care [6]. The study also found differences according to previous service experience: youth without prior mental health service use more often emphasized concerns such as gossip and judgment, whereas those who had previously received services more frequently identified problems within the organization and continuity of care [6]. At the national level, [7] demonstrated provincial and territorial variation in reported barriers to health care among Canadian children and youth with mental and neurodevelopmental concerns, reinforcing the importance of considering Canada's decentralized and geographically diverse health system when evaluating access.

Primary-care access also has important implications for youth mental health. Statistics Canada's analysis of the 2023 CHSCY found that children and youth without a regular health-care provider experienced additional barriers to accessing professional mental health support [8]. This is particularly relevant because family physicians and other primary-care professionals frequently act as initial points of recognition, assessment, treatment, and referral. Difficulties accessing primary care can therefore create an additional barrier before a young person reaches specialized or community-based mental health services.

Fragmentation between services presents another challenge. Young people may be required to navigate separate primary-care, mental-health, substance-use, school, social, and specialist systems, each with different referral processes and eligibility requirements. Transitions from child and adolescent services to adult mental health care are particularly important within the 12 - 24-year age range considered in this review. Canadian research examining transition readiness among youth accessing child and adolescent mental health services has highlighted the importance of preparation, health-system navigation, and continuity as young people move toward adult care [9].

These limitations have contributed to growing interest in Integrated Youth Services (IYS) in Canada. IYS models seek to reduce fragmentation by bringing mental health, substance-use, primary-care, peer, social, and other youth-oriented supports into coordinated, low-barrier systems. Canadian research on the implementation of these models, including Youth Wellness Hubs Ontario, suggests that integration is being increasingly used as a system-level response to gaps in conventional youth mental health services [10]. However, expanding integrated services does not itself resolve broader concerns surrounding workforce shortages, geographic inequities, service capacity, culturally appropriate care, transitions between systems, and sustainable funding. These issues require evaluation alongside the accessibility benefits of integration.

Taken together, the contemporary literature indicates a significant mismatch between mental health needs and timely access to care among Canadian youth. Rising rates of mood and anxiety disorders, persistent unmet needs, increasing community counselling waits, geographic variation, stigma, provider shortages, fragmented pathways, and transition difficulties suggest that barriers occur throughout the care-seeking pathway rather than at a single point. Accordingly, this literature review examines the evidence on barriers to timely access to primary and community-based mental health care among youth aged 12 - 24 years in Canada. Particular attention is given to individual, socioeconomic, geographic, cultural, provider, organizational, and health-system barriers, followed by an evaluation of policy and system-level approaches, including integrated youth services, strengthened primary mental health care, improved service navigation, workforce strategies, and more equitable models of care that may improve timely access for Canadian youth.

2. Aim and Objectives

This literature review aims to examine recent evidence on barriers to timely access to primary and community-based mental health care among youth aged 12 - 24 years in Canada. Specifically, the review seeks to identify individual, socioeconomic, geographic, cultural, provider, and health-system barriers that contribute to delayed or unmet mental health care and to examine current policy and system-level strategies aimed at improving timely and equitable access.

3. Methods

3.1. Review Design

A narrative literature review with a structured search approach was undertaken to examine barriers to timely access to primary and community-based mental health care among youth in Canada. A narrative approach was selected because the review sought to synthesize evidence from heterogeneous sources, including quantitative, qualitative, mixed-methods, health-services, and policy literature, rather than estimate a pooled intervention effect. The review focused on both barriers to accessing care and current Canadian initiatives intended to improve service accessibility.

3.2. Definitions and Access Measures

For the purposes of this review, timely access was defined as a young person's ability to progress through the mental health care pathway without unnecessary or clinically significant delay, from initial help-seeking or first contact with services through assessment, initiation of appropriate treatment, and ongoing connection with care. Because the included literature used heterogeneous definitions and measures of timeliness, no single universal waiting-time threshold was imposed across studies. Instead, timeliness was evaluated using pathway-based measures reported in the included evidence.

Measures considered indicative of timely access included: (1) time from initial help-seeking, referral, or first service contact to assessment; (2) time from assessment or referral to initiation of appropriate treatment or services; (3) waiting time for community mental health counselling or other relevant services; (4) the proportion of youth assessed or treated within specified service benchmarks; (5) unmet or partially met mental health care needs; and (6) continuity and engagement in care, including successful referral, follow-up, transitions between services, and maintenance of connection with appropriate care. Where studies reported program-specific benchmarks, these were retained rather than standardized across studies. For example, ACCESS Open Minds evaluated assessment within 72 hours and connection to appropriate services within 30 days.

Primary care was defined as first-contact, general health care delivered by providers such as family physicians, nurse practitioners, and interdisciplinary primary-care teams, including mental health identification, initial assessment and treatment, monitoring, referral, and follow-up. Community-based mental health care refers to non-inpatient services delivered within community settings, including community mental health agencies, counselling and psychotherapy services, Integrated Youth Services, youth wellness hubs, school- or community-linked services, navigation programs, and relevant virtual or hybrid services. Specialized services were included when they formed part of a referral, transition, or continuity pathway originating in primary or community-based care.

Accordingly, access was conceptualized as a care pathway rather than a single service encounter. Evidence was therefore considered relevant to timely access when it addressed delays or barriers occurring at entry into care, assessment, referral and navigation, treatment initiation, or continuity of care.

3.3. Search Strategy

The review focused primarily on literature published between 2020 and 2026 to capture contemporary evidence on youth mental health needs, barriers to care, and service delivery in Canada. Earlier studies were considered when they provided important evidence regarding the development, implementation, or evaluation of major Canadian youth mental health initiatives, particularly Integrated Youth Services such as ACCESS Open Minds. Peer-reviewed literature was identified primarily through PubMed/MEDLINE and Google Scholar.

Searches combined terms representing four main concepts: the target population, mental health, access or service pathways, and the Canadian context. The principal PubMed/MEDLINE search was structured as follows:

("youth" OR "adolescent" OR "young adult") AND ("mental health" OR "mental health services") AND ("access" OR "access to care" OR "barrier*" OR "unmet need*" OR "wait time*" OR "waiting time*" OR "help-seeking" OR "service navigation" OR "continuity of care") AND ("primary care" OR "community mental health" OR "community-based care" OR "integrated youth services") AND ("Canada" OR "Canadian")**

Additional targeted searches were conducted to identify evidence relating to specific barriers and service models identified during the review. These combined youth and mental-health terms with concepts including rural and remote access, geographic disparities, stigma, workforce availability, primary-care attachment, cultural and socioeconomic inequities, immigrant and refugee youth, service transitions, virtual care, Integrated Youth Services, Youth Wellness Hubs Ontario, and ACCESS Open Minds.

Google Scholar searches used shorter combinations of the same concepts because of differences in search functionality. Examples included "youth mental health access Canada," "youth mental health wait times Canada," "youth mental health barriers primary care Canada," "community mental health youth Canada," "integrated youth services Canada," "ACCESS Open Minds timely access," "Youth Wellness Hubs Ontario access," "rural youth mental health barriers Canada," and "youth mental health service navigation Canada."

Reference lists of highly relevant publications were also examined to identify additional Canadian studies and foundational publications concerning major service models. Peer-reviewed evidence was supplemented by targeted searches of authoritative Canadian grey-literature sources, particularly Statistics Canada and the Canadian Institute for Health Information (CIHI), for contemporary national or provincial data on mental health prevalence, unmet care needs, primary-care attachment, service utilization, and community mental health waiting times.

3.4. Eligibility Criteria

Studies were considered eligible if they: (1) included adolescents or young adults within or substantially overlapping the target age range of 12 - 24 years; (2) were conducted in Canada or presented clearly identifiable Canadian findings; (3) examined access to, utilization of, barriers to, or delivery of primary or community-based mental health services; and (4) were available in English. Quantitative, qualitative, mixed-methods, and relevant review studies were eligible.

The primary population of interest was youth aged 12 - 24 years. However, because Canadian surveillance systems and individual studies use varying definitions and age categories for youth, studies and national datasets using slightly different or adjacent age ranges were included when their populations substantially overlapped with the target population or their findings were directly relevant to the review question. This included studies using age ranges such as 12 - 25 or 15 - 24 years, as well as national datasets reporting broader categories such as 1 - 17 or 18 - 34 years. Findings from broader or adjacent age groups were explicitly identified in the text and were not assumed to represent the entire 12 - 24-year-old population.

Studies were excluded if they focused exclusively on populations outside the relevant age range, did not provide Canadian-specific evidence, or did not address mental health service access or delivery. Studies concerned exclusively with inpatient treatment were generally excluded unless their findings contributed directly

to understanding pathways into, transitions within, or gaps in primary and community-based mental health care.

3.5. Evidence Selection and Synthesis

Search results were screened sequentially for relevance to the review question. Titles and available abstracts or search-result summaries were initially examined to identify potentially relevant publications. Sources clearly unrelated to Canadian youth mental health service access, primary or community-based care, or the target or substantially overlapping age population were excluded at this stage. Potentially relevant publications were then examined in greater detail against the eligibility criteria.

Final source selection was based on the extent to which each publication contributed evidence relevant to at least one component of the review question: barriers to obtaining care, delays along the care pathway, unmet mental health needs, primary-care access, community-based service access, service navigation or fragmentation, continuity of care, equity in access, or the implementation or effectiveness of Canadian strategies intended to improve access. Particular priority was given to recent Canadian empirical studies, nationally or provincially representative data, studies directly examining youth service experiences or access outcomes, and evaluations of established Canadian service models.

Where multiple sources addressed similar issues, preference was given to more recent evidence, larger or more directly relevant Canadian samples, national or provincial datasets, and studies reporting access outcomes directly relevant to the review objectives. Earlier publications were retained when necessary to describe the development or original design of major Canadian initiatives. Authoritative grey literature was selected when it provided national or provincial access indicators not readily available in peer-reviewed studies, particularly waiting times, unmet need, and primary-care attachment.

Because the review was narrative rather than systematic, study selection did not involve duplicate independent screening or a formal risk-of-bias assessment. The purpose of screening was to identify a focused body of contemporary Canadian evidence capable of addressing the review objectives rather than to produce an exhaustive systematic evidence set.

Considerable heterogeneity existed across study populations, settings, methodologies, and outcome measures; therefore, statistical pooling or meta-analysis was not undertaken. Findings were synthesized narratively and organized according to recurring themes identified across the included literature. These themes included service capacity and waiting times; access to primary care; fragmentation and service navigation; stigma and help-seeking; workforce availability; geographic and transportation barriers; socioeconomic, cultural, and equity-related barriers; and continuity of care. Canadian responses including Integrated Youth Services, primary-care and collaborative approaches, navigation strategies, virtual and hybrid services, school- and community-based interventions, culturally re-

sponsive services, and workforce strategies were subsequently examined in relation to these barriers and to available evidence of improved access.

3.6. Limitations of the Review Method

As a narrative rather than a systematic review, this review did not involve the exhaustive study identification, duplicate independent screening, formal risk-of-bias assessment, or meta-analysis typically expected of a systematic review. The inclusion of heterogeneous study designs and grey literature also limits direct comparison across sources. Nevertheless, the structured search approach and thematic synthesis enabled the integration of contemporary Canadian evidence from multiple methodological perspectives and were appropriate for examining the complex individual, community, and health-system factors influencing timely access to youth mental health care.

An additional limitation relates to variation in age categories across Canadian studies and national surveillance datasets. Not all sources reported findings specifically for youth aged 12 - 24 years; therefore, evidence from substantially overlapping or adjacent age groups was included when directly relevant to the review objectives. Consequently, estimates derived from broader age categories should not be interpreted as applying uniformly to the entire 12 - 24-year-old population.

4. Barriers to Timely Access to Primary and Community-Based Mental Health Care

4.1. Long Wait Times and Limited Service Capacity

Long wait times remain a major barrier to timely mental health care in Canada. Recent national data indicate that access to publicly funded community mental health counselling has not kept pace with demand. Between 2020 and 2024, wait times for community mental health counselling increased by 36% [4]. In 2024-2025, approximately 94,000 referrals for community mental health counselling were recorded across reporting jurisdictions; half of referred individuals received their first appointment within 30 days, while one in ten waited more than four months (131 days) [3].

These delays are particularly concerning for youth because early access to counselling and other community-based interventions may prevent worsening symptoms and reduce the need for more intensive services. [11] noted that prolonged waits can be associated with worsening symptoms and reduced likelihood of attending the eventual first appointment. Although children and youth waited slightly less than adults in the 2023-2024 national community counselling data, substantial waiting periods persisted across the system [11].

Service capacity is closely connected to workforce availability. In 2024, vacancies among psychologists, psychotherapists, and social workers accounted for 16% of all health-care job vacancies reported by CIHI, highlighting the workforce pressures affecting the delivery of mental health services [4]. Thus, waiting lists should not be viewed solely as administrative inefficiencies; they also reflect underlying

limitations in the availability and distribution of professionals able to provide timely community-based care.

4.2. Limited Access to Primary Care

Primary care represents an important entry point into the mental health system because primary-care providers can identify mental health concerns, initiate treatment, monitor symptoms, and facilitate referrals to counselling or specialized services. However, Canadian evidence indicates that lack of attachment to a regular health-care provider is associated with substantially poorer access to needed mental health care.

Data from the 2023 Canadian Health Survey on Children and Youth showed that 19% of Canadian children and youth aged 1 - 17 required mental health care during the preceding year. Overall, 18.2% of those requiring mental health care did not have all of their needs addressed, including 14.5% whose needs were only partially met and 3.7% who received none of the required care [8].

Differences according to primary-care attachment were substantial. Among children and youth with a regular health-care provider who required mental health care, 83.3% had their needs fully met, compared with only 64.1% among those without a regular provider. Conversely, 24.5% of those without a regular provider had only partially met needs and 11.4% had completely unmet needs, compared with 13.7% and 3.0%, respectively, among those with a regular provider [8].

These findings suggest that primary-care attachment is an important component of mental health accessibility. Without a regular provider, youth may experience difficulties obtaining initial assessment, specialist referrals, treatment monitoring, and coordinated follow-up [8]. Strengthening youth access to longitudinal primary care should therefore be considered part of mental health system reform rather than a separate health-system issue.

4.3. Fragmentation and Difficulties Navigating Services

The existence of mental health services does not necessarily mean that young people can easily find or access them. Canadian youth mental health care is distributed across primary care, community agencies, hospitals, schools, specialized psychiatric programs, substance-use services, and private providers. Different services may have separate eligibility criteria, referral processes, waiting lists, and age restrictions, creating a system that can be difficult for young people and their families to navigate.

This problem is evident in research examining caregivers' experiences. [12] qualitatively examined 26 caregivers in the Greater Toronto Area who were navigating mental health and/or addiction services for youth aged 13 - 26. Caregivers described substantial external and systemic factors affecting their ability to locate and access appropriate services, while also assuming considerable responsibility for coordinating their young person's care [12].

Similarly, a study involving 259 Ontario caregivers found that perceived barri-

ers to youth mental health and addiction services were associated with rural residence, concurrent mental health/addiction concerns, and patterns of currently seeking or accessing services [13]. Importantly, the persistence of barriers among families already seeking or using services suggests that difficulties do not end once help-seeking begins; obstacles continue during navigation and entry into treatment [13].

Fragmentation may be especially consequential for youth with complex needs who require support from multiple sectors. Research involving youth experiencing homelessness in Toronto, for example, identified challenges in coordinating pathways between primary care, mental health, addiction, shelter, and other services [14]. These findings support the need for more coordinated pathways in which young people are assisted through the system rather than expected to independently navigate multiple disconnected services.

4.4. Stigma and Delayed Help-Seeking

Stigma represents another important barrier occurring before and during contact with mental health services. [5] conducted four focus groups involving 22 Ontario youth with lived experience of mental health challenges and found that stigma influenced decisions about whether and when to seek professional support. Participants described uncertainty about whether their problems were sufficiently severe to justify treatment and a continuing tension between feeling "sick enough" and "not sick enough" to qualify for services [5].

Importantly, the study demonstrated that stigma does not operate exclusively at the individual level. Youth perceived that expectations regarding what a person with a legitimate mental health problem should look like could also influence provider decisions and service eligibility. Some participants reported delaying contact with services, while others described feeling that their difficulties were trivialized or did not fit the expected profile for receiving care [5]. Consequently, reducing stigma requires not only improving public mental health literacy but also ensuring that services offer appropriate early intervention before symptoms reach crisis-level severity.

4.5. Geographic, Socioeconomic, and Equity-Related Barriers

Geographic location can further influence access. Rural residence was independently associated with greater perceived barriers in the Ontario caregiver study by [13], suggesting that service availability and navigation challenges may be intensified outside major urban centres. Geographic inequities may interact with workforce shortages, transportation limitations, reduced availability of specialized services, and concerns regarding privacy in smaller communities.

Access barriers may also be greater for populations experiencing structural disadvantage. A 2024 Canadian study examining barriers to mental health care found significant disparities for Indigenous and Black Canadians across several mental health conditions, illustrating that availability of services does not necessarily

translate into equitable access [15].

Newcomer youth and families may encounter additional linguistic, cultural, and system-navigation barriers. In a qualitative Canadian study involving 33 frontline and leadership staff from 14 health, education, settlement, and social-service organizations, service providers identified barriers operating simultaneously at system, provider, individual, and family levels for immigrant and refugee children and families seeking mental health support [16]. These findings reinforce the importance of culturally responsive services, interpretation and language supports, trusted community partnerships, and mental health pathways that recognize differing understandings of mental illness and help-seeking.

Socioeconomic circumstances may also influence access to youth mental health care through both primary-care attachment and the affordability of services outside the publicly funded system. Canadian data demonstrate income-related differences in access to regular primary care: in the 2023 Canadian Health Survey on Children and Youth, 94% of children and youth in the highest-income households had a regular health-care provider, compared with 89% of those in the lowest-income households. This is relevant to mental health access because primary-care providers frequently facilitate initial assessment, treatment, referral, and follow-up. CIHI has also reported socioeconomic variation in patterns of mental health service use among children and youth, with those living in the lowest-income neighbourhoods experiencing higher rates of hospitalization but lower rates of physician visits. Ontario qualitative research further identifies the cost of services as a structural barrier for some youth and families seeking mental health and addiction care. Taken together, these findings suggest that socioeconomic disadvantage may restrict access through multiple pathways, including reduced primary-care attachment, financial barriers to non-insured services, and differences in patterns of service use.

4.6. Summary of Barriers

Overall, recent Canadian evidence indicates that barriers to timely youth mental health care are cumulative and interconnected rather than isolated. A young person may first experience stigma or uncertainty about seeking help, then encounter difficulty obtaining primary care, subsequently face a complex referral pathway, and finally wait weeks or months for community treatment. Geographic location, socioeconomic circumstances, cultural background, and the complexity of the young person's mental health needs may further influence each stage of this pathway.

The literature therefore suggests that increasing mental health awareness or expanding a single category of service will be insufficient on its own. Improving timely access requires simultaneous attention to service capacity, workforce availability, primary-care attachment, navigation and coordination, geographic accessibility, cultural responsiveness, and early intervention. These interconnected barriers provide the rationale for integrated and community-based approaches to

youth mental health care that are examined in the following section.

5. Current Interventions, Evidence of Effectiveness, and Remaining Policy Priorities

Canada has implemented several approaches to improve timely access to youth mental health care, including Integrated Youth Services (IYS), enhanced primary-care involvement, service navigation, virtual and hybrid care, school and community-based interventions, and equity-oriented service models. However, the evidence supporting these strategies varies considerably. Some Canadian interventions have demonstrated improvements in rapid assessment and access to treatment, whereas others have strong theoretical or implementation support but limited direct evidence demonstrating reductions in wait times or unmet mental health needs. Distinguishing between implemented interventions, demonstrated effectiveness, and remaining evidence gaps is therefore important when considering future policy.

5.1. Integrated Youth Services: The Strongest Emerging Canadian Evidence

Integrated Youth Services represent one of Canada's most established responses to fragmentation in youth mental health care. IYS models seek to provide mental health, substance-use, primary-care, peer, social, educational, and other support through coordinated and youth-friendly points of access. In Ontario, for example, Youth Wellness Hubs Ontario (YWHO) was developed as a community-based "one-stop" model for youth aged 12 - 25 years, emphasizing walk-in access, integrated services, equity, youth engagement, measurement-based care, and continuous quality improvement [17].

Among Canadian IYS initiatives, ACCESS Open Minds (ACCESS-OM) provides some of the strongest direct evidence concerning timely access. The initiative was implemented across geographically and culturally diverse Canadian settings, including urban, rural, First Nations, Inuit, post-secondary, and homeless-youth settings. Its service-transformation model emphasized early identification, assessment within 72 hours, connection to appropriate services within 30 days, continuity across the 11 - 25-year age range, and meaningful youth and family engagement [18].

More importantly, recent research has evaluated whether these objectives translated into measurable improvements in timeliness. Iyer *et al.* [19] conducted a cohort study of youth aged 11 - 25 years referred to 11 ACCESS Open Minds sites between 2016 and 2020. A total of 7889 youth were referred, and 4519 youth evaluated before March 2020 contributed to the principal pre-pandemic analyses. The study examined changes in referral volume and two predefined timeliness benchmarks: being offered an initial evaluation appointment within 72 hours of referral and receiving services within 30 days of the initial appointment.

Timeliness improved over the implementation period. The cumulative proba-

bility of being offered an initial appointment within 72 hours increased from 48% in year 1 to 62% in year 2 and 64% in year 3 ($p < 0.001$). In adjusted analyses, each additional six months of implementation was associated with an approximately 3% reduction in delay to the first offered appointment. Service connection was already relatively high during the first year but also improved: the cumulative probability of receiving services within 30 days of the initial appointment increased from 85% in year 1 to 86% in year 2 and 89% in year 3 ($p = 0.01$). The proportion receiving a service on the same day as their first appointment also increased from 68% in year 1 to 79% in year 3. Each six-month progression was associated with an approximately 3% reduction in the delay from initial appointment to first service. Referral reach also increased over time, with each six-month period associated with a 10% increase in referral rates (IRR 1.10, 95% CI 1.07 - 1.13).

These findings provide direct longitudinal evidence that implementation of ACCESS Open Minds was associated with improvements in both service reach and predefined measures of timeliness. The improvement was particularly pronounced for rapid initial assessment, while the 30-day service-connection benchmark showed a smaller increase from an already high baseline. On this basis, ACCESS Open Minds provides some of the strongest emerging Canadian evidence identified in this review for improving rapid entry into youth mental health assessment and services. However, the findings derive from an observational cohort rather than a randomized comparison, and evidence from this model should not automatically be generalized to all provincial Integrated Youth Services networks.

The available evidence therefore supports continued development of IYS as a strategy for reducing fragmentation and improving rapid entry into care. However, evidence from one integrated model should not automatically be generalized to every provincial IYS network. YWHO research, for example, demonstrates the feasibility of providing integrated, community-based, youth-centred services, but the initial implementation study did not establish that the model reduced population-level waiting times or unmet mental health needs across Ontario [17]. Future evaluations should therefore consistently measure time from first contact to assessment, time from assessment to treatment, service engagement, unmet need, clinical outcomes, and continuity of care.

5.2. Primary-Care Integration: Strong Association, but Causal Evidence Remains Limited

Strengthening primary mental health care is another important component of Canadian service reform. Primary-care providers can identify mental health concerns, initiate treatment, provide follow-up, and facilitate access to specialized or community services. National Canadian evidence supports an important relationship between primary-care attachment and whether youth receive needed mental health care.

Among Canadian children and youth who required mental health care in 2023,

83.3% of those with a regular health-care provider had all of their mental health needs met, compared with 64.1% of those without a regular provider. Conversely, completely unmet needs were reported for 3.0% of those with a regular provider compared with 11.4% of those without one [8].

These findings provide a strong rationale for improving primary-care attachment and incorporating mental health expertise into primary-care teams. IYS models such as YWHO already integrate primary-care services with mental health, substance-use, peer and social supports, demonstrating that this approach is being implemented rather than merely proposed [17].

Nevertheless, the Statistics Canada findings are observational and should not be interpreted as proof that primary-care attachment itself causes shorter mental health waiting times. The evidence establishes an association between regular-provider access and having needs met, but additional Canadian research is needed to determine whether interdisciplinary primary-care mental health teams, shared-care psychiatry, or rapid specialist consultation independently reduce referral delays, emergency presentations, or specialist waiting lists.

5.3. Service Navigation and Coordinated Entry: Implemented but Under-Evaluated

Difficulties navigating services remain a significant barrier for youth and families. [12], in a qualitative study involving 26 caregivers of youth aged 13 - 26 in the Greater Toronto Area, found that caregivers assumed substantial responsibility for finding and accessing appropriate mental health and addiction services. Their experiences were affected by systemic and social factors as well as the demands associated with navigating care [12]. Similarly, [13] found significant barriers among 259 Ontario caregivers attempting to access youth mental health and addiction services, with greater perceived barriers associated with factors including rural residence and more complex mental health/addiction needs [13].

Current Canadian IYS models partially address these difficulties through open entry, walk-in services and coordinated access. ACCESS-OM, for example, was explicitly designed to accept referrals through multiple sources and rapidly connect youth to assessment and appropriate care [18] [19]. YWHO similarly uses integrated community-based service delivery intended to reduce the need for youth to independently navigate disconnected systems [17].

The direction of reform is therefore appropriate, but navigation interventions remain comparatively under-evaluated as independent strategies. Further research should determine whether dedicated youth navigators, centralized access, warm transfers, shared referral systems, and active follow-up reduce referral abandonment, repeated assessments, caregiver burden, and time to treatment.

5.4. Workforce Expansion and Geographic Redistribution: Necessary but Evidence Gaps Remain

Workforce capacity is fundamental to reducing waiting times because expanding entry points into care has limited value if insufficient professionals are available

to provide treatment. Canadian evidence demonstrates that workforce availability is particularly problematic in rural communities. In a survey of rural Nova Scotia adolescents, [6] identified shortages of qualified mental health professionals, provider turnover, limited awareness of available resources, and inadequate communication among providers as important community-level barriers to accessing care [6].

Potential policy responses include expanding training positions, improving recruitment and retention, increasing interdisciplinary practice, providing rural incentives, developing distributed training opportunities, supporting specialist consultation to rural primary-care providers, and appropriately extending the roles of trained non-specialist professionals.

However, these recommendations should be presented cautiously. Although the literature establishes that workforce shortages contribute to access problems, there is limited Canadian youth-specific comparative evidence identifying which workforce intervention produces the greatest reduction in wait times. Workforce policies should therefore be evaluated according to outcomes such as provider retention, caseload capacity, referral-to-treatment time, rural access, and youth-reported unmet need rather than simply increases in staffing numbers.

5.5. Virtual and Hybrid Care: Greater Reach but Uncertain Effects on Overall Timeliness

Virtual care offers an important mechanism for addressing geographic and transportation barriers, particularly in rural and remote communities. Canadian integrated service models increasingly incorporate virtual options alongside community-based services, reflecting the recognition that physical distance should not determine whether a young person can initiate contact with mental health services [17].

However, virtual availability should not automatically be interpreted as equivalent to improved access. Youth may lack reliable internet connectivity, appropriate technology, digital literacy, or a private environment in which to discuss sensitive concerns. Clinical complexity and personal preference may also determine whether virtual treatment is appropriate.

Consequently, the evidence currently supports virtual care primarily as an additional pathway to services rather than a replacement for local capacity. Hybrid systems that permit movement between virtual and in-person care may offer greater flexibility. Future Canadian evaluations should compare virtual, in-person, and hybrid approaches according to waiting times, engagement, treatment completion, clinical outcomes, youth preference, and equity of access.

5.6. School and Community-Based Early Intervention: Promising but Dependent on Treatment Capacity

Schools provide an important setting for mental health promotion, early recognition, and connection to services because they reach large numbers of adolescents before those young people necessarily enter the health system. The rationale for

school and community-based interventions is supported by evidence that some access barriers originate before formal help-seeking. Rural Canadian adolescents have identified inadequate mental health education, limited awareness of available resources, fear of judgment, and other community-level factors as barriers to accessing services [6].

School-based mental health literacy, counselling and referral pathways may therefore facilitate earlier identification. However, earlier identification does not necessarily produce earlier treatment when downstream services lack capacity. Increasing recognition without expanding treatment availability could instead increase referrals to already constrained community services.

Accordingly, school-based initiatives should be evaluated according to whether youth identified as needing help actually reach appropriate assessment and treatment, rather than solely according to improvements in mental health knowledge or screening rates. Stronger links among schools, primary care, community organizations and IYS networks represent a reasonable policy direction, but further Canadian outcome evaluation is required.

5.7. Equity-Oriented and Culturally Responsive Services: Essential but Effectiveness Must Be Demonstrated

Equitable access requires recognition that youth do not encounter the mental health system under identical circumstances. Rural residence, cultural and linguistic differences, socioeconomic disadvantage, discrimination, and other structural factors may influence whether services are available, acceptable, and accessible. The rural findings of [6], together with Ontario caregiver evidence showing greater perceived barriers associated with rural residence, demonstrate that geographic and contextual factors influence access [6] [13].

Canadian service reform increasingly emphasizes culturally responsive and locally adapted approaches. ACCESS-OM is particularly relevant because its transformation principles were implemented across culturally and geographically diverse settings, including First Nations and Inuit communities, while allowing implementation methods to reflect local resources, geography, culture and population needs [18].

Nevertheless, the presence of culturally responsive services should not itself be considered evidence that inequities have been eliminated. Future evaluations should determine whether these approaches reduce time to assessment and treatment, improve retention and perceived cultural safety, decrease unmet need, and produce comparable outcomes among populations that have historically experienced poorer access.

5.8. Current Evidence and Priorities for Further Reform

Taken together, the evidence indicates differing levels of support for current Canadian approaches to improving youth mental health access. Integrated Youth Services, particularly ACCESS Open Minds, provide the strongest emerging direct evidence identified in this review for improving rapid entry into assessment and

services. ACCESS Open Minds demonstrated measurable improvements against predefined timeliness benchmarks, while Youth Wellness Hubs Ontario provides evidence that integrated, community-based, youth-centred services can be implemented at a provincial level, although evidence of population-level effects on waiting times and unmet need remains less established [17]-[19].

Primary-care integration, service navigation, virtual and hybrid care, and school-community partnerships are also being implemented across Canada and are supported by evidence demonstrating the barriers they are intended to address. However, Canadian evidence directly establishing their independent effects on youth waiting times or unmet need remains comparatively limited. For example, primary-care attachment is strongly associated with having mental health needs met, but available observational data do not establish a causal effect on waiting times [8]. Similarly, caregiver studies demonstrate substantial navigation difficulties without establishing which specific navigation model produces the greatest improvement in access [12] [13].

Evidence concerning workforce and equity-oriented interventions is less developed. Canadian studies document professional shortages, geographic disparities, cultural and structural barriers, and other inequities affecting access, particularly among rural and underserved populations [6] [13] [15] [16]. However, comparatively few Canadian studies have evaluated whether specific workforce or equity-oriented interventions produce measurable reductions in waiting times, unmet need, or disparities in access.

Overall, the evidence is strongest for the ability of integrated service models to improve rapid entry into care, while evidence for several other promising strategies remains primarily observational, implementation-focused, or indirect. Across intervention categories, substantial heterogeneity in access measures limits direct comparison of effectiveness.

6. Discussion

This review demonstrates that the central challenge in Canadian youth mental health care is not simply the absence of services, but the difficulty of converting available services into timely, continuous, and equitable care. Across the literature, barriers emerge at multiple stages of the care pathway: recognizing a need for help, identifying an appropriate entry point, obtaining an assessment, navigating referrals, reaching treatment, and maintaining continuity of care. These stages are influenced by service capacity, primary-care attachment, workforce availability, geography, stigma, cultural and socioeconomic factors, and the organization of the health system.

6.1. Access Is a Pathway Rather than a Single Event

A major implication of the evidence is that access should be conceptualized as a pathway rather than a single encounter with the health system. Increasing the availability of an entry point does not necessarily mean that a young person will

receive appropriate treatment in a timely manner.

Barriers can accumulate sequentially. Youth may initially delay seeking help because of stigma or uncertainty about whether their symptoms justify professional intervention [5]. After deciding to seek care, they may encounter difficulty accessing a regular primary-care provider, identifying appropriate services, meeting eligibility requirements, navigating referrals, or waiting for treatment. Caregivers may consequently assume substantial responsibility for locating and coordinating services across otherwise disconnected systems [12] [13].

This pathway perspective helps explain why improving one component of access may not eliminate overall delays. For example, strengthening mental health literacy may encourage earlier help-seeking, while walk-in services and integrated youth hubs may make initial contact easier. However, these improvements will have limited effects on overall timeliness if youth subsequently encounter insufficient treatment capacity or prolonged waits for counselling, psychology, psychiatry, or other services. Access reform must therefore consider the entire trajectory from initial help-seeking to appropriate treatment and continuity of care.

6.2. Why Access Barriers Persist Despite Service Expansion

Canada has made substantial progress in developing Integrated Youth Services and other approaches intended to simplify entry into mental health care. The persistence of unmet need and waiting times despite this expansion suggests, however, that service availability and system capacity are not equivalent.

One explanation is that increasing entry points may reveal or intensify pressure further downstream. When more young people are identified through primary care, schools, virtual services, community programs, or integrated youth hubs, the demand for assessment and treatment may increase accordingly. If treatment capacity does not expand at a similar rate, delays may shift from the point of initial contact to later stages of care. National evidence showing increasing community mental health counselling wait times is consistent with continuing pressure on service capacity [4].

Workforce limitations are therefore central to understanding why expanded access points may not consistently translate into timely treatment. Rural adolescents have identified shortages and turnover of qualified professionals as barriers to care [6]. More broadly, limited availability of mental health professionals constrains the capacity of services to respond to increasing demand. Consequently, successful access reform requires alignment between strategies that increase help-seeking and entry into care and strategies that expand the capacity to deliver appropriate treatment.

6.3. Integration Should Be Viewed as a Means Rather than an Outcome

The expansion of Integrated Youth Services represents an important shift away from fragmented and diagnosis-dependent pathways toward more coordinated

and youth-centred care. However, the findings of this review suggest that integration itself should not be considered the final measure of success.

The relevant question is not simply whether mental health, substance-use, primary-care, peer, and social services are located within an integrated model, but whether integration improves the experience and outcomes of young people seeking assistance. Meaningful evaluation therefore requires attention to whether youth are assessed sooner, receive appropriate treatment more rapidly, experience fewer disruptions between services, remain engaged in care, and report that their needs have been met.

This distinction is important because Canadian Integrated Youth Service models vary in population, geography, staffing, funding, partnerships, and local implementation. The effectiveness of one model or site cannot automatically be assumed to apply to all integrated youth services. Continued expansion should therefore occur alongside evaluation that identifies which components of integration contribute most directly to improved access and which contextual factors influence their effectiveness.

6.4. Primary Care Is Necessary but Cannot Function in Isolation

The association between having a regular health-care provider and having mental health needs met demonstrates the importance of primary care within the youth mental health system [8]. However, the collective evidence suggests that primary-care attachment should be understood as one component of a broader pathway rather than a complete solution.

Primary-care providers can identify mental health concerns, initiate treatment, provide follow-up, and facilitate referrals, but their effectiveness depends partly on the availability of services to which young people can subsequently be connected. Improving primary-care attachment without adequate counselling, community mental health, specialist consultation, and referral pathways may improve recognition without resolving downstream delays.

Accordingly, primary-care reform and mental health service reform should not proceed independently. Stronger connections among primary care, community organizations, Integrated Youth Services, schools, and specialized mental health services may be more important than expanding any individual component in isolation.

6.5. Equity Must Be Evaluated within Access Outcomes

Another important implication is that improvements in average access may conceal persistent disparities between populations and regions. Rural residence has been associated with greater perceived barriers to youth mental health and addiction services, while rural youth have identified professional shortages, provider turnover, limited knowledge of services, and concerns about judgment as barriers to care [6]. Provincial and territorial variation further demonstrates that access is not experienced uniformly across Canada [7].

Cultural, linguistic, socioeconomic, and structural factors may similarly affect

whether services are acceptable and practically accessible. Newcomer children and families can experience barriers at family, provider, organizational, and system levels [16]. Broader Canadian evidence also demonstrates disparities in barriers to mental health care among population groups [15].

These findings suggest that equity should not be treated as a separate objective after overall access has improved. Instead, equity should be incorporated into how access itself is measured. An intervention that reduces average waiting times but leaves rural, remote, culturally diverse, or otherwise underserved populations with substantially poorer access cannot be considered fully successful.

6.6. From Program Expansion to Evidence-Based Accountability

The next phase of Canadian youth mental health reform should place greater emphasis on determining whether existing investments produce measurable improvements in access. The presence of additional programs, hubs, virtual platforms, referrals, or service contacts provides information about system activity but does not by itself demonstrate that young people are receiving appropriate care more quickly.

Evaluation should therefore follow the youth care pathway. Important outcomes include time from initial help-seeking to first assessment, time from assessment to appropriate treatment, proportion of identified needs that are fully met, continuity between services, treatment engagement, clinical and functional outcomes, and youth-reported experience of care. These outcomes should also be examined across geographic and population groups to determine whether improvements are equitably distributed.

This approach would help distinguish interventions that successfully increase initial contact from those that improve access across the entire care pathway. It would also allow policymakers to determine whether additional investment is required at the point of entry, assessment, treatment, workforce capacity, navigation, or continuity of care.

6.7. Implications for Canadian Youth Mental Health Policy

Taken together, the evidence does not suggest that Canada requires another wholesale redesign of youth mental health services. Rather, the findings support strengthening and evaluating the reforms already underway while addressing the capacity limitations that prevent these initiatives from achieving their full potential.

Integrated services may simplify entry into care; primary care can facilitate recognition, treatment, referral, and continuity; navigation strategies can reduce the burden placed on youth and families; virtual and hybrid services may extend geographic reach; and culturally responsive approaches may improve the acceptability and appropriateness of care. However, these strategies ultimately depend on sufficient treatment capacity and effective connections across primary, community, and specialized services.

Policy should therefore increasingly focus on capacity, coordination, equity,

continuity, and measurable accountability. Interventions with emerging evidence of improved access should be expanded while continuing to be evaluated, whereas promising strategies with less-established effectiveness should be implemented alongside rigorous outcome measurement.

The central measure of progress should ultimately be whether a young person who seeks help can enter the system without unnecessary barriers, receive an appropriate assessment, reach effective treatment within a reasonable period, and remain connected to care. Reframing access in this way moves evaluation beyond determining whether services exist toward determining whether the mental health system functions effectively from the perspective of the young person who needs it.

6.8. Limitations and Future Research

The findings of this review should be interpreted in the context of several limitations. As a narrative review, the search was structured but was not designed to provide exhaustive identification of all relevant Canadian literature. The included evidence was heterogeneous in study design, population, geographic setting, age range, and outcome measurement, limiting direct comparison between studies. National and provincial administrative and survey data were also used alongside peer-reviewed empirical research to provide contemporary information on service access and unmet need.

The available evidence also limits conclusions regarding the comparative effectiveness of individual interventions. Although several studies identify barriers to care and provide strong rationales for primary-care integration, navigation, workforce expansion, virtual care, and equity-oriented approaches, fewer Canadian studies directly evaluate whether these strategies independently reduce waiting times or unmet need among youth. Observational associations should therefore not be interpreted as evidence of causation.

Future research should prioritize prospective and comparative evaluations of youth mental health service models using standardized access outcomes. Particular attention should be given to time from help-seeking to assessment and treatment, continuity of care, unmet need, youth-reported experience, clinical and functional outcomes, and differences across geographic and population groups. Consistent measurement across Canadian initiatives would make it possible to determine not simply which programs can be implemented, but which approaches most effectively provide timely, equitable, and continuous mental health care.

7. Conclusions

Timely access to youth mental health care in Canada is shaped by barriers occurring across the care pathway, from initial help-seeking and primary-care access to assessment, treatment, navigation, and continuity of care. The evidence reviewed indicates that improving entry into services alone is insufficient when treatment capacity, workforce availability, coordination, geographic accessibility, and equity remain constrained.

Integrated Youth Services, particularly ACCESS Open Minds, provide the strongest emerging Canadian evidence identified in this review for improving rapid entry into assessment and services, while several other approaches including primary-care integration, navigation, virtual and hybrid care, and equity-oriented models remain promising but require stronger evaluation of their effects on timeliness.

Future progress should ultimately be judged by whether young people can obtain appropriate assessment and treatment without unnecessary delay and remain connected to care. Consistent measurement of timeliness, unmet need, continuity, outcomes, and equity will be essential for determining whether ongoing Canadian reforms translate into meaningful improvements in access.

Author Contributions

Conceptualization, I.C.D. and J.A.F.; methodology, I.C.D., J.A.F., and S.O.O.A.; investigation and literature searching, I.C.D., J.A.F., S.O.O.A., B.O.S., A.Y., F.K.A., and B.B.; data curation and organization of the literature, I.C.D., J.A.F., S.O.O.A., B.O.S., A.Y., F.K.A., and B.B.; formal analysis and interpretation of the literature, I.C.D., J.A.F., and S.O.O.A.; resources, I.C.D., J.A.F., S.O.O.A., B.O.S., A.Y., F.K.A., and B.B.; writing—original draft preparation, I.C.D.; writing—review and editing, I.C.D., J.A.F., S.O.O.A., B.O.S., A.Y., F.K.A., and B.B.; supervision, I.C.D.; project administration, I.C.D. All authors have read and agreed to the published version of the manuscript.

Conflicts of Interest

The authors declare no conflicts of interest.

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