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Original qualitative research

Access to mental health for Black youths in Alberta

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Abstract

Introduction: The objective of this study was to examine the barriers that influence access to and use of mental health services by Black youths in Alberta.

Methods: We used a youth-led participatory action research (PAR) methodology within a youth empowerment model situated within intersectionality theory to understand access to health care for both Canadian-born and immigrant Black youth in Alberta. The research project was co-led by an advisory committee consisting of 10 youths who provided advice and tangible support to the research. Seven members of the advisory committee also collected data, co-facilitated conversation cafés, analyzed data and helped in the dissemination activities. We conducted in-depth individual interviews and held four conversation café-style focus groups with a total of 129 youth. During the conversation cafés, the youths took the lead in identifying issues of concern and in explaining the impact of these issues on their lives. Through rigorous data coding and thematic analysis as well as reflexivity and member checking we ensured our empirical findings were trustworthy.

Results: Our findings highlight key barriers that can limit access to and utilization of mental health services by Black youth, including a lack of cultural inclusion and safety, a lack of knowledge/information on mental health services, the cost of mental health services, geographical barriers, stigma and judgmentalism, and limits of resilience.

Conclusion: Findings confirm diverse/intersecting barriers that collectively perpetuate disproportional access to and uptake of mental health services by Black youths. The results of this study suggest health policy and practice stakeholders should consider the following recommendations to break down barriers: diversify the mental health service workforce; increase the availability and quality of mental health services in Black-dominated neighbourhoods; and embed anti-racist practices and intercultural competencies in mental health service delivery.

Keywords: *African, Alberta, Black, Caribbean, mental health, youth*

Highlights

- Black youths face barriers accessing mental health services.
- Factors that limit Black youths access to and use of mental health services include a systemic lack of cultural inclusion and safety; a lack of knowledge about and information on mental health services; the cost of mental health services; geographical and locational barriers; stigma and judgmentalism; and limits of resilience.
- To address existing barriers to mental health services for Black youths, policy makers must diversify the mental health service workforce, increase the availability and quality of mental health services in Black-dominated neighbourhoods, and embed anti-racist practices and intercultural competencies in mental health service delivery.

Introduction

Mental health and substance use disorders account for a significant proportion of the global burden of disease; they are the leading cause of disabilities worldwide.[1,2] This situation is aggravated by a service gap: globally, 70% of individuals in need are unable to access quality mental health services.[2] This disparity is the result of fragmented service delivery models, a global undersupply of trained mental health providers, limited infrastructure and shortages of human resources.[2] Lack of access is further compounded by social determinants such as poverty, stigma and social deprivation; for example, those with a lower socioeconomic status traditionally face high costs, longer wait times, lower quality services and inadequate care,[3,4] circumstances that strain the reliable access to and uptake of mental health services.

Research into the barriers to health care points towards the need for a balanced care model, or primary health care model. In a community-based model, mental health services are provided holistically alongside community services and within the communities, as opposed to within institutionalized settings.[5,6] These models reach beyond diagnosis and treatment frameworks, and position mental health promotion and prevention strategies as equally important. Such models also push for the development of mental health services that cater to the specific needs of the communities and people who access them.[6-9]

Barriers to access and uptake of mental health services are largely systemic and disproportionately affect those with lower socioeconomic status as well as immigrants,

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refugees and racialized minorities. Immigrants new to Canada are twice as likely to have difficulties accessing care as longer-established Canadians.[8] Refugees report lower mental health service utilization than their non-immigrant counterparts, despite the fact that conditions of forced displacement and migration put them most at risk for mental health disorders.[10,11] Individuals living at lower socioeconomic status who experience challenges accessing services are susceptible to lower self-reported mental health and lower life expectancy; they are also vulnerable to critical or chronic illnesses.[4,12] Ethnic minorities are frequently subject to greater health care disparities than their White counterparts; these disparities not only compromise the quality of care people receive, but also reduce their level of trust in the health care system.[13-15]

Challenges in accessing mental health services are heightened for individuals who possess an intersection of these identities.[3,8,12] From a public health perspective, this may justify more concerted attention on these populations.

Colonization, structural racism and systemic injustices and inequities have subjected Black people to adverse socioeconomic conditions, discrimination and restricted access to health care and support systems.[16,17] In the United States, Black youth are less likely to utilize mental health services than their White counterparts[18] despite being at a higher risk of diagnosed major depressive disorder and six times more likely to die by suicide as a result of their depression.[19,20]

In 2016, there were approximately 1.2 million Black people living in Canada, including 198 610 youths aged 15 to 24 years.[21] Relative to the national average, a higher proportion of Black individuals live in low-income environments, face lower levels of employment, achieve lower levels of education and face a distinct wage gap.[22] If unaddressed, these social conditions, coupled with the young age of this demographic—which heightens vulnerability to adverse mental health conditions—leave Black people susceptible to a mental health crisis.[23-25]

Past research into Black immigrants' and refugees' experiences with the Canadian health care system found that stigma, racism/discrimination, lack of knowledge regarding mental health, cost, lack of culturally appropriate services and inaccessibility posed major barriers to accessing health care.[20,26] Although the province of Alberta has the fastest growing population of Black Canadians, with 129 390 people, including 17 530 youths aged 15 to 24 years,[21] to our knowledge no research has considered the mental health of Black youth in Alberta.

The purpose of this qualitative research study was to identify the barriers and facilitators to mental health care for Black youth in Alberta. Our specific research question was: What are the barriers and facilitators to access and use of mental health services for Black youths in Alberta?

Methods

Youth empowerment model

We used a youth empowerment model situated within intersectionality theory to understand access to health care for Black youths. In creating a safe and supportive environment and encouraging meaningful participation, we acknowledged the different histories and impacts of social, economic and political marginalization experienced by Black communities.[27,28] Using the empowerment model also equalizes power dynamics between adults and youth, provides opportunities for personal and community development, and encourages critical reflection on broader processes and structures that shape youths' lives.[29]

These five dimensions guided the research design to ensure adherence to participatory and community-driven principles. Safe and supportive spaces for critical reflection and community engagement allowed the youths to understand the forces that influence their lives, articulate their experiences and recognize their capacity for creating change. By using an empowerment model, we made explicit our commitment to providing a space for youths to use their voices and to simultaneously recognizing their strengths and capacity for resilience as well as the oppressive structures and narratives that hinder agency.

Participatory action research approach

We used a youth-led participatory action research (PAR) approach to better understand access to health care for Black youths. PAR is a power-equalizing, collaborative research approach that sees community members as partners in the research process and experts on the issues of concern in their lives.[30,31] This methodology is based on principles of shared leadership, collaborative decision-making and researcher–community trust building. The aim is to create sustainable, action-oriented research outcomes.

Quality in PAR is defined as ensuring the principles of empowerment, local knowledge development and social action are safeguarded in all aspects of the research process.[30-32] The use of a youth empowerment model grounded in intersectionality theory to guide the PAR allowed the research team to uphold quality in research by ensuring the research questions are useful to the community: our research findings are grounded in the community's experiences, and final outcomes support sustainable changes in the community through knowledge dissemination.

We also wrote reflexive memos to record our experiences in the field and reflect on how our social locations (including ethnicity and sex/gender) might have influenced the research process.

The youths were active participants in all stages of the research project. Including youths in the data collection, analysis and writing phases allowed for greater transparency, ownership and legitimacy of findings within the community, which is also crucial to assuring rigour in PAR.[33]

Researchers and the advisory committee

The research project was co-led by an advisory committee consisting of 10 youths who provided advice and tangible support to the research. Seven members of the advisory committee also collected data, co-facilitated conversation cafés, analyzed the data and contributed to dissemination activities. The youths had leadership roles throughout all stages of the study, from the conceptualization of the study (prior to submitting the grant application) to the dissemination of findings (including as co-authors on this work).

Non-youth members of the research team identified as being from racialized communities and/or had expertise working with marginalized youths.

Recruitment and interviewers and study participants

Upon receiving ethics approval from the University of Alberta Research Ethics Board (REB 1 Committee Protocol: Pro00079877), we conducted 30 individual interviews to obtain an in-depth understanding of the youths' challenges accessing mental health services. We used posters and peer–youth recruiters to inform people of the study.

Interviews were conducted by Black youths and a graduate research assistant. They each received training in interview techniques, research ethics, qualitative methodologies and participatory research. We used purposeful sampling to recruit information-rich cases[32] and continued recruitment until we reached data saturation, that is, when a sufficient amount of data had been collected to render the research question answerable in ways that could inform our research and practice.[34,35]

Study participants

All 129 participants in this study identified as Black and were between 16 and 30 years old and fluent in English.

We interviewed 30 participants, and another 99 engaged in our conversation cafés. Interview participants identified as male (n = 10), female (n = 18) and non-binary or other (n = 2) and were predominantly Christian (n = 21) or Muslim (n = 4), with 5 identifying as non-religious or following another religion.

Conversation café participants identified as male (n = 22), female (n = 76) and non-binary or other (n = 1) and were predominantly Christian (n = 67) or Muslim (n = 24) with 8 identifying as either non-religious or following another religion. Participant country of birth included Botswana, Burundi, Canada, Democratic Republic of Congo, Egypt, England, Ethiopia, Gambia, Germany, Ghana, Guinea, Haiti, Jamaica, Kenya, Lebanon, Liberia, Libya, Nigeria, Rwanda, Saudi Arabia, Sierra Leone, Sint Maarten (the Netherlands), Somalia, Sudan, South Sudan, Tanzania, the United States, Zambia and Zimbabwe.

Data collection

Data were collected in two phases: Phase 1 involved interviews with 30 Black youths and Phase 2 involved engaging in conversation cafés with an additional 99 Black youths.

Individual interviews lasted approximately 1 hour; most were conducted at the University of Alberta. Individual interviews included a sociodemographic questionnaire (available from the corresponding author on request) and semistructured interview questions centred on personal mental health experiences; barriers and facilitators to mental health; culturally appropriate and effective strategies to improve access to and uptake of mental health services; and implications for research, policy and practice.

In Phase 2, we engaged in conversation cafés with Black youths. The conversation cafés effectively fostered youth engagement and dialogue because the participants took the lead in identifying their issues of concern and in explaining the impact these issues have on their lives.

After conducting individual interviews but before the conversation cafés, the research team and advisory committee completed a preliminary analysis of the interview data and met to reflect on the results in order to come up with specific topics for the conversation cafés. These topics were based on data collected from interviews and the advice of the advisory committee members. The topics included the following: introduction to the mental health of Black youths; intersectionality experience and mental health; intergenerational relations and mental health; and mental health policy.

The cafés were conducted monthly over 4 months. These 3-hour conversation cafés included a guest speaker for about 20 minutes, followed by small-group breakout discussion sessions and a larger discussion by all attendees. We kept field notes for the cafés and collected sociodemographic information from all 99 participants.

All data were transcribed verbatim by a skilled transcriptionist. We used thematic analysis to identify and analyze patterns in the data while situating these patterns within the broader contexts of their occurrence.[36] Our data analysis encompassed several steps: (1) familiarizing ourselves with data through repeated readings of the transcripts; (2) generating initial codes; (3) searching for themes based on identified codes; (4) reviewing, expanding and refining identified themes; (5) defining and naming the themes; and (6) writing the final report. We considered intersectional experiences throughout all stages of the analysis process. Data analysis was completed by two Black youths under the supervision of the lead researcher (BS), who is an expert in qualitative methods.

Results

Study participants identified key barriers that prevent access to and use of mental health services by Black youth in Alberta. These include lack of cultural safety and inclusion; lack of knowledge/information on mental health services; cost of mental health services and geographical and locational barriers; stigma and judgmentalism; and limits of resilience.

Lack of cultural safety and inclusion in service delivery

Our research participants considered cultural safety and inclusion a major concern. They observed that Canada has a majority White population, and as such, many services provided across different sectors of society appear to be designed to serve White people as the standard, excluding everyone else.

The participants described the mental health system as an "othering" service that contributes to the exclusion and marginalization of Black people. Participants who had used mental health services reported frequently experiencing being excluded and marginalized by White health providers, who they noted, often lacked intercultural training/understanding of the complexities of ethnicity. Because their ethnicity and culture define a large part of their lives, the youths felt service providers without relevant training could not serve them adequately.

In the context of intercultural competence and awareness, the majority of the youths affirmed that the mere thought of experiencing a culturally inappropriate health provider was sufficient to deter them from accessing mental health services. This stance towards accessing mental health services was linked to the disconnect, discomfort and insecurity that many youths said they felt when exposed to existing mental health services. One participant underscored the helplessness of encountering a culturally disconnected health provider:

> Oh, like [I describe that] I'm experiencing racism. They'd be like, "What? … are you sure? Okay, let's get you some … strategies you can [apply to] deal with like the workplace or something." But it's, like, no… Someone who has not experienced that, or has any idea what it's like, I just feel like it'd be really difficult for them to empathize and relate, and sort of just, like, advise you on what you can do, or strategies and things like that. — Participant 010, female, born in Lebanon of South Sudanese–born parents

The youths feared that their experiences with racism would be invalidated during mental health sessions. Critiquing the popular "colour-blind approach" as emotionally invalidating, damaging and draining, one youth offered his experience-based perspective:

> Don't … you shouldn't be saying this. If you're going to [laughs] enter a space of all Black people, you can't say, "I don't see colour." You're invalidating us and our experiences. And I know you can acknowledge my colour. So and if these are the people who are supposed to be offering us services, how can we take them seriously? It's not a safe space, you know? It could trigger you. You can have more trauma in that way, yes. — Participant 013, male, born in Nigeria

When given the opportunity to design a mental health hub, conversation café participants described their ideal community hub as one that would be centrally located in the community; be serviced by culturally safe and Black health providers; show Black art on the walls; and accommodate a greater variety of counselling/therapies. The youths prioritized the need for Black representation in their services along with culturally safe practitioners.

Lack of knowledge and information on mental health services

A general lack of understanding of the nature of mental health prevents Black youth from accessing services. The participants said that, regardless of the severity of a mental health episode, they often normalized their poor state of mental health, unaware that what they were experiencing was serious. This pattern of response to mental health difficulties often resulted in an inability to codify their symptoms as abnormal, due to repeated normalization of adverse experiences. One interviewee admitted how a lack of knowledge previously kept her in the dark:

> … when something has been named, it's like, "Oh, like this is considered depression or anxiety." I feel, like, before, I sort of just brushed off the symptoms … I didn't have the language to describe … the situation, if that makes sense. — Participant 010, female, born in Lebanon of South Sudanese–born parents

Compounding this lack of knowledge is a lack of awareness of the available services/resources that help maintain mental health or treat mental health episodes, as alluded to by an interviewee:

> Um, I just think that in my community I just don't know where to go, or we just don't know where to go, for resources to stay mentally healthy, or we're not totally sure about, like, what can we do to stay mentally healthy and, like, commit to that, you know? So maybe not so much accessibility. — Participant 024, female, born in Somalia

The lack of awareness with respect to both mental health and related health care services creates a community of people that are deeply unfamiliar with the mental health care system. Moreover, this unfamiliarity creates significant delays in accessing and receiving mental health supports.

Geographical, economic and locational barriers

Participants highlighted the clustering of mental health service providers outside their own communities and in the communities of their richer White counterparts. The combination of being a visible minority and living at a lower socioeconomic status created a sense of unwelcomeness, discomfort and/or exclusion for the youths in this context. This constitutes a barrier that prevents them from accessing services. A participant offered this perspective:

> But, like, you don't want to go to a place, if you're not even comfortable … Even if you are, like … I don't want to go to a place where I feel like people are going to be, like, I'm like the odd one out… — Participant 027, female, born in Zimbabwe

The ability of individuals to access mental health services is further stratified by socioeconomic class. The majority of the youths we interviewed were in higher education, and devoted a large amount of time, energy and money towards those ventures. In addition, as Black youth typically come from lower socioeconomic backgrounds, they also often help support their families. After accounting for all of their expenses, there is rarely enough money left to access mental health services:

> And so I know I'm not making as much. I'm making enough. And then when you contribute that on top to help out the family, there's really not that much left sometimes to, like, go for services, to like [sic] for health services. — Participant 003, non-binary, born in Canada

Aside from generating feelings of discomfort, geographical and locational barriers also served as physical barriers to access. A notable number of the participating youths said that they cannot afford the travel costs or time to access mental health services. They stated that there was a need for the services to be available in Black-dominated communities to increase familiarity, alleviate the feeling of unwelcome/discomfort and increase accessibility for more of the Black community:

> I think if we're going to have these services … they need to be in the places where most of our people are, especially the ones who are … who like, I guess, who would … need it the most. — Participant 023, female, born in Nigeria

Stigmatization and judgmentalism within Black communities

The participants highlighted pervasive stigma in their communities against the mental health system and against individuals who struggle with their mental health. This stigma stemmed from a lack of knowledge combined with cultural beliefs and idiosyncrasies that are often reinforced by family members. The youth participants mentioned that, in their cultures, certain forms of life struggles are

glorified and seen as more severe than mental struggles. To struggle with mental health is viewed by some as weakness or failure on the individual's part, to be brushed aside because its impact can only be minor. Often, the youths internalize this message to the point of assuming overwhelming personal responsibility for their poor mental health/illness and its management:

> Like, they don't believe that mental health is as important as physical health, so they tend to, like, disregard mental health as just nonsense or … just overblown, and they would say like just … just get over it. — Participant 007, male, born in Canada

Stigma also manifests at times in a one-dimensional presentation of individuals who struggle with their mental health. Some youths said they believed in a caricature of a "crazy" individual as a representation of mental health struggles. As a result, they often delay or even forego treatment to avoid being viewed in a negative light.

Limits of self-sufficiency in confronting mental health stressors

The struggles and traumas that Black people in Canada historically faced has created a culture of independence where resilience and self-sufficiency are highly valued. Individuals are expected to outwardly exhibit these traits regardless of extreme adversity. Mental health struggles are considered a threat to the projection of resiliency and self-sufficiency, with youth expected to manage privately and alone, often to their detriment. The youths reported being encouraged by family and other members of their community to endure or ignore problems despite the resulting exacerbation of the issues. They were regarded as weak for addressing their struggles and traumas, and strong for refusing to acknowledge them—even when this reduced their likelihood of accessing care. The narratives of the following two participants echo the feelings expressed by several others:

> … the belief that you can handle anything that life throws at you is a good thing to have, but when it's like obviously bringing you down and they're like, "No, no, like you can just handle it. Like, don't worry about it. Just … take it and go!" It's … sort of debilitating to me, because it's, like, I can't do that at that moment, and they're sort of making me feel worse about it than I, like, would if I just sort of kept it to myself. So it's more like … if, like, I were to like have an anxiety attack, or, like, my anxiety levels rose when I was around them, I'd have to keep it to myself … — Participant 017, female, born in Canada

> My parents, most immigrants … we go through like [sic] a lot. I can't even say … I'm not an immigrant, I was born here, but my parents and my siblings, they went through a lot of hardship from, you know, the day they stepped into this world until now, still struggling until this very day. So they have this strength that I really admire, but often that means, like hey, these things, the stress, the … these, like, illnesses that we have that aren't just physical … if we talk about them, it's like … it's like we're weak. Or it's, like, we've been through so much like it's not even an illness. This is just something we go through. — Participant 027, female, born in Canada

We found differences in the mental health statuses of immigrant and non-immigrant Black youths: youths whose parents had experienced trauma prior to coming to Canada struggled to convey the importance of mental health to their parents. Participants indicated that their immigrant parents often perceived that the youths need to be stronger and as resilient as the parents who had gone through severe trauma.

Discussion

There is ample and growing evidence that Black youth in Canada are disproportionately affected by challenges in accessing mental health services.[20] The results of our study confirm that a number of barriers impede the access to mental health services by Black youth in Alberta.

The implications of these findings are discussed in the following sections.

Cultural inclusion and representation

Accessibility with respect to mental health services should not simply be defined or understood in terms of receiving any type of care. The nature, quality, context, timeliness of care as well as the receiver's satisfaction with the care matter, among other factors. The American Institute of Medicine[37,p.4] views "access" as "a broad set of concerns that centre on the degree to which individuals and groups are able to obtain needed services from the medical care system"; they define it as "the timely use of personal health services to achieve the best possible health outcomes."

Black youth in Canada typically first access mental health services or interventions through pathways of crises, such as interactions with the justice system or when in need of intensive care.[38,39] Once their symptoms degenerate into depression, Black people tend to have more severe and chronic mental health episodes compared to the overall population.[40] These troubling trends warrant serious attention and responses from health care policy makers and service providers given the well-established reality that poorer mental health also disproportionately impacts life outcomes for racialized and marginalized people.

Our study participants strongly perceive or believe the existing health care system is not sufficiently friendly or inclusive as it was not designed with their cultural needs or concerns in mind. This explains their insecurities and unwillingness to be immersed in the system or to take advantage of the services. The distrust evoked by a lack of culturally friendly services, and past or anticipated negative service encounters, further contribute to their exclusion despite their risk of poorer health and life outcomes.

Another element discouraging Black youth from accessing and participating in the mental health system is the lack of proximity of such services to their communities coupled with the stark underrepresentation of Black and interculturally competent health providers when services are accessed. These factors, together with prohibitive costs of services/medication for socioeconomically disadvantaged youth, create a cluster of barriers that render mental health services unattractive and unattainable luxuries.

Underlying these barriers to inclusion and representation are systems of discrimination, inequity and oppression that overtly

or covertly work to maintain privilege/access for some and oppression/exclusion for others.[41-45] The onus is therefore on policy makers and health service providers to work alongside members of marginalized and historically excluded communities to find solutions that work for everyone. In doing this, they must strive to better understand culturally based barriers to access; challenge colonial, discriminatory policies and practices embedded in health care systems and services; and explore intentionally inclusive policies and service delivery models that accommodate ethnocultural differences and attract and satisfy the mental health care needs of Black youth.

Overemphasis on hardiness and self-sufficiency

The tendency of some parents, elders, family members and community members to overemphasize hardiness or self-sufficiency constituted a barrier to accessing mental health care for several study participants. An overreliance on strength-based traits can be detrimental to accessing timely and quality care. The role of intergenerational/familial trauma and culture in shaping help-seeking behaviour of Black youth must be better understood and factored into mental health education and service provision strategies.

While the overemphasis on hardiness and self-sufficiency should be discouraged, the importance of resilience should not be ignored. Resilience is a dynamic process whereby an individual or community utilizes available protective factors to their advantage, which leads to positive health outcomes.[46] Some approaches to enhancing resilience can include fostering positive coping skills and utilizing external resources, such as family support, that can protect the individual from negative mental health outcomes.[46] In this study, youths discussed negative coping strategies such as avoidance and lack of familial and community support related to mental health. The youth empowerment model we used to bring forward the voices of Black youth is an approach recommended to building resilience in young adults.[47]

One future area of research will be to examine the ways Black youth and their communities can strengthen their capacity for resilience using inherent community strengths and addressing stigma around mental health issues. Community education/engagement programs can simultaneously acknowledge traumatic histories while demonstrating the benefits of addressing trauma-induced and other mental health challenges.

In addition, Black families' multiple social and economic stressors likely influence familial coping strategies and parenting styles. Hence, interventions addressing the overall well-being of their families are needed to improve Black youths' mental health outcomes.[48] Family- and community-centred approaches to delivering mental health programs to youths have led to greater program participation and retention and positive mental health outcomes. Previous Canadian research has also highlighted the need to further explore the design and implementation of such programs in ethnically and culturally diverse communities.[49]

Addressing intersectional mental health marginalization

Marginalized people with intersecting adverse social locations and characteristics are disproportionately affected by numerous historical factors of discrimination.[50-52] The multiple and interrelated effects of the barriers to access identified in our study mean that Black youth face intersectional mental health marginalization in Alberta. Our collective findings point to these often-ignored cumulative intersecting factors being anchored in systemic inequities and historical structures of discrimination that covertly and overtly work to aggravate mental health conditions while reinforcing the exclusion of Black youth from quality mental health services.

This situation persists in part because health policies and interventions often only target certain barriers or aspects of the problem without considering the related or intersecting factors that contribute to the status quo.[53] For example, understanding the intersectionality of being a Black immigrant youth from an ethnocultural minority and living at a lower socioeconomic status, and how these different social locations interact to impact the actions and motivations of youth in need of help, can completely change the way policies and services are conceived and implemented to overcome barriers to access.

Similarly, solutions to address accessibility issues might be more equitable and relevant if they consider the interplay and accumulation of intersecting factors such as mental health literacy, ethnocultural beliefs and customs, stigmatization and structural challenges, among other barriers. Adding the other traditional dimensions of social difference (such as age, sex/gender, sexual orientation and so forth) can further underscore the complexity at play. The extent to which these factors influence each other and impact Black youths' help-seeking behaviours and motivations are so profound that continuing to ignore them in favour of more isolated/traditional responses will not change the current state of marginalization. We argue that health policy-making and service provision should embrace a deeper understanding of the complex intersecting identities of Black youth and address the multiple underlying discriminations/inequities that generate intersectional mental health marginalization in this demographic. This may serve as a much-needed equalizer and stimulate pathways to accelerated/improved mental health care access for this population.

The results of this study suggest health policy and practitioners should consider the following recommendations to break down barriers while optimizing Black youth agency to facilitate greater uptake and sustainable access to care:

- Diversify the mental health provider workforce by hiring, mentoring and supporting the professional development of Black service providers/professionals who have intercultural competencies;
- Increase multi-level (federal/provincial/municipal) government support for Black organizations that engage in quality/priority mental literacy and treatment activities in Alberta;
- Intensify efforts to collect ethnicity-based data and understand intersectional barriers (and facilitators) that influence the utilization of mental health services by Black youth;
- Address the racism Black people experience by ensuring service providers embed anti-racism into their practices;
- Partner with Black youth organizations, communities and researchers to design and provide culturally appropriate/

accessible education that enhances mental health literacy;

- Enlist the services of interculturally competent and/or Black educators and practitioners in mandatory intercultural training/orientation for mental health service providers;
- Allocate mental health and wellness resources and services in communities with a high concentration of Black/racialized youth; and
- Target/address systemic and structural factors that constitute or reinforce inequities and structural barriers to accessing mental health services.

Strengths and limitations

Our project has several strengths: a large sample size (i.e. 129 participants) for a qualitative study; engagement of youths in collecting data (after rigorous training); and exercising reflexivity and member checking. However, we only collected data from youths in Edmonton, and thus cannot generalize our findings to other parts of the country. We do provide contextual information to facilitate transferability of our findings.

A central weakness of this study is that the participants were largely female. Our advisory committee and research assistants were female based on the leadership of our partner organization, and our research assistants mainly recruited individuals of the same sex/gender. Future research should ensure diverse representation on advisory committees.

Conclusion

As is the case in much of North America, Black youth in Alberta face unequal and inequitable access to quality mental health services compared to the majority of the population. This situation is sustained by a range of harmful, culturally related and intersecting barriers that combine to exclude them from quality care. The resulting state of intersectional mental health marginalization warrants a comprehensive culturally sensitive response alongside a focus on the heterogeneity of barriers to access.

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Conflicts of interest

The authors declare they have no conflict of interest.

Authors' contributions and statement

BS: Conceptualization, Formal analysis, Funding acquisition, Investigation, Project administration, Methodology, Supervision, Writing – Original Draft, Writing – Review & Editing

BD: Investigation, Project administration, Supervision, Writing – Original Draft, Writing – Review & Editing

RT: Investigation, Writing – Original Draft

NA: Formal Analysis, Investigation, Writing – Original Draft

MJ: Conceptualization, Funding acquisition, Writing – Review & Editing

MA: Investigation, Writing – Review & Editing

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