Lost in the Gap: Youth Mental Health Access in Rural Canada

by

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Abstract

Rural Canadian youth face distinct barriers to accessing mental health services, shaped by geographic isolation, socioeconomic constraints, systemic inequities, and cultural stigma, all of which interact and can be explored through an ecological lens to illustrate how individual, community, and societal factors shape mental health accessibility. This capstone is guided by the research question: How can telehealth-based mental health interventions support improved access to mental health services for rural Canadian youth? Rural communities are host to several service modalities, such as walk in clinics, community-based programs, emergent and primary care clinics, and telehealth services, all with their own strengths and limitations. Long travel distances, limited local services, practitioner shortages, economic constraints, and confidentiality concerns in small communities are common geographical and systemic obstacles to care. Cultural norms emphasize self-reliance, along with stigma surrounding mental illness, further discourage help-seeking among rural youth. While digital and community integrated approaches have been integrated into current mental health care models, their effectiveness is constrained by infrastructure gaps and systemic inequalities. Recommendations emphasize the need for coordinated, multilevel interventions that expand rural workforce capacity, strengthen infrastructure, enhance cultural safety, and promote community engagement. The results highlight the importance of holistic, ethically grounded strategies to reduce disparities and improve mental health accessibility for rural youth across Canada.

Keywords: mental health accessibility, rural Canada, mental health service barriers, youth, development, travel burden

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Chapter 1: Introduction

Despite rural Canada comprising the majority of the country's landmass, Canada's most recent national census shows that only 20% of the population live rurally (Statistics Canada, 2022). Canada's three territories, Nunavut, the Northwest Territories, and the Yukon, comprise nearly 40% of the country's landmass, but only 0.3% of its population (Statistics Canada, 2022). Statistics Canada (2022) defines rural as locations outside a major population centre, with less than 1000 individuals living close to another, and less than 400 individuals in any square kilometer. At a growth rate of 0.4% since the previous census in 2016, rural Canada's population is also growing at a slower rate compared to their urban counterparts, which has grown at a rate of 6.3% (Statistics Canada, 2022). Despite the population growth, Canada still has one of the lowest rates of rural inhabitancy and one of the largest landmasses, when comparing to other westernized countries (Statistics Canada, 2022). While it's expected that Canada's rural regions will continue to grow in population, these rates are significantly slower as compared to urban regions, leading to a larger divide between urban and rural populations within Canada. Further, the largest growth factor in Canada's rural populations is inter and interprovincial migration, whereas urban centers witness significantly higher rates of immigration, leading to much higher rates of cultural diversity within the population (Statistics Canada, 2025a).

Rural individuals are often quite dispersed geographically, and their daily life often includes longer travel durations, higher costs of goods and services, and frequency of necessary travel to meet their basic needs (Moroz et al., 2020). This is largely due to increased costs required to import goods and services into rural areas, as well as limited availability of services in rural areas. For example, this can result in higher-than-average grocery costs, and restricted access to health care (Statistics Canada, 2022). In 2024, the Canadian Institute for Health

Information (CIHI) explored the rates of travel burdens on healthcare accessing, defining it as a socioemotional burden associated with time, cost, opportunity, availability, and quality of healthcare (CIHI, 2024c). For rural individuals, the CIHI estimates that 1 in 4 individuals have a very high travel burden to access healthcare, whereas 75% of urban individuals report a low travel burden (CIHI, 2024c). This travel burden is increased when hospitalization is urgent, the individual needs to travel greater distances, the patient lives in a different community than the hospital, or the patient is a child or youth (CIHI, 2024c). Travel burden increases with the number of factors encountered. As such, children and youth are a unique, and particularly vulnerable group as the only group possible of encountering all factors. Due to this potential for a heightened vulnerability to diminished healthcare access, Canada's youth are an important population to focus on in health research.

While there were over 7 million youth living in Canada in 2019, only 15% of these youth lived in rural locations (Statistics Canada, 2019). Further, rural Canada's youth population has been decreasing and is projected to continue to decrease (Statistics Canada, 2024a). A lack of employment opportunities, services, and education is contributing to youth relocating away from rural Canada (Statistics Canada, 2019). Comparatively, urban centers provide a variety of opportunities that motivate rural youth to migrate out of their local communities. Researchers Sano et al. (2020) found that urban centers provided more opportunity for postsecondary education, higher income, employment diversity, and access to social services. Further, youth with higher middle school and high school success were more likely to leave and pursue these opportunities. Canadian rural youth are also less likely to return to rural areas after gaining a postsecondary education (Sano et al., 2020). As such, youth living in rural Canada appear to be faced with an environment that does not provide adequate opportunities as compared to their

urban counterparts, which may be leading to the decreasing youth growth rate in the rural Canadian population year after year. As limited services and opportunities motivate rural Canadian youths to migrate to urban centers and today's youth will likely make up a significant portion of Canada's future workforce, a shortage in rural youth population may have the ability to affect the rural workforce in the future (Sano et al., 2020). This would then further affect the availability of services, such as healthcare, in rural Canadian communities.

From 2019 to 2023, Canadian youth, aged 12–17, trended negatively when reporting on their perceived health, with roughly 70,000 more individuals reporting fair or poor health, and roughly 210,000 less reporting excellent or very good health (Statistics Canada, 2024c). Canadian youth also reported higher usage of health risk behaviours, such as smoking, use of e-cigarettes, vaping, and cannabis use from 2019 to 2023 (Statistics Canada, 2024c). Also reported are higher rates of ill health symptoms from 2019–2023, such as headaches, stomachaches, and backaches (Statistics Canada, 2024c).

Twenty percent of Canadian youth have a mental illness or a diagnosed disorder, however, only 1 in 5 youths report being able to access appropriate mental health care (Canadian Mental Health Association, 2021). Trending similarly to reports on general health, Canadian youth also reported perceiving their mental health as significantly poorer from 2019 to 2023, with over 500,000 less reporting excellent or very good mental health, and over 300,000 more reporting their mental health as fair or poor (Statistics Canada, 2024c). Canadian youth, from 2019 to 2023, also reported trends toward negative mental health symptoms, such as increased preoccupation with looking thinner, decreased life satisfaction, increased stress, and difficulty getting 8 hours of sleep each night in the past 7 days. Within the Canadian youth population,

girls are also more likely to rate their mental health as poor and were less likely to shift from poor to good from 2019 to 2023 (Statistics Canada, 2024b).

Rural Canadians living in the northernmost regions of the country may face additional barriers than those living closer to the southern border. Living in a remote, northern locale has been associated with higher rates of suicidality, depression, and anxiety symptoms (Trout & Wexler, 2020). These symptoms have been attributed to societal context and social factors, such as inability to access care and systemic trauma present within the indigenous communities disproportionately living within northern Canadian locations (Kumar & Tjepkema, 2019; Trout & Wexler, 2020). It should also be noted that long winters with minimal daylight hours in northern Canada, which typically has a low population density, may also play a role in mental illness prevalence. The connection between lack of daylight, low vitamin D, and low mood has been continuously reinforced in modern contexts (Kim et al., 2021). As such, the geographical location and lack of daylight during winter may create an additional hurdle for rural Canadian youths when accessing adequate mental health services.

To access mental health services, rural Canadians face several barriers, which can leave lasting impacts on the lifespan (Moroz et al., 2020). Barriers include cost of services, time and cost taken for travel, lack of available services within the individual’s rural locale, lack of adequate or timely care, and a lack of knowledge on available service options, and how to access them (Moroz et al., 2020). For instance, cost of living in rural Canadian communities is often higher due to goods and services requiring transport into rural locales or lengthier travel by the individual into larger centers to obtain them (CIHI, 2024c). Lower annual incomes and lower rates of comprehensive health insurance may also create an additional cost burden for rural residents seeking mental health care (Moroz et al., 2020).

Rural communities typically have lower rates of professional providers, both within the physical and mental health sectors, as compared to urban centers (Hilty et al., 2020; Wilson et al., 2020). Further, there are a lesser numbers of mental health care providers as compared to general health practitioners overall, as well as minimal growth rates for mental health service practitioners between 2014 to 2023 (CIHI, 2023). On average, there was only one mental health service worker for every 59 Canadians in 2021 (CIHI, 2021). This limited access to care affects the availability of mental health service to rural citizens and shapes the way rural communities receive, access, and perceive their access and need for mental healthcare.

Attitudes around healthcare in rural communities often lean toward emergent rather preventative healthcare (Myers, 2019). These barriers can delay or inhibit access to mental health care for youths, potentially leading to worsening health outcomes over time. When mental health care is inaccessible and/or mental illnesses go without treatment, the individual can face significant outcomes such as increased suicidal ideation (Myers, 2019). Stigma often shapes the discourse around preventative mental health promotion, negatively affecting individuals' perceptions on when and how to access care (Hussain et al., 2013; Knight & Winterbotham, 2020). In rural Canada within the farming community, discourse around mental health care focuses on difficulty finding and affording mental health services, maintaining secrecy around mental health within their community to avoid negative perceptions of mental health struggles, as well as committing to the travel burden it takes to access (Hagen et al., 2022, p. 115–118). As stigma appears to play a critical role in accessing and maintaining access to mental health services, the influence of stigma affecting the discourse surrounding these efforts needs to be considered.

These disparities highlight the need for customized approaches toward healthcare and system supports in rural settings, where geographic features have implications on health outcomes. The literature showcases the complex interplay of structural and social factors. As such, appropriate solutions to healthcare barriers in rural Canada must address these factors and adopt an intersectional approach, combining both social and structural elements, to increase access to care.

Purpose Statement

This capstone will rest on the observation that rural and remote living creates difficulties in accessing mental health services. Living in rural locations has been associated with several barriers to mental health service access, such as increased cost of living and transportation times, and reduced access to mental health services can lead to higher levels of anxiety and depression (Moroz et al., 2020; Radez et al., 2021; Roberts et al., 2022). As such, this capstone aims to explore which barriers continue to exist that impact accessibility to mental health services for youths in rural Canada. Specifically, this capstone then aims to answer the following research question: How can telehealth-based mental health interventions support improved access to mental health services for rural Canadian youth?

Reviewing relevant barriers that limit access to mental health service for rural Canadian youths that have been previously explored in recent literature may provide further insight into themes amongst mental health service barriers. This may provide potential insight into solutions to navigate such barriers, and as a result, aid in increasing positive health outcomes for these youth. These insights may provide applicable knowledge on how to best support rural Canadian youth seeking and/or currently utilizing mental health care. Further, as rural research across global domains tends to explore similar factors, such as accessibility and efficacy of care, this

capstone may provide insight to individuals beyond those just living and working within Canada or with Canadian youths (Ferris-Day et al., 2021).

Theoretical/Conceptual Framework

As this capstone aims to analyze and explore a broader issue related to youth development, the theoretical lens through which the author analyzes the literature is the ecological model of child development, developed by Urie Bronfenbrenner (1977). As rural youths face a variety of different environmental factors that affect their ability to access mental health services as compared to their urban counterparts, the ecological model of development proves to be an applicable theory through its ability to explain environment across different levels of involvement. Bronfenbrenner's ecological model provides a theoretical mechanism that aids in understanding an individual's greater environment and the smaller systems within it, while maintaining that the relationship between the systems is still paramount.

These systems, in order from what has the most direct effects on the individual to the least, are: the microsystem, the mesosystem, the exosystem, the macrosystem, and the chronosystem (Bronfenbrenner, 1977). At the center of these systems is the individual themselves. The microsystem encompasses the interactions between those individuals and the individual themselves. As such, the microsystem encapsulates factors affecting the individual most directly (Broffenbrenner, 1977). Within the mental health service context, this may include impacts to the individual through family and peer support, lack of support, or actions done toward the individual (Stupak & Dobroczyński, 2021).

The mesosystem is comprised of the relationships between those in the individual's microsystem, such as between the individuals' school peers, or between parents and teachers (Broffenbrenner, 1977). It encompasses the interactions between those members who have direct

contact with the individual, and how they affect the individual when they interact amongst themselves. Examples within the mesosystem may include beliefs about mental health held by individuals in the microsystem, or collaboration between an individual's therapist and their parents (Broffenbrenner, 1977).

The exosystem includes broader societal institutions, such as employment, education, media, or available mental health care within the community the individual operates (Broffenbrenner, 1977). This system operates by influencing the members within the individual's microsystem, and highlights how availability of services within the individual's locale may trickle down throughout the systems to affect the individual. Examples within the exosystem may include local mental health initiatives, local government policies, a parent or spouse's workplace policies or health insurance, and availability of mental health services within the community the individual lives (Dove & Costello, 2017). Authors Dove and Costello (2017) integrate the exo-, meso-, and microsystem to limit barriers to youth mental health care by introducing a school-based mindfulness campaign for students, teachers, and parents which showed positive affects for all involved.

The macrosystem is comprised of broad societal structures, such as culture, social conditions, the economic system, the political regime within the individual's locale, and ideologies that are present in the individual's life (Bronfenbrenner, 1977). In the context of mental health services, attitudes on mental health in rural communities may influence a youth's perception of mental health, when to look or ask for care, or their sense of identity in context to their mental health. Reupert (2017) highlighted how social stigma fits within the macrolevel of the ecological model, as well as cultural norms.

Lastly, the chronosystem is comprised of life events and historical contexts (Broffenbrenner, 1977). These may be common for all individuals of the same age generation, such as economic recessions, pandemics, or wars. At the chrono-level, emerging technologies, such as virtual care and telehealth, are addressing how to shorten the mental health service access gap (Myers, 2019). In general, the chronosystem aims to conceptualize how time itself has an impact on the development of the individual (Broffenbrenner, 1977).

Similarly to the systems closer to the individual, the macro and chronosystem operate by influencing the individual through affecting the systems comprised within them, where the impact then trickles down to affect the individual (Broffenbrenner, 1977). Due to the evidenced failures of noncomprehensive healthcare models, researchers have begun calling for a model that addresses all levels of impact to the individual (Jensen et al., 2019; Stupak & Dobroczyński, 2021). When such comprehensive health care models that address broader levels of impact to the individual, such as the effect stigma or funding can have on an individual are adopted, the effect appears to be largely positive (Reupert, 2017). By analyzing accessibility of mental health services for rural Canadian youth through Bronfenbrenner's (1977) ecological model, it may allow for insights into how accessibility to mental health services is affected by, and affects, all individuals and levels of society, from the individual to the broader societal institutions and structures. As such, potential solutions should reference and consider cultural, institutional, and systemic factors.

Methodology

Research used within this capstone included primary academic sources, along with seminal work to highlight theoretical concepts. Data from 2019 to 2025 from Statistics Canada and CIHI 2021–2024 were also referenced. Search engines used included City University of

Seattle's library website, Google Scholar, and the search features within specific databases such as PubMed, PsychInfo, and PsychArticles. These databases were chosen as they cater to housing articles pertaining to the field of psychology and health, and thus held many relevant articles for this capstone. PsychInfo was particularly useful as a starting point to collect articles, as it primarily houses abstracts, journal titles, and book chapters (American Psychological Association, [APA], 2008). PsychArticles was then referenced to locate the full text of an article if the article could not be easily located using a search engine, as this database houses full text articles. PubMed was primarily utilized to search for articles of a more medical nature.

Search criteria included but was not limited to key words of rural, Canada, youth, mental health services, accessibility, barriers, health outcomes, and telehealth. Searching using these key words on a database such as Google Scholar results in a massive selection of 17,000 articles, when restricting publication data from 2018–2025. In place of youth, adolescent or child was also accepted, if the article was relevant and contained several other keywords. In place of mental health services, other similar key words were accepted, such as mental health therapies and psychological services. The primary focus when selecting key literature was a recent publication date within the last 7 years, and articles that were highly referenced by another peer reviewed work and published by a well-known database.

To filter irrelevant articles out, fundamental articles used in this capstone were selected for by containing three of the five following keywords: rural, Canada, youth, mental health, accessibility, barriers. This filtering system was chosen to ensure articles selected for this capstone focused on a relevant population, allowing for greater chances to be able to explore the complex mental health service accessibility concerns for rural Canadian youth. Further, articles that contained many key words, were published in or after 2020, and were also cited by a

minimum of 50 other articles were preferentially chosen. Articles that were not relevant to the Canadian context were filtered out from selection, unless the article provided specific or foundational context, such as Bronfenbrenner's (1977) study exploring his ecological framework. Articles chosen for this foundational body of research that were not relevant to Canada were not chosen unless the population within the study were rural youth, and articles that did not study youth in particular were only chosen if they focused on the rural Canadian context. Through this search, thirteen foundational articles were selected.

Several additional articles were selected to add depth and additional knowledge to this capstone. These articles were searched for on either Google Scholar or City University of Seattle's library website, and were restricted to the years of 2018–2025. Keywords for these supplemental articles included mental health services, rural, Canada, youth, and accessibility, and also contained various other keywords depending on the section of the capstone the article was intended for. As such, these supplemental key words include, but are not limited to, indigenous, LGBTQ, cultural, migration, social media, and expenses. These articles were chosen in the same manner as the foundational articles, by selecting for most recent publication date, high frequency of keywords, and inclusion of two of the three keywords when describing the study population: rural, Canada, youth.

Contribution to the Field

Understanding barriers that exist and their sequential effect on youth mental health may provide insight toward solutions that aid in improving rural Canadian youth mental health outcomes. As the population of Canada ages and the percentage of youth and individuals living within rural locations decreases, increasing adequate access to health services and needs for youth is crucial to ensure youth retention and wellness in rural communities (Statistics Canada,

2019, 2022). Increasing access goes beyond making services physically accessible. Several researchers have demonstrated that when mental health care is provided from individuals outside the community, and especially from individuals who have inadequate understanding of the rural culture, the quality of care is lower (Hagen et al., 2022; Rourke, 2007). Coincidentally, Rourke (2007) suggests that for effective rural mental health care in Canada, physicians must understand the rural culture in which they practice in, which should include living within the community. They also suggest that the most effective mental health physicians for rural communities are the ones that have either been raised in a rural community or have taken the effort to understand the challenges rural individuals face and educate themselves on the matter. Unfortunately, there is still a gap in available physicians for rural locations as compared to urban (Moroz et al., 2020).

What is not adequately found in the literature is research that bridges the gap between rural Canadian youth, barriers to mental health services, and the potential outcomes when those services are restricted or blocked. Research specific to rural Canadian youth within the last decade is limited, and especially so when searching for mental health service barriers and long-term outcomes of these barriers within this population. Despite this, some relevant current research found includes descriptions of general concerns of rural citizens in different nations (Ferris-Day et al., 2021; Gangamma et al., 2022); studies exploring specific rural populations, such as students or farmers, or for very specific geographical locations (Church et al., 2020; Hagen et al., 2022; Hussain et al, 2013); barriers for children and adolescents, though not limited to rural or Canadian locations (Radez et al., 2021; Roberts et al., 2022); and barriers for rural Canadians, though not specific to youths (Dyck & Hardy, 2013; Moroz et al., 2020; Wilson et al., 2020). Relevant to COVID-19, there appears to be an influx in research analyzing telehealth as a rural mental health service alternative (Hilty et al., 2020; Myers, 2019; Reay et al., 2020).

This capstone contributes to the counselling field by synthesizing recent research on rural mental health disparities and applying it to rural Canadian youth. By outlining the relationship between structural barriers, provider shortages, cultural incongruence, and delayed service access, this capstone can aid counsellors in increasing knowledge on how systemic inequities contribute to long-term mental health risk amongst rural Canadian youth. The findings support the development of culturally responsive and contextually informed counselling practices, reinforcing the importance of rural competency and community integration in service delivery (Hagen et al., 2022; Moroz et al., 2020). This aligns with the Canadian Psychological Association's (CPA, 2017) ethical principles of responsible caring and respect for the dignity of persons, which emphasize competence, cultural awareness, and advocacy when working with marginal populations. Further, through identifying service gaps, this capstone aims to explore telehealth as an alternative service delivery model to increase access for rural Canadian youths. Further, through examining recent research on telehealth delivery within the rural Canadian context, this capstone aims to provide an empirical foundation for telehealth delivery for rural Canadian youths.

Reflexivity and Positionality Statement

I was born into a rural agricultural farming family, and this lifestyle has become central to my identity. Several members of my family struggled with mental health concerns, as well as myself. As a youth living in an isolated rural environment, this environment served to alter my lifestyle and was a significant barrier in access to any mental health service. My early perception of mental health was also heavily influenced by my family's and my communities' beliefs. These beliefs contributed to a heavily stigmatized view of mental health, and posited that mental health is something to be treated in private, and away from the public knowledge. This specific stigma

and accessibility barriers appear to be common among many rural communities (Knight & Winterbotham, 2020; Moroz et al., 2020).

I moved to an urban environment to pursue secondary education in the field of psychology after the age of 18, and then back into a rural environment several years later while completing graduate studies in the field of counseling. Through living in a vastly different experience that held none of the previous rural barriers to mental health service, I was able to re-shape my lens of mental health from one of a "hide and don't talk about it" mentality, to one that values sharing one's experience with mental health. This experience significantly highlighted how the difference in one's living situation can shape youth development, and how all the unique levels of human interaction contribute to this.

Due to my direct experience with rural accessibility barriers to mental health services, I have a specific passion for advocacy for adequate mental health service in rural communities. Currently, I work within the mental health field and as a provider, am faced with the direct effects of inaccessible mental health services in rural communities daily. Due to the unavailability of mental health services in my own rural community, I commute nearly an hour and work within an urban environment on the outside of a major urban center. In this work, several clients share they face similar travel barriers. For me, these first-hand experiences highlight how rural communities are still facing several of the same barriers I experienced in childhood.

While I acknowledge that personal and professional experiences shape my interest in this topic, steps have been taken to mitigate potential bias. A structured and systemic approach to the literature selection was applied, prioritizing peer-reviewed, recent, and relevant research. Further, diverse perspectives across geographical regions were captured and explored, with efforts taken

to explore the cultural complexities of marginal populations within rural Canada, such as indigenous, black, and LGBTQ+ youth. Efforts were also made to engage critically with the literature, exposing strengths and limitations, and analyzing relevancy of literature populations, to avoid overgeneralizations.

My hope for this capstone is to further my own understanding of the rural mental health network in Canada. Further, I hope to expand my knowledge base on barriers for rural residents, and to add this information into the current knowledge pool to aid others. By increasing others understanding of mental health in rural communities, I hope this may aid in destigmatization efforts and potential policy changes to aid in increasing access to mental health services for rural Canadians.

Key Terms

These definitions are developed to aid the reader in understanding common factors between key terms used in this paper. Most notably, this includes defining rural, youth, and mental health terms.

Mental health practitioner: An individual carrying out mental health services, as described below. These individuals are often educated at a postsecondary level, and have undergone further education in mental health services, such as diagnosis specific treatment or assessments. Within Canada, this may include psychiatrists, psychologists, counselors, nurses, family physicians, and other mental health professionals such as addiction therapists (Moroz et al., 2020).

Mental health service: Any service pertaining to the wellness of an individual's mental health, such as counselling, psychological treatment, therapy, psychotherapy, and psychological assessments and/or diagnostic interviews. Care may pertain to treatment and/or support for depression, anxiety, substance abuse, interpersonal relationship difficulties, general life stress,

and/or trauma (Cormier et al., 2017). Services may be carried out in-person, virtually (via telehealth, with or without video screen access), in groups, or individually. Services may take place in an office, a home-office, with or without other mental health practitioner's operating in the same location, or, in the case of virtual therapy, in the client's home.

Mental health service accessibility/barriers: Accessibility for mental health services pertains to an individual's ability to utilize any such services. Barriers may be the physical, social, or perceived obstacles to accessing these supports. Common barriers may include transportation, costs, and availability of practitioners (Moroz et al., 2020).

Rural: Locations outside of a major urban center, housing less than 1000 individuals, and less than 400 individuals in any square kilometer. This may include villages, hamlets, agricultural land, remote land, undeveloped land, estates, subdivisions, and wilderness lots. This definition is in accordance with the definition established by Statistics Canada (2022).

Travel burden: The burden travelling to health services may have on the individual stemming from the time, costs, and potential of lost opportunities (CIHI, 2024c).

Youth: Research cited in this capstone defines youth at varying ranges, from 12–30 years of age (Church et al., 2020; Dove & Costello, 2017; Kumar & Tjepkemam 2019; Moroz et al., 2020; Radez et al., 2021; Sano et al., 2020; Statistics Canada, 2019, 2024b, 2024c). As such, youth will refer to this age range.

Overview of Capstone Project Chapters

This capstone is organized into three chapters: Chapter 1: Introduction, Chapter 2: Literature Review, and Chapter 3: Discussion and Application. Chapter 2 presents a comprehensive review of the literature related to rural mental health accessibility in Canada, with an emphasis on barriers affecting youth populations. The literature review is organized into four

themes: rural mental health services, geographical barriers, structural and systemic barriers, and cultural and social barriers.

Chapter 3 focuses on discussing these themes within Bronfenbrenner’s (1977) ecological framework, to situate the body of literature within a systemic model, as well as analyzing efforts to increase access and mitigate barriers as they have been discussed in the literature. This chapter will also explore a telehealth model that addresses the relevant barriers prevalent to rural Canadian youths. Lastly, Chapter 3 will include a section on the author’s growth throughout the capstone progress, along with a concise conclusion for the capstone.

Chapter 2: Literature Review

This literature review will explore challenges faced by rural Canadian youth when accessing mental health services. The aim of this literature review is to examine potential common rural living, youth, and rural mental health service delivery and apply these experiences to a rural Canadian context. As rural regions comprise a significant portion of Canada's landmass but a significantly smaller portion of Canada's population, mental health services must operate in unique circumstances as compared to the more populated Canadian regions (Moroz et al., 2020; Statistics Canada, 2022). Specifically, this review will explore the structural, geographical, systemic, and cultural and social factors which inhibit mental health access for rural youths, as well as the unique ethical considerations rural communities must make to offer support to rural Canadian youths. Further, this review will explore any subsequent psychological outcomes when mental health supports are unavailable or limited.

Within this capstone, there are several delivery models of mental health services, and the inherent strengths and limitations present in each model. The service modalities explored include walk-in treatment, private practices, publicly funded supports, and emergent care services. Further, this section will also explore innovative solutions to mental health service barriers, such as telehealth and community-based support, and how they may provide an accessible solution for rural Canadian youth facing barriers when accessing other mental health supports.

Living in rural Canada presents several unique geographical challenges when accessing mental health services, such as physical isolation, long travel distances, and lack of public transportation (Ferris-Day et al., 2021; Moroz et al., 2020). The geographical barrier theme explores how these factors contribute to mental health service accessibility for rural Canadian youth, and any connected mental health outcomes as a result of this accessibility level.

The availability of mental health services and professionals is limited in rural Canada (Church et al., 2020; Hagen et al., 2022; Moroz et al., 2020). As some authors present this as a systemic limitation, this theme will explore the complex societal and political systems in place that restrict access to mental health care for rural youth (Church et al., 2020; Moroz et al., 2020; Trout & Wexler, 2020). This section will explore specific subthemes related to limited mental health resources, such as limited facilities and professionals, how economic shifts in Canada have affected mental health services, and how technology is presented as both an innovative solution and with a warning label for youth (Mushquash et al., 2024; Wilson et al., 2020).

Cultural and social belonging strongly shape rural youths' mental health trajectories, with a sense of belonging supporting wellness, and stigma creating barriers to access care (Church et al., 2020; Ferris-Day et al., 2021). The belief that help-seeking behaviour, especially regarding mental health, is often still considered to be a weakness or indicative of craziness in rural Canada (Church et al., 2020; Hagen et al., 2022). Gender norms further complicate inaccessibility of mental health services. Masculine ideals in rural Canada often further discourage men from seeking support, and rural women often carry the responsibility of ensuring mental wellness for their inner social circle (Ferris-Day et al., 2021; Hagen et al., 2022). Indigenous, queer, and other marginalized youth groups face additional barriers due to cultural and social inequalities, lack of culturally appropriate services, and limited cultural and youth specific understanding amongst mental health professionals (Church et al., 2020; Faber et al., 2023; Gower et al., 2021). Finally, the increasingly technological and connected world today's youth live in can create further solutions for mental health care access barriers, however, may also exacerbate mental health concerns (Kingsbury & Arim, 2023; Mushquash et al., 2024).

Theme 1: Rural Mental Health Services

Moroz et al. (2020), in their comprehensive analysis of Canadian mental health policy analysis, describe several common service deliveries, such as walk-in, or same day, treatment, peer and volunteer facilitated supports, emergent care, community programs and supports, and specialist treatment. Some of these types of supports may be privately funded only or be entirely publicly funded. In Canada, over 80% of individuals rely on their primary physician or emergency room for mental health care (Moroz et al., 2020). Most health care services within primary or emergent care in Canada is publicly funded which removes the financial burden off the individual; however, these services often incur long wait times, and individuals often report a lower quality of care (Hagen et al., 2022; Milliken et al., 2024; Moroz et al., 2020). As such, there are a variety of different mental health care supports for youth that are explored in the literature, however, they all have varying levels of availability, affordability, and appropriateness in rural settings. While Moroz et al. (2020) provide valuable and valid data to explore this theme on service delivery models, the study is more narrative in nature, relies on secondary data, and focuses on cost-effective solutions. As such, this study is limited as it neglects to tell us the direct effect of inaccessibility of mental health care for Canadians.

Primary Care and Emergent Support

Primary and emergent care, such as walk-in clinics, appointments with one's family doctor, or utilizing emergency room services, are designed to provide general health care to individuals across Canada (Moroz et al., 2020). Increasingly, these settings serve as the first access point for Canadian youth seeking care for mental health concerns, particularly in rural communities (CIHI, 2024b; Moroz et al., 2020). In many rural areas, the emergency department acts as the central point of contact for a wide range of health concerns, including mental health

crisis (Church et al., 2020; Moroz et al., 2020). Within primary care, pediatricians and family physicians are often tasked with providing mental health screening, diagnostic assessments, psychopharmacological treatments, and referrals to specialized programs such as inpatient services or psychiatric care (Arruda et al., 2023). The focus of primary and emergent care models is to offer immediate stabilization, early identification, and coordinated referral within the medical system, ensuring that individuals in distress can access help when and where they need.

One of the main strengths of emergency care is the capacity to provide immediate access to treatment and reducing further harm to the individual (CIHI, 2024b). Another strength is that these services support larger scale system monitoring and data collection, allowing for further research on the efficacy of mental health care through emergency services (Milliken et al., 2024). Primary and emergent health care settings also provide comprehensive mental health services, including mental health screenings, assessments, and psychopharmacological treatment, to address both physical and psychological needs (Arruda et al., 2023). Further, many emergency services across the country have expanded to include crisis phone and text lines to offer increased access for rural individuals. Although youth mental health services are often distributed across unconnected organizations and provincial systems, the ability for emergent care to act as a centralized access point aids many rural youths in beginning the process of accessing more specialized psychological support (CIHI, 2024b).

Despite their importance, primary and emergent care models do face several limitations that affect accessibility and continuity of care for rural Canadian youths. Mental health services in these models rely heavily on individual provider training, resources, and referral networks, and can vary widely across provinces and regions (Arruda et al., 2023). As such, care can be inconsistent, leading to greater confusion for youth on how, when, and where to access care

(Read et al., 2023). Emergency and primary care are also reactive rather than proactive. This reactive model contributes to systemic strain, including overburdened emergency rooms, limited aftercare capacity, and weak integration with long-term mental health services (Arruda et al., 2023; CIHI 2024b; Moroz et al., 2020). Over 80% of Canadians rely on their family physician to provide care for mental health concerns, while only 23% of family physicians report feeling qualified to do so (Moroz et al., 2020). Emergency department presentations for mental health among youth are ever increasing, putting strain on existing hospital resources, and increasing the financial burden on the medical system (Milliken et al., 2024; Statistics Canada, 2024c). When the emergency room is utilized as a first response for mental health support, the impact on the medical system is exponential, causing further strain on the entire system (Tourville & Shrestha, 2025). Overall, primary and emergent mental health services play a critical role in providing immediate access, stabilization, and triage, but their effectiveness is limited by provider shortages, reactive structures, and inconsistent care and aftercare.

Walk-in Treatment. While a form of primary, and sometimes integrated within emergent care centers, walk-in mental health support is where no previous relationship to a service provider is required (Read et al., 2023). While similar to emergent support, hospital emergency rooms cater to general health emergencies, while mental health walk-in services aim to provide immediate psychological support and crisis intervention (Moroz et al., 2020; Read et al., 2023). Further, walk-in services may also function as a triage service where referrals for more long-term psychological support is eventually provided (Read et al., 2023). The primary use of walk-in psychological treatment is to deliver immediate mental health assistance while preventing symptom escalation and take the strain off emergency departments (Read et al., 2023).

Walk-in therapy has become increasingly utilized across Canada, suggesting youth may find these services accessible and easy to use (Read et al., 2023). Another strength of walk-in therapy is its potential for a reduction in further harm and potential hospitalizations. Walk-in therapy centers offer somewhat immediate access and safety, often providing extended hours to ensure support during moments of acute need (CIHI, 2024b). This is both a benefit to the individual and to the broader societal structures, by decreasing costs on the medical system (Arruda et al., 2023). Research also shows that youth, and rural Canadian youth, are more likely to engage in care that is offered by trusted individuals within their community and social networks, making locally operated walk-in centers effective at increasing utilization of community mental health services (Ferris-Day et al., 2021). The qualitative and integrated review by Ferris-Day et al. (2021) is used extensively in this literature review due to the authors ability to synthesize key structural, geographical, and stigma-related barriers within the rural context, while also identifying service-level facilitators, such as social connections and support networks. As such, this article is highly relevant for this capstone as it provides a broad conceptual framework across several themes of this literature review, namely the structural and geographical domains. While the review by Ferris-Day et al. strengthens the thematic exploration through its cross-study consistency, the authors do not focus entirely on the Canadian context, nor directly on youth, decreasing its ability to generalize findings across populations. Building on Ferris-Day et al.'s identification of service-level facilitators alongside persistent structural gaps, it is necessary to critically examine whether innovative access models meaningfully resolve these systemic constraints in practice.

Despite the increased accessibility, walk-in therapy models still have several limitations. Some programs, despite their intent to provide immediate services, still end up with long wait

times due to the number of individuals attempting to access the service (Moroz et al., 2020). This greatly decreases accessibility for those needing immediate care. Further, there is a lack of consistency and standardization among walk-in programs, as service delivery models, staffing, and clinical frameworks differ between provinces (Read et al., 2023). The absence of standardized outcome measures on walk-in therapy programs also makes it difficult to evaluate the efficacy of these programs and ensure equitable service quality for all Canadian youth (Read et al., 2023). These challenges suggest a need for national coordination among programs and evidence-based evaluation to ensure walk-in therapy models continue to meet their intended purpose.

Psychotherapy and Psychological Supports

Psychotherapy and psychological supports play a crucial role as one method of mental health care in Canada; however, access and care quality remain as complex concerns. In 2019, Canadians spent $1.1 billion privately on psychological treatment, making up 6% of Canada’s total mental health expenditure (Milliken et al., 2024). Private psychological services can offer unique advantages, including greater privacy and flexibility in treatment settings (Moroz et al., 2020). Ferris-Day et al. (2021) discovered that men perceived private counselling services as more anonymous and felt more comfortable accessing those services as compared to community based mental health care. Hagen et al. (2022) offer an in-depth qualitative study that provides insight into stigma, masculinity norms, and cultural barriers within rural Canadian contexts, specifically within the farming community. In Hagen et al.’s study, individuals expressed that one of the largest barriers to seeking out mental health care was in “not wanting anyone to know” about their struggles (p. 117). These findings suggest psychotherapy, particularly in the private practice sector, may help mitigate stigma-related barriers that commonly deter rural individuals

from seeking help. While Hagen et al. focused on participant driven qualitative analysis in their study, the reliability of the study is limited due to the sample being restricted to a niche farming population, comprised only 75 participants. This article is also limited in its ability to be generalizable to a youth specific population, as the study sample only included individuals aged 25 to 78. Despite this, Hagen et al. highlight how the stigma and norms described in this population are prevalent across their families and when the participants were youths, suggesting that this stigma exists across the lifespan.

Accessibility and cultural appropriateness of psychotherapy in rural Canada remain limited. Long wait times are a persistent concern, with some individuals waiting months to years for care (Myers, 2019). Cost of private psychotherapy can perpetuate this barrier, as private practice services are often perceived as expensive by Canadians and not fully covered by public healthcare systems, making them inaccessible for many individuals (Hagen et al., 2022; Milliken et al., 2024). Additionally, a potential lack of cultural awareness of practitioners or understanding of the experiences of rural lifestyles and cultural groups in rural communities causes individuals to feel they are underqualified, and discredit their expertise (Gower et al., 2021; Hagen et al., 2022). This can decrease help-seeking behaviour based on community perceptions of available mental health care practitioners through community discourse or discourage continued engagement in therapy. In a rural Canadian, youth-focused qualitative study, authors Church et al. (2020) describe how specifically, child and youth mental health care were scarcely available in rural Canadian communities. This article is used extensively in this capstone literature review due to its youth-centered perspective and qualitative nature, which provides strong credibility through participant voice. Despite these strengths, it should be noted that this article may not describe the situation of all rural Canadian youths, as it focuses on a niche population in Cape

Breton, Nova Scotia, and relies on the perception of participants, rather than objective data. Overall, while psychotherapy and psychological supports are a large component of the available mental health care services in rural Canada, systemic barriers, such as affordability, wait times, and cultural disconnects limit their effectiveness and accessibility.

Community Programs and Supports

Community mental health resources often encompass multi-service models of mental health care offered in the local community they are operated from (Malla et al., 2019; Moroz et al., 2020). Often these programs include counselling, peer support, psychopharmacological treatment, social program, and advocacy efforts. One notable community resource offered across Canada is ACCESS Open Minds (adolescent/young adult connections to community-driven early strengths-based and stigma-free services). This service aims to provide integrated mental health services, walk-in and single session therapy, provide appropriate referrals to outside networks, and reduce difficulty for youths transitioning into adult-oriented care models (Malla et al., 2019). The ACCESS Open Minds model has shown to provide treatment to youths early, access services prior to crises, and has increased youth engagement in mental health care (Malla et al., 2019).

As these programs often aim to support the individuals by reducing stigma, providing direct services, working to increase further access, they provide an integrative, holistic approach (Malla et al., 2019; Moroz et al., 2020). These approaches thus work to increase service utilization by working within multiple levels in ecological levels. When mental health care is integrated within general health community supports, individuals find ease of access increases (Ferris-Day et al., 2021). As this accessibility is increased, individuals can get appropriate care sooner, potentially limiting further concerns and reducing the severity of future mental health concerns (Moroz et al., 2020).

A defining strength of community-based mental health programs is the inclusion of peer support, which incorporates elements of relational trust and relevance to local youth (Halsall et al., 2021; Malla et al., 2019). Prior research has demonstrated that relevance of care and trust among community members is important to youth (Ferris-Day et al., 2021; Hagen et al., 2022). In a study the authors describe as a hybrid realist-evaluation, Halsall et al. (2021) use qualitative data to explore mental health programs and the systems they are embedded within. Through this model, these authors showcase how community models built on factors such as trust, relevant care, and peer support can also reduce stigma and increase overall accessibility for youth (Halsall et al., 2021). While the study by authors Halsall et al. is highly relevant for this capstone literature review, it does not focus exclusively on rural Canadian youth, rather, it provides a more general outlook for all Canadian youth. As such, this article may not capture all the complexities rural Canadian youth deal with when attempting to access mental health services. Peer-based approaches have shown promise, however, for rural Canadian populations. For example, rural Canadian farmers expressed interest in peer support models as they felt it would be more accessible due to familiarity (Hagen et al., 2022).

As community resources typically operate within the community itself, they also reduce transportation barriers, which are a major challenge for many rural Canadians (CIHI, 2024a). These programs also frequently rely on collaborative partnerships with education, health, social services, and familial networks (Malla et al., 2019). By relying on integrated support systems, community mental health supports work to further break down boundaries and increase future access.

Despite these strengths, several limitations affect the sustainability and equitable accessibility for community-based mental health supports in Canada. Community programs are

typically funded by community and governmental supports (Malla et al., 2019). As a result, long-term sustainability of these programs is reliant on external funding, putting the programs in a vulnerable place. Further, a lack of professionals remains another key limitation, particularly in smaller or more remote communities, where there are fewer trained clinicians to meet demand (Halsall et al., 2021). Another limitation is the lack of standardization amongst community resources, which can contribute to a non-cohesive youth mental health care system. This can contribute toward a knowledge-based barrier, where youth are left wondering where and how to access services (Halsall et al., 2021). Furthermore, many rural locations continue to lack dedicated community mental health supports altogether and are reliant on technology to access supports operated from larger communities, which is still the case for most ACCESS Open Minds centers (Malla et al., 2019). This reliance on virtual or externally operated services underscores persistent geographic inequities in youth mental health access, even within otherwise effective community-based mental health support models.

Technological Supports

Technology-based supports have become an increasingly prominent method of addressing mental health care service gaps (Myers, 2019). These supports, often placed under the umbrella term of "telehealth" can include virtual counselling, social media platforms, and mental health apps that can both provide self-monitoring, advice, and online communities (Høgsdal et al., 2024; Mushquash et al., 2024). These technological innovations for service delivery are often considered as a promising solution to mitigate geographical barriers between rural residents and mental health services (Ferris-Day et al., 2021; Hagen et al., 2022).

Evidence demonstrates that telehealth can improve access to timely mental health support for rural youth, as well as work at triaging mental health care. In a quantitative analysis focusing

on mental health shortages within rural American populations, authors Tourville and Shrestha (2025) discuss how a crisis helpline has been created in Idaho, USA, that works to triage individuals into the mental health care system, and the result is less individuals accessing the emergency room with mental health related concerns. While this study provides recent, relevant, and unique research on an innovative tech-based approach to limiting the accessibility gap for rural youths, it may not be completely generalizable to the Canadian context due to its specific population of American residents. Despite this, other research points out how youth appear receptive to technology-based mental health care, with many reporting openness to trying them (Høgsdal et al., 2024). Further, youth also perceive mental health apps and telehealth services to be more accessible, which increases help-seeking behaviour amongst youth with mental health concerns (Friesen, 2019; Høgsdal et al., 2024).

However, despite the accessibility benefits of technology-based mental health care, several barriers remain. Telehealth is heavily dependent on stable internet or cellular connection, which is not consistently available in all rural Canada (Hagen et al., 2022). Age-related disparities also exist, with younger individuals demonstrating greater willingness to engage with online supports, and older adults feeling more apprehensive about technology-based support (Ferris-Day et al., 2021). Further, older adults are more likely to perceive telehealth as lower quality and more difficult (Ferris-Day et al., 2021). Additionally, certain marginalized youth groups may be at a higher risk accessing telehealth than other groups. LGBTQ+ youth are particularly vulnerable to online harassment, which can undermine the safety and inclusivity of community-based app features or social media spaces intended for mental health support (Kingsbury & Arim, 2023). These challenges suggest that while telehealth offers substantial potential to reduce geographical and systemic barriers in rural mental health care for youth, they

must be implemented with user safety, systemic inequities, and digital literacy to ensure effective and safe access across populations.

Taken together, these service modalities illustrate that each intervention type alone cannot address the foundational issues created by distance, isolation, and uneven infrastructure in rural communities. This is reflected in broader literature on geographical barriers, which continues to identify physical location as a critical factor shaping access.

Theme 2: Geographical Barriers

Rurality and one's geographical living placement plays a role in access to mental health services (Ferris-Day et al., 2021; Moroz et al., 2020). What is considered as rural, and geographically isolated, may differ from study to study. A similar concern was noted by authors Ferris-Day et al. (2021), when they described how rural Australia often meant individuals had to travel hours to access services, whereas rural in New Zealand was a matter of a 50-kilometer difference. In rural Canada, some farmers explained how their closest mental health providers were hundreds of kilometers away (Hagen et al., 2022). Statistics Canada (2022) considers rural as any territory outside of a population center. This may include small communities with less than 1000 residents, and undeveloped, remote, and agricultural land. While levels of rurality differ, there are several types of barriers that exist as a result of rural living, such as geographical isolation and travel barriers, which can negatively affect one's physical and mental well-being (Moroz et al., 2020; Myers, 2019).

Geographical isolation is often described as when an individual has difficulty accessing community resources, supports, and resources (Beehler et al., 2023; Moroz et al., 2020). For many rural residents, particularly those living in small or remote communities far away from urban centres, the burden of travelling to access services can significantly affect the accessibility

level of mental health care, and the willingness of the individual to seek out care (Hagen et al., 2022; Moroz et al., 2020). Hagen et al. (2022) found that farmers were even more unlikely to seek out mental health support during their busiest and most stressful times of the year, due to travel time. Since farms can be hundreds of kilometers from the nearest urban center, rural Canadian farmers may be relying on their primary healthcare, the general doctor or the local emergency room, or choosing to forego seeking out mental health care (Hagen et al., 2022; Moroz et al., 2020). This travel burden can compound with other personal stressors to affect rural Canadians' mental health even further (CIHI, 2024c).

Long Travel Distances

Long travel distances are noted as a barrier to accessing and seeking out mental health care in several studies (Beehler et al., 2023; Faber et al., 2023; Hagen et al., 2022; Moroz et al., 2020). Travel burden is described by the CIHI (2024c) as a multilevel burden on the individual stemming from the time, costs, and potential of lost opportunities. From 2018–2019 and 2022–2023, 1 in 4 Canadians hospitalized in rural communities reported a high travel burden, and about 79% of rural and remote Canadians reported a travel burden higher than very low (CIHI, 2024a). In contrast, 75.2% of urban Canadians reported a travel burden of very low (CIHI, 2024a). As factors increase, such as level of urgency, level of remoteness, if the individual is a youth, and specialty of care, travel burden also increases (CIHI, 2024c). This highlights how those who may be in the most need for services, such as a rural youth urgently needing specialist mental health care, travel is likely to be reported as a significant barrier.

Travel burden can compound with other factors as well. Moroz et al. (2020) describe how goods and services often increase in cost due to the travel distance required to bring them to more rural and remote communities. In urban communities, this cost burden is partially offset

with community programs, such as public transportation. In rural Canada, there is often very little public transportation available, if at all (Moroz et al., 2020). Authors Ghanouni and Naimpally (2025) highlight how without public transportation, accessing specialty care for rural autistic youth in Canada is incredibly difficult, and by having this transportation barrier, many rural autistic youths have increased difficulty transitioning into adulthood.

In Hagen et al.'s (2022) qualitative study, which included a sample of 37 men and 37 women, 25–78 years old, who resided in farming communities across Canada, long travel distance was cited as a significant barrier for many rural Canadian farmers. These Canadian farmers described how there were no mental health supports accessible in their community, and to travel to access one in the closest urban centre would be upwards of 3 hours for a round trip of travel time. Further, the farmers explained that during the most stressful times of the year, it's even more difficult to justify the immense travel distance, since they need to be present on the farm (Hagen et al., 2022). Times of immense stress may be when farmers are at the highest risk. If travel burden is too great, then mental health supports become inaccessible to those who reside on rural Canadian farms in the time they are the most needed.

Due to Canada's size and location in proximity to the equator, weather patterns within the country may vary greatly. Pronounced seasonal shifts and duration of winter months also increase the likelihood of winter-related travel delays. Coupled with the average travel distance from a rural location to an urban center, it can be surmised that the barriers rural Canadians face not only limit their access to mental health services, but also compound over time, creating a cycle of unmet needs and worsening health outcomes (Trout & Wexler, 2020).

While geographic isolation creates visible challenges such as a long travel distances and limited physical access to services, these barriers are closely intertwined with broader structural

and systemic issues. In many rural communities, the lack of local providers and transportation options reflect deeper systemic patterns of underfunding, workplace shortages, and uneven resource distribution.

Theme 3: Structural and Systemic Barriers

Structural and systemic barriers remain persistent challenges affecting mental health service accessibility in rural Canada. These barriers are rooted in economic disparities, service availability, and funding inequities (Moroz et al., 2020). Rural communities often experience higher rates of unemployment, lower average incomes, and greater economic instability (Beehler et al., 2023; Moroz et al., 2020). These structural conditions are further affected by limited access to affordable care, with Canadians often having to bear the brunt of financial responsibility for most mental health care outside of hospital-based and primary care programs, such as psychotherapy or specialty psychological supports (Milliken et al., 2024). As a result, lower income households report facing greater difficulty accessing care, and decreased willingness to seek out care (Faber et al., 2023).

On a systemic level, shortages of mental health professionals and facilities exist, causing widespread accessibility gaps. Canadian national census data shows that while Canada had on average 1,721 mental health providers per 100,000 people in 2021, rural regions had significantly less than urban and remained critically underserved (CIHI, 2023). These shortages can contribute to long wait times for services, and as a result, push individuals toward utilizing emergency care (Faber et al., 2023; Tourville & Shrestha, 2025). When emergency and primary care is utilized for non-emergent mental health concerns, it places financial stress on the economy, as well as the individual and potentially worsening mental health outcomes (Milliken et al., 2024; Tourville & Shrestha, 2025). Additionally, many rural residents lack knowledge on

available supports and how to navigate mental health systems, which highlights a lack of pervasive mental health knowledge within rural Canadian communities (Church et al., 2020; Faber et al., 2023; Hagen et al., 2022; Radez et al., 2021).

The Economy of Rural Canada

Rural communities often have increased economic stress, and often have inadequate resources to aid those with lower income levels during times of stress (Moroz et al., 2020). Historically, rural communities have lower socioeconomic status, lower annual incomes, and higher unemployment rates than urban spaces in both America and Canada (Beehler et al., 2023; Government of Canada, 2024; Moroz et al., 202). Rural Canada also faces significant labor shortages, especially within the agricultural sector, which has contributed to substantial amounts of lost income (Government of Canada, 2024).

Authors Beehler et al. (2023), in a recent literature review, found that rural communities are more vulnerable to financial stress due to their higher reliance on the natural environment. While authors Beehler et al. (2023) provide modern analysis of a wide body of literature and add context to the disparities rural communities face, this review focused on the American context, so it may not describe all the complexities of the rural Canadian context. Within Canada, 30% of the country’s GDP comes from rural sectors: mining, forestry, agriculture, fisheries, energy extraction, and electricity production (Government of Canada, 2024). These employment sectors are often vulnerable to extreme weather, climate change, and government policy, making rural communities particularly vulnerable to large scale economic shifts (Beehler et al., 2023). Further, rural Canadians often must face a higher cost of living, less affordable housing, lower labour force participation, and ageing populations (Government of Canada, 2024). Seemingly because of these factors, many young individuals in rural Canadian communities are choosing to leave

their communities, often in hopes of gaining further education, access to more resources, or find employment (Sano et al., 2020). Since the beginning of the century, Canadian statistical records have found that most rural youth aged 15–19 are leaving their rural communities, and less than 25% will return (Dupuy et al., 2000). More recent research highlights the continuation of this trend (Statistics Canada, 2022). A similar trend is happening in rural areas in Europe, Australia, and the USA (Sano et al., 2020). This phenomenon has contributed to ageing rural populations, which require more specialized physical and mental health care, and place increased stress on rural economies (Statistics Canada, 2022).

The financial constraints can affect rural Canada on the individual level, by affecting those potentially caring for elderly family members or friends, and on a systemic level, by affecting the broader economy of the rural community (Sano et al., 2020). For rural Canadian youth, there can be several detrimental mental health effects associated with lower socioeconomic status. Researcher's Kingsbury and Arim (2023) explore cyberbullying in a multilevel qualitative analysis of the Statistics Canada 2019 Canadian Health Survey on Children and Youth, which contained results from 13,602 individuals across Canada, and found that rural Canadian youth who also belong to a marginalized group, or are living with other health conditions, are at an increased risk for cybervictimization. Since a large portion of youth today often occupy online spaces, and cyberbullying has been associated with poorer mental health, depression, anxiety, eating disorders, suicidal ideation, and suicidal actions, this is a significant risk factor (Kingsbury & Arim, 2023; Mushquash et al., 2024).

Cost of Services

While most health care is publicly funded to some degree in all Canadian provinces, often the financial responsibility of mental health treatment beyond emergency care and

pharmaceutical treatment is on the individual accessing the care (Milliken et al., 2024). Within Canada, health care generally falls under two categories. Publicly funded supports, where the financial cost of the support does not fall directly on the individual accessing the support, and privately funded supports, where the individual is solely responsible for paying for the care received (Milliken et al., 2024). In 2019, approximately $4.9 billion was spent within the public sector on mental health care in hospitals and primary care facilities, and $0.5 billion privately, such as through counselling, private psychiatrists, and specialty psychological treatment (Milliken et al., 2024).

Even when healthcare is covered for an individual by insurance companies, the insurance company providing the coverage can cause accessibility concerns. In a recent study by Faber et al. (2023), several Canadians described how insurance companies restricted their access to mental health care by deeming the individual's concerns as "not in need of treatment," "gatekeeping who is a qualified therapist," or restricting coverage (p. 321). Cost of services is a significant factor that contributes to whether rural Canadian youth will encounter barriers when attempting to access mental health care. Authors Faber et al. (2023) discovered that 28% of their sample population of 1,501 Canadians have difficulty accessing mental health care live in households with an income less than $50,000 a year. Further, over 50% of individuals in their study sample of over 1,500 individuals stated mental health care is too expensive to access.

Limited Mental Health Service Availability:

Rural Canadians face substantial limitations in the availability of mental health professionals and facilities (Moroz et al., 2020). In 2021, there were over 650,000 mental health care service providers in Canada, averaging 1,700 providers per 100,000 Canadians, however, these providers were disproportionately accessible across urban and rural communities (CIHI,

2023). As a result, rural communities face a shortage of service providers as compared to urban communities. This shortage directly impacts accessibility, with several researchers finding correlation between heavily increased wait times and lack of available providers (Hagen et al., 2022; Moroz et al., 2020; Tourville & Shrestha, 2025). Faber et al. (2023) found that many individuals stated they had difficulty finding a mental health care provider, or that there was a lack of resources and professionals in their community. Further, they also mentioned long waitlists as a barrier. On average, wait times for mental health services in Canada tend to be about a month for mental health services, whereas youth specific services can be from 600–900 days, on average (Faber et al., 2023). In rural communities this can be significantly longer, or completely inaccessible, forcing rural Canadian youth to travel far distances to urban centers to access care, or rely on telehealth, if possible (Church et al., 2020). When care is inaccessible and individuals are forced to go without, mental health outcomes may worsen. Tourville and Shrestha (2025) discovered that there is a 5-month lag from a mental health service shortage to a mental health hold in an emergency care center. While this research does not follow the individuals specifically, it does highlight the pattern of increased mental health holds and utilization of emergency services for mental health concerns following mental health care shortages within the same area.

This effect may be further compounded by the amount of youth leaving their rural communities, and only about 25% choosing to return (Dupuy et al., 2000). Since rural Canadians often leave their communities out of necessity due to a lack of available education or job opportunities, this leaves rural communities with less available professionals (Sano et al., 2020). As rural communities in Canada, on average, are growing much slower than urban and have a significantly lower rate of individuals entering the labour force, rural Canadian communities are

facing a potential deficit of professional services, with trends highlighting a continuous decline (Statistics Canada, 2025b).

Beyond a shortage of available professionals, a lack of knowledge on available mental health services also exists. Several studies have reported that many rural residents, and particularly rural youth, are either unaware of what mental health services exist or how to access them (Church et al., 2020; Ferris-Day et al., 2021; Hagen et al., 2022; Moroz et al., 2020; Radez et al., 2021). In a study on a variety of different barriers existing for rural Canadian school-aged youth, Church et al. (2020) found that a lack of awareness of available mental health supports and lack of knowledge on mental health in general was the most prominent barrier to accessing mental health care. As a result of the age of the participants of this study, they highlight how school-based programs may be the best way at increasing awareness of services (Church et al., 2020). Similarly, Radez et al. (2021) found that education on mental health amongst youth in general was lacking. Youth often perceived barriers of not knowing where to access help, not knowing what level of mental health concerns warranted support, and expectations that their mental health problems would resolve without support. These findings indicate that knowledge-based barriers are pervasive amongst youth and restrict their ability to access timely and appropriate mental health support.

Additionally, rural communities often lack youth-specific services, further restricting accessibility for younger individuals (Radez et al., 2021). This is an effect that compounds with age. As youth get older, they are more likely to receive care, with younger adolescents falling through service gaps (Radez et al., 2021). Further, youth are more likely to access behavioral supports, and youth with emotional disturbances have greater difficulty finding appropriate mental health care (Radez et al., 2021). For very young rural Canadian youth requiring

emotional, or both emotional and behavioral mental health support, these findings highlight the potential for individuals such as this to go without adequate care.

Together, these findings showcase the structural and systemic barriers, such as provider shortages, long wait times, low awareness of supports, and limited youth-specific services, that significantly reduce access to mental health support in rural Canada. These challenges delay care, along with the potential for worsening mental health outcomes for rural youth who already face heightened risks due to geographical isolation, economic strain, and distance to services. Although structural and systemic issues play a significant role in limiting access, cultural dimensions also shape how services are perceived, sought, and experienced. These cultural barriers intersect with systemic inequities, influencing the willingness of rural youth to engage with available mental health supports.

Theme 4: Cultural and Social Barriers

Cultural and social belonging can have a significant impact on one's mental health. Ferris-Day et al. (2021) have found that when community connection and leadership align, and individuals feel a stronger sense of belonging, mental health outcomes increase. In the same way that community connectedness can influence mental health outcomes, a sense of otherness, or being disconnected, stigmatized against, or separated from one's social network, can create adverse mental health effects (Ferris-Day et al., 2021). There are several different mechanisms through which youth are often marginalized within their communities. Stigma and negative perceptions of mental health care appear as significant contributors to restricting mental health care access for youth (Church et al., 2020; Gower et al., 2021; Hagen et al., 2022).

Stigma in Rural Communities

Stigma remains a significant barrier preventing rural Canadians, particularly youth, from accessing mental health care. Feelings of discomfort, distrust, perceived inaccessibility and discreditation of mental health care providers can discourage individuals from seeking help for mental health concerns in the first place (Hagen et al., 2022; Moroz et al., 2020). Within rural Canadian farming communities, stigma can manifest through internalized cultural expectations of strength and resilience (Hagen et al., 2022). In a study on perceived stigma surrounding mental health, some rural Canadian farmers discussed a pressure to not speak about mental health concerns, and an even heavier pressure to maintain "stoicism" and to act like the "tough, stubborn, old bastard" (Hagen et al., 2022, p. 117). This mentality places inherent value on acting strong and stoic, and reinforces a norm that equates vulnerability with weakness, making it difficult for individuals to express distress or access mental health care without a fear of judgement.

Similar themes appear among rural Canadian youth, who also experience strong social pressure that perpetuates mental health stigmatization (Gower et al., 2021). Church et al. (2020) found that many youths in rural communities believed that seeking help for mental health concerns was a sign of weakness, or that only individuals who were truly crazy needed to access mental health care. These beliefs were not shared with their urban counterparts, suggesting Canadian youth hold a unique set of beliefs that may be contributing to stigma restricting access to mental health care at the social level (Church et al., 2020). Additionally, some rural Canadian youth felt pressure to rely on their family to access care, due to travel or cost barriers, and most of them considered this to be a barrier to care, as it decreased a sense of privacy and confidentiality (Church et al., 2020). Further, the most significant fears of rural Canadian youth

when accessing mental health care is gossip, social exclusion, bringing shame to their family, and feeling othered from peer groups (Church et al., 2020). Collectively, these findings suggest that internalized mental health stigma exists in rural Canadian communities which associates mental illness with weakness and otherness, which fosters fear amongst rural Canadian residents, youth and adults alike.

Rural Gender Norms and Mental Health

Gender norms within rural Canadian communities can also play a critical role in shaping attitudes toward mental health and influencing help-seeking behaviours. For rural men, particularly those in agricultural settings, traditional beliefs of masculinity, such as self-reliance, stoicism, and emotional restraint, often function as barriers to care (Hagen et al., 2022). These beliefs, when internalized, can work to limit access to mental health care from inside the individual. Authors Ferris-Day et al. (2021) found that rural Canadian men are more likely to forego mental health care due to feelings of shame, fear of social judgment, and concerns over losing their social standing. In some rural Canadian communities, this pressure manifests as a norm about not speaking on one's mental health, limiting rural Canadian males from understanding their mental health, and accessing care (Hagen et al., 2022). However, emerging research suggest male youth are open to engagement when services are presented transparently and with practical skill-based approaches, and given from experts (Lisk et al., 2023; Roberts et al., 2022). This indicates that while traditional masculine norms remain a barrier, interventions that provide clarity, structure, and autonomy may encourage participation.

Rural femininity also presents unique challenges for women and girls, particularly in balancing community expectations with personal mental health needs. Authors Faber et al. (2023) found that rural Canadian women reported more financial barriers, difficulty with long

waiting lists, and negative experiences with mental health providers than men. Further, more women than men seek out mental health care, as well as report difficulties accessing that care (Faber et al., 2023). A higher proportion of women than men also reported that they faced difficulties every time they sought out mental health care (Faber et al., 2023). Additionally, rural Canadian women in farming communities expressed feeling pressure to be responsible for upholding their own and their family's mental health (Hagen et al., 2022). These women often described how the onus fell on them to provide peer support, as well as seek out professional supports. Further, they reported feeling like they had less available peer support overall than their male counterparts. While this study explored mental health barriers amongst rural Canadians, it was not specific to rural Canadian youth, however, several other studies exploring rural Canadian youth, and youth in general, found supporting findings (Church et al., 2020; Radez et al., 2021). Authors Radez et al. (2021) analyzed a large sample of academic papers on youth mental health and found that in 24% of the studies a preference for informal peer support over professional support was seen as a barrier to accessing mental health care.

Despite these observed gender-based trends, not all studies report clear differences in how male and female rural youth perceive mental health barriers. Church et al. (2020) found no significant gender differences in perceptions of stigma or help-seeking among rural Canadian youth, suggesting that while gendered expectations persist in many rural contexts, they may vary by community, age, or individual experience. Overall, while masculinity and femininity shape the ways rural individuals engage with mental health care, these patterns are nuanced and context-dependent, emphasizing the need for gender-sensitive and community-informed approaches to rural mental health support.

Indigenous Canadian Youth and Access to Mental Health Services

Indigenous Canadian youth represent one of the fastest-growing populations in the country and face distinct cultural, historical, and systemic barriers to mental health care. Recent statistic reports from Canadian census data showcases how the population of Indigenous youth is increasing at a rate of 39%, whereas the non-Indigenous youth population is only increasing at 5% (Statistics Canada, 2019). Additionally, Indigenous Canadian youth are often more exposed to risk factors for mental health, such as early childhood adversity, intergenerational trauma, and economic and housing instability (Mushquash et al., 2024). These risk factors have the potential to have severe effects on the wellness of Indigenous Canadians.

In a study by Faber et al. (2023), Indigenous Canadians were the highest proportion of individuals who sought out mental health care and reported difficulty accessing that care. Among these participants, 69% reported financial barriers to care, which is the highest of any cultural ethnic group in this study. Further, approximately half of the Indigenous participants in this study reported having negative experiences with mental health providers. Authors Mushquash et al. (2024) highlighted how Indigenous youth in Ontario experience longer wait times to access care than their non-Indigenous peers, while authors Kumar and Tjepkema (2019) describe how ongoing systemic trauma and colonial legacies continue to limit access to consistent and culturally appropriate services within rural Indigenous communities. Additionally, these authors used Canadian census data to showcase how Indigenous Canadian youth having significantly higher suicide rates than other cultural and ethnic groups within Canada (Kumar & Tjepkema, 2019). As such, negative past experiences with service providers, along with the forced appliance of westernized institutional systems to Indigenous youth, can contribute to inequitable access to culturally appropriate mental health care.

Other Marginalized Youth Groups

Marginalized youth populations, including LGBTQ+ and racialized youth, face distinct social and cultural barriers that further complicate their access to mental health care in Canada. For LGBTQ+ youth, one of the most persistent accessibility challenges is the lack of affirming or identity-competent providers (Gower et al., 2021). Faber et al. (2023) identified the scarcity of LGBTQ+ and allied mental health professionals as a significant barrier to care, particularly in rural areas where service options are already limited. Although overall rates of bullying among youth have declined in recent years, this decrease has occurred much more slowly for LGBTQ+ youth, especially for LGBTQ+ girls, who remain disproportionately at risk for severe mental illness compared to their cisgender, heterosexual peers (Gower et al., 2021). Research attributes part of this disparity to ongoing bullying and victimization, which continue to negatively affect LGBTQ+ youths' mental health outcomes (Gower et al., 2021).

The social environments in which LGBTQ+ youth live and learn also strongly influence their willingness to seek help. Gower et al. (2021) found that many Canadian LGBTQ+ youth reported feeling unsafe or stigmatized in schools and community spaces, with these experiences often intensified in rural communities. As a result, youth actively avoided environments they perceived as unwelcoming or discriminatory, and frequently dismissed the opinions of authority figures, such as teachers or school counselors, who failed to establish inclusive or affirming spaces. Safety and inclusivity were identified as central factors in LGBTQ+ youths' decisions about which spaces to occupy and which professionals to trust. These findings highlight the crucial importance of cultural competence and active allyship in fostering environments that support positive mental health engagement among LGBTQ+ youth.

Racial and cultural disparities also persist in Canadian youths' access to mental health services. Radez et al. (2021) observed that youth who identify as White are more likely to receive mental health support than their peers of color, indicating systemic inequities in both outreach and service delivery. Faber et al. (2023) similarly found that while only 48% of White Canadians who sought mental health care reported difficulty accessing it, over 50% of Indigenous, Black, Middle Eastern, and Latin American Canadians experienced access barriers. Within their study of over 1,500 participants, no Black or Latin American respondents reported being able to access mental health care without difficulty, and only 3% of Indigenous and South Asian, and 2% of East Asian respondents reported the same. Cultural representation also emerged as a significant factor. Thirty-one percent of Black Canadians reported difficulty finding a provider from their own cultural or ethnic background, compared to only 2% of Indigenous and White participants. These findings reveal the compounding effects cultural mismatch, systemic inequities, and racial bias have in mental health care for rural Canadians. Taken together, the findings across these youth populations, particularly those from marginalized and rural locales, underscore the complex interplay of structural, geographical, and cultural factors shaping mental health accessibility for rural youth in Canada.

Summary of Thematic Analysis

Across the themes, the literature depicts layered levels of access for rural Canadian youth. Mental health care is commonly initiated in primary and emergency settings, supplemented by walk-in services, psychotherapy, community programs, and technology-based supports (Arruda et al., 2023; CIHI, 2024b; Milliken et al., 2024; Moroz et al., 2020; Read et al., 2023). Geography amplifies barriers, such as distance, weather, and transportation while systemic challenges, such as workforce shortages, long wait times, financial constraints, and low

service awareness, further limit adequate mental health care (CIHI, 2024a, 2024c; Faber et al., 2023; Hagen et al., 2022; Radez et al., 2021). Social context matters as well, where stigma, gendered norms, and cultural mismatch may reduce trust and continuity of services (Faber et al., 2023; Gower et al., 2021). Further, Indigenous, racialized, and LGBTQ+ youth face disproportionate obstacles and poorer experiences of care (Faber et al., 2023; Kumar & Tjepkema, 2019; Mushquash et al., 2024).

Regarding efficacy, models with integrated, community specific features, such as the ACCESS Open Minds hubs, peer support networks, and local walk-in mental health services show promise for early engagement, triage, and relevance for youth (Ferris-Day et al., 2021; Malla et al., 2019; Read et al., 2023). Telehealth increases reach and triage capacity, however, its benefits are limited due to connectivity, lower digital literacy, privacy and safety concerns, and a lack of user trust, which are all more prevalent amongst rural individuals (Friesen, 2019; Hagen et al., 2022; Høgsdal et al., 2024). Primary care and emergent care systems are essential for stabilization yet remain reactive, variably trained, and weakly linked to aftercare, limiting longer-term outcomes (Arruda et al., 2023; CIHI, 2024b; Moroz et al., 2020).

Key critiques and limitations include a lack of standardized outcomes across walk-ins and community programs, underrepresentation of youth in evaluative research, urban-focused datasets that mask the rural nuance, and early pandemic telehealth evidence that may not reflect current practices (Faber et al., 2023; Read et al., 2023). Potential applications emerging from these gaps, as suggested in the literature, include region-specific workforce incentives and youth-specific services, school-based mental health literacy and system navigation supports, transportation and travel cost supports and relief programs, culturally safe and identity-affirming care, standardized measurement for walk-ins and community programs, and telehealth scaled

with privacy safeguard and connectivity supports (Arruda et al., 2023; CIHI 2024a, 2024c; Government of Canada, 2024; Gower et al., 2021; Lisk et al., 2023; Malla et al., 2019). These insights set the stage for Chapter 3's discussion, which situates this body of literature within an ecological and equity lens to better understand practical applications for decreasing barriers to mental health care for rural Canadian youth.

Chapter 3: Discussion and Application

Discussion

Bronfenbrenner's (1977) ecological model provides a valuable framework for understanding the complex and interconnected barriers that influence rural Canadian youths' access to mental health services. The model conceptualizes human development as it occurs within nested environmental systems, titled the micro, meso-, exo-, macro-, and chronosystems (Broffenbrenner, 1977). Each level can shape the individual's lived experience, through interaction with others and other levels of the model. This model remains relevant in modern psychological research, where recent studies reference and mirror Bronfenbrenner's systemic view of development and emphasize interdependence between the personal, relational, and environmental factors (Dove & Costello, 2017; Kelly & Coughlan, 2019; Stupak & Dobroczyński, 2021). When applied to the findings of this capstone, the barriers identified in Chapter 2 manifest across all ecological levels, compounding to create a multilevel structural disadvantage for rural Canadian youth.

At the microsystem level, youth are influenced by their closest social contexts, such as family, peers, and local caregivers (Broffenbrenner, 1977). Within rural communities, family and peer stigma toward mental illness significantly restricts openness, support, and help-seeking behaviour (Church et al., 2020; Hagen et al., 2022). Fear of gossip or community judgment often prevents youth from disclosing distress or accessing available services. Dependence on family members for transportation further limits youths' autonomy in pursuing care, as parents may be unwilling or unable to prioritize mental health appointments (Hagen et al., 2022). Small-community familiarity also heightens confidentiality concerns, creating distrust toward local practitioners and discouraging engagement in treatment (Lisk et al., 2023). Despite these

challenges, the microsystem can also function protectively when supportive networks are present. Peer-driven or youth-focused initiatives, such as the ACCESS Open Minds program, provide stigma-free spaces where youth can engage with trusted adults and peers, strengthening social connection and early intervention (Malla et al., 2019).

The mesosystem reflects interactions between the various microsystems surrounding the youth, such as the relationships between families, schools, and healthcare services (Broffenbrenner, 1977). Limited communication and inconsistent mental health literacy among teachers and parents weaken early identification of concerns and delay access to support (Church et al., 2020). Poor coordination between local schools, clinics, and social service agencies further fragments the continuity of care and creates confusion regarding where and how to seek services (Moroz et al., 2020). Conversely, programs that integrate multiple settings demonstrate positive effects. For instance, mindfulness-based group interventions implemented in schools, which include collaboration among students, teachers, and parents, have been shown to enhance emotional regulation and strengthen shared responsibility for well-being (Dove & Costello, 2017). Such findings highlight the value of mesosystem cohesion in mitigating barriers at the individual level.

The exosystem encompasses broader community structures and institutional forces that indirectly affect youth well-being (Broffenbrenner, 1977). A defining barrier within rural Canada is the shortage of mental health professionals and treatment facilities (CIHI, 2023; Moroz et al., 2020). When services are scarce or distant, rural youth face substantial travel burdens, exacerbated by limited transportation infrastructure and harsh seasonal conditions (CIHI, 2024c; Hagen et al., 2022). Financial stress compounds these issues, as private counselling or psychotherapy often requires out-of-pocket payment and insurance coverage may be inadequate

or restrictive (Faber et al., 2023; Milliken et al., 2024). Furthermore, gaps in internet or cellular service limit the feasibility of telehealth, which otherwise holds potential to bridge geographical divides (Hilty et al., 2020). Community-based models such as ACCESS Open Minds have shown promise at this level by embedding services within local institutions and fostering collaboration between providers and community stakeholders, which links the micro and exo-layers (Malla et al., 2019).

At the macrosystem level, societal norms, economic forces, and cultural ideologies shape attitudes toward mental health and the distribution of resources (Broffenbrenner, 1977). In many rural regions, masculine ideals of self-reliance and stoicism reinforce perceptions that seeking psychological help signifies weakness (Ferris-Day et al., 2021; Hagen et al., 2022). Economic instability and low average incomes further constrain both service provision and the capacity of individuals to access care (Government of Canada, 2024; Moroz et al., 2020). For marginalized populations, cultural mismatch between clients and practitioners can lead to alienation or withdrawal from services. Indigenous and LGBTQ+ youth frequently report difficulty finding culturally safe or identity-affirming care, underscoring the need for inclusive and community-responsive practice (Faber et al., 2023; Gower et al., 2021). Policy initiatives such as the *Rural Opportunity, National Prosperity Strategy* (Government of Canada, 2024) demonstrate efforts at the macrosystem level to address economic and infrastructural inequities that indirectly affect mental health accessibility.

The chronosystem accounts for the temporal dimension of development, acknowledging how historical events and technological shifts shape mental health access over time (Broffenbrenner, 1977). The COVID-19 pandemic prompted a rapid transition to telehealth services, revealing significant disparities in digital infrastructure between urban and rural areas

(Hilty et al., 2020; Reay et al., 2020). Simultaneously, the growing availability of mental health applications and online interventions has introduced innovative yet unevenly distributed avenues of care (Mushquash et al., 2024; Myers, 2019). Demographically, persistent youth out-migration continues to erode local continuity and reduces the future supply of rural mental health professionals (Sano et al., 2020). Nevertheless, generational shifts in public discourse demonstrate gradual destigmatization, as younger cohorts normalize mental health conversations and advocate for systemic change (Kelly & Coughlan, 2019).

Many of the identified barriers operate simultaneously across multiple ecological layers. Stigma permeates the micro-, meso-, and macrosystems, by affecting perceptions of family and peers, schools and communities, and societal and cultural norms (Reupert, 2017). Economic stress connects macrolevel policy decisions to exosystem labour markets and, ultimately, to microlevel family finances (Milliken et al., 2024). Technology access reflects an interplay between exosystem infrastructure, macrolevel funding priorities, and individual capacity for digital engagement. Similarly, cultural competence influences the mesosystem through the therapeutic relationship and the macrosystem through societal inclusion and equity (Gower et al., 2021). Understanding these intersections underscores the necessity of multilevel, coordinated responses to effectively address mental health disparities for rural Canadian youth.

Analysis

The analysis will synthesize the literature review findings, situate them within the ecological framework as outlined above, and answer the previously defined research question: Which barriers continue to exist that restrict rural Canadian youths from accessing mental health services? The literature describes several barriers which interact across all ecological levels, as discussed above. Stigma, financial strain, service limitations, and systemic inequities emerge as

significant barriers that affect rural Canadian youths' wellbeing (Church et al., 2020; Faber et al., 2023; Moroz et al., 2020). Each barrier may interact with another, compounding the disadvantageous effects, and resulting in diminished help-seeking behaviour, delayed intervention, and poorer mental health outcomes (Church et al., 2020; Hagen et al., 2022; Kumar & Tjepkema, 2019).

Interconnectedness Among Barriers

Rural Canadian youth encounter multiple barriers that may restrict access to timely and appropriate mental health care. Geographical barriers remain foundational. Long travel distances and limited infrastructure restrict in person access (CIHI, 2024c; Hagen et al., 2022). Structural barriers further exacerbate these geographical effects, where rural locations are described to have fewer mental health professionals and facilities than urban centers, and as a result, experience longer wait times and a heavier reliance on emergency services for non-urgent care (CIHI, 2023; Moroz et al., 2020). Combined with the commonly long travel distances and transportation costs, finding mental health services when fewer available professionals operate within rural locations can be difficult.

Financial barriers also play a role, where private psychotherapy services often remain unaffordable for individuals or families with lower incomes, forcing greater reliance on publicly funded services, such as emergency units or community operated services (Faber et al., 2023; Milliken et al., 2024). Financial and structural barriers intersect, describing an overall economic decline in rural Canadian communities, and as a result, a decline in professionals willing to stay, or return to work within their communities (Beehler et al., 2023; Sano et al., 2020). Further, travel distances can be immense, and cost of travel alone can inhibit individuals from accessing mental health care (CIHI, 2024c). This often results with individuals needing to search outside of

their communities to find mental health support, having to rely on telehealth services, or delaying or avoiding seeking mental health care entirely (Hilty et al., 2020).

Stigma also intersects with other barriers, where rural Canadians describe how they feel many professionals are not equipped to understand rural lifestyles, and this creates distrust within the therapeutic relationship (Hagen et al., 2022). Further, individuals often delay or avoid help-seeking due to fear of displaying weakness, gossip from the community, or beliefs that mental health professionals are unable to help (Church et al., 2020; Ferris-Day et al., 2021; Hagen et al., 2022). Collectively, these barriers reflect an intersectional system of disadvantage where barriers exist across multiple domains, compounding and amplifying the level of restriction rural Canadian youth face when attempting to seek mental health support. As a result, rural Canadian youth face higher levels of distress, suicidality, and reduced long-term functioning (Kumar & Tjepkema, 2019; Meyers, 2019).

On a broader level, the barriers that exist contribute to perpetuating the cycle of disadvantage for rural Canadian youths. Due to the heavy reliance on emergency services for non-emergent mental health care, societal costs increase to attempt to keep up with the demand for services (Milliken et al., 2024). This places further strain on rural communities, who already face a greater economic disadvantage than urban centers (Beehler et al., 2023; Moroz et al., 2020). Further, during periods of greater economic stress, rural locales are often hit the strongest, and the broader financial effects are then felt on an individual level, often increasing levels of stress and leading to difficulty accessing appropriate mental health services (Tourville & Shrestha, 2025). Overall, this can contribute to increasing wait times, which in turn, creates a greater need for emergent services, as individuals' mental conditions worsen due to inability to access early interventions (Tourville & Shrestha, 2025).

The consequences of restricted mental health care access extend beyond individual well-being to multiple areas of Canadian youths' lives. Academic outcomes often suffer as untreated anxiety, depression, and stress may reduce concentration, attendance, and performance (Church et al., 2020). Social functioning may also be impaired, as stigma and confidentiality fear limit peer support and increase feelings of isolation (Hagen et al., 2022). Economically, family financial strain contributes to heightened stress among youth, reinforcing a sense of instability and hopelessness (Arruda et al., 2023). For marginalized rural youth, lack of culturally safe and affirming spaces undermines belonging and self-concept, particularly for Indigenous and LGBTQ+ youth (Gower et al., 2021). These factors all compound to create a cumulative disadvantage that potentially affects the developmental trajectory of rural Canadian youth.

Efforts to Increase Access

Recent efforts to improve mental health accessibility for rural youth in Canada reflect a shift toward community-based, integrative, and technologically mediated models of care. Programs such as ACCESS Open Minds demonstrate how early intervention, prevention efforts, youth engagement, and community partnerships can improve outcomes by addressing both micro- and exosystem factors (Malla et al., 2019). The ACCESS Open Minds program also aims to reduce stigma and streamline referral processes, working to increase interservice collaboration. In general, research showcases how some rural Canadian youth prefer when providers and peer supports are embedded within their community context and share similar cultural values (Ferris-Day et al., 2021; Halsall et al., 2021).

Telehealth services have expanded in recent years, particularly since COVID-19, allowing youth to connect with mental health professionals remotely (Hilty et al., 2020; Myers, 2019). National and provincial crisis helplines, such as the 988 National Suicide Crisis Helpline

or the Kids Help Phone, play a role in triaging emergencies, reducing reliance on emergency services, and provide immediate emotional support (Find a Helpline, 2025; Tourville & Shrestha, 2025).

Finally, federal policy efforts in Canada, such as the *Rural Opportunity, National Prosperity Strategy* (Government of Canada, 2024) aim to strengthen rural infrastructure and economic stability, indirectly improving conditions for mental health service delivery. Although the shifts represented in this literature show progress toward greater rural youth mental health accessibility, their successes may depend on sustained funding, culturally responsive training, and multilevel coordination across systems.

Efficacy of Rural Service Modalities for Youths

Understanding the effectiveness of various mental health service modalities for rural Canadian youth requires examination of accessibility, relevance, and sustainability. The literature demonstrates that while multiple approaches have been implemented to bridge service gaps, their success is contingent upon consistent quality and integration across systems to avoid systemic barriers (Moroz et al., 2020; Read et al., 2023). Each modality has unique strengths, yet all face limitations when confronted with geographic, economic, and cultural realities of rural Canadian communities.

Several modalities have the ability to provide early intervention: community-based supports, walk-in therapy, telehealth services, and primary and emergent care (Arruda et al., 2023; Malla et al., 2019; Myers, 2019; Read et al., 2023). Telehealth provides flexibility as well, allowing youth to choose between video-calling, text-based programs, or even social media type supports (Hilty et al., 2020; Mushquash et al., 2024). Telehealth also expands the diversity of available practitioners, allowing for greater cultural matching between youth and therapists,

which can foster better therapeutic outcomes and increased well-being (Gower et al., 2021). Further, telehealth may reduce geographical isolation and reduces reliance on the already diminished number of mental health practitioners available in rural Canadian communities by allowing youths to access supports outside of their community, without having to be restricted by travel barriers (Church et al., 2020).

Research suggests that local community and peer support programs are more likely to be trusted among youth (Halsall et al., 2021). Community programs operate within the community, so often reduce transportation barriers and stigma by situating the youth within familiar and trusted environments (Malla et al., 2019). Further, community-integrated models work to increase long-term engagement and foster a sense of agency among youth (Ferris-Day et al., 2021; Halsall et al., 2021).

As economic factors work to reduce access for many rural Canadians, primary and emergent healthcare models, and some community-funded models, reduce the financial burden placed on the individual (Arruda et al., 2023; Malla et al., 2019). Further, these models may also provide individuals a gateway into specialized supports through referral networks, due to their integrative nature (CIHI, 2024b; Malla et al., 2019).

Despite these strengths, several persistent challenges limit the efficacy and equity of rural mental health services. Walk-in and community-based programs often vary widely in structure, staffing, and clinical approaches across provinces and territories (Read et al., 2023). The absence of standardized outcome measures and national guidelines also make it difficult to evaluate program effectiveness and ensure equitable service quality for youth. Inconsistency can lead to confusion among potential service users about what is available and how to access care (Hagen et al., 2022; Read et al., 2023).

While telehealth may address geographical barriers, it is not universally accessible. Many rural areas lack reliable internet and cellular coverage, particularly in northern and remote communities (Hilty et al., 2020). Furthermore, adequate technology for telehealth can be expensive, and some families may be unable to afford the technology required (Hilty et al., 2020). Confidentiality of telehealth remains a significant concern as well, as individuals in shared living spaces may not be able to access somewhere safe and confidential to attend telehealth sessions (CPA, 2023; Friesen, 2019).

Another critical limitation involves treatment models that fail to reflect cultural values, traditions, and lived experiences of rural youth, particularly Indigenous and LGBTQ+ individuals (Faber et al., 2023; Gower et al., 2021). When mental health supports neglect cultural context or use language that lacks resonance with the individual's worldview, trust in the support can deteriorate (Tranchese & Suguira, 2021). Furthermore, lack of culturally competent providers in rural areas further compounds accessibility issues and perpetuates systemic exclusion from care (Tranchese & Suguira, 2021).

Overall, the efficacy of rural mental health modalities depends on how well they respond to the unique geographical, structural, and cultural variables that shape rural life. Programs that work within the community infrastructure show the greatest promise by addressing several barriers in Broffenbrenner's (1977) ecological model. These programs, however, require stable funding, evaluation, and cultural adaptability to ensure long-term impact.

Limitations of this Study

Several limitations must be acknowledged to contextualize the findings and scope of this capstone. While the literature reviewed provides valuable insight, the evidence base may be

uneven. These limitations relate to the availability and scope of the existing research, and the applicability of the chosen theoretical framework.

A notable limitation of this capstone lies in its focus and scope, as this capstone focused on rural Canadian youth within a current context. As such, available research was limited due to the requirement that reviewed literature must have been published within the last 5–7 years. Further, the availability of the research was limited by focusing on rural Canadian youth within this timeframe. As a result, many of the studies that do focus on this population within this timeframe rely on qualitative or small-sample methodologies. While rich in contextual depth, this does limit generalizability. To add depth to this capstone, several articles were chosen that matched several of the criteria, but not all. For example, some articles focused on rural Canadians and mental health accessibility, but were not specific to youth, or were specific to rural youth and mental health accessibility, but not specific to the Canadian context.

Another limitation involves the use of Bronfenbrenner's (1977) ecological model as the primary theoretical framework. Due to the model's age and the emergence of virtual communication, teletherapy, and globalized social media networks, there are complex social factors not originally accounted for in Bronfenbrenner's original formulation. For instance, the concept of the microsystem in contemporary youth life now extends into virtual spaces, where online communities and digital interaction may hold equal influence to in-person social networks. Despite these limitations, recent research supports the model's continued relevance in explaining developmental processes and recovery trajectories among youth (Kelly & Coughlan, 2019). Thus, while adaptations are required to address modern technological and global dynamics, the ecological framework still provides a valuable lens for conceptualizing systemic interactions that affect mental health access.

Another constraint pertains to the uneven distribution of research across Canada's geographic regions and youth demographics. Much of the literature focuses on more densely populated areas, leaving northern and remote communities, particularly those with larger Indigenous populations, underrepresented (Kumar & Tjepkema, 2019; Mushquash et al., 2024). As a result, this capstone may not fully capture the nuanced intersection of geographic isolation, colonial legacies, and cultural determinants that shape mental health experiences in northern Canada. Additionally, most studies aggregate data across youth age ranges, making it difficult to distinguish between the unique developmental needs of adolescents as compared to emerging adults (Church et al., 2020; Radez et al., 2021). This categorization may obscure differences in service utilization patterns and overall accessibility.

Finally, limitations exist regarding the evaluation and integration of mental health service accessibility outcomes. The literature reveals a lack of standardized outcome measures across programs and geographic areas (Read et al., 2023). As a result, the long-term effects of accessibility barriers on youths' well-being, such as sustained engagement, relapse prevention, or psychosocial development, remain difficult to ascertain. This restricts the ability to draw definitive conclusions about which interventions yield the most improvements in mental health outcomes for rural Canadian youth in regard to barrier reduction.

In summary, while this capstone contributes to an evolving understanding of rural mental health accessibility for Canadian youth, its findings must be interpreted within the context of these limitations. The restricted scope of current Canadian and youth-specific research and the nature of the theoretical framework highlight the need for continued investigation in rural, culturally grounded, and longitudinal approaches to youth mental health.

Practical Application: A Telehealth Framework for Rural Canadian Youth

Improving access to mental health services for rural Canadian youth should address the barriers discussed in this capstone: geographical, structural, systemic, and sociocultural. Research consistently demonstrated that rural Canada faces providers shortages, transportation challenges, confidentiality concerns, cultural mismatch, and stigma-related hesitancy when seeking care (CIHI, 2021; Church et al., 2020; Ferris-Day et al., 2021; Hagen et al., 2022; Moroz et al., 2020). Telehealth-based interventions offer a viable service model for reducing these barriers, by negating the need for travel, increasing the number of available practitioners rather than restricting the individual to practitioners within their local area, decreasing costs associated with travel, and increasing anonymity through allowing individuals to access mental health care from their own trusted locations (Hilty et al., 2020; Mushquash et al., 2024; Myers, 2019). Despite these strengths, a telehealth framework that addresses all accessibility concerns for rural Canadian youths will also need to ensure it can match culturally appropriate practitioners to youths, address confidentiality concerns, and maintain confidentiality. As such, the proposed telehealth framework includes three components: tiered digital access points, culturally responsive provider matching through ethical intake sessions, and community-embedded telehealth hubs, all of which should be grounded in ethical practice, system-level advocacy, and the reduction of stigma.

First, a tiered access model for telehealth provides graduated levels of intervention, to best match youth needs at the time care is accessed. The first tier is more general, focusing on distribution of psychoeducation and a peer support online moderated forum, providing access that is cost-effective and can be available on a large scale. As Canadian youth often cite how they lack knowledge of mental health and thus delay seeking out help, the focus on this tier is

increasing knowledge of mental health concerns and supports (Radez et al., 2021). Further, this tier aims to facilitate early intervention. Research has demonstrated that early intervention models improve outcomes when youth can access adequate care without prolonged wait times (Kingsbury & Arim, 2023; Malla et al., 2019). The second tier should include more in-depth treatment, of brief virtual intake meetings, which can be done via text, call, or video call, in order to triage the youth and match them with a culturally competent provider. A variety of communication methods provide youth with choice and greater agency, and through this, may reduce confidentiality barriers (Friesen, 2019). Further, by making intakes a part of the model, culturally competent matches can be made, which increases youth engagement with therapy, and allows for better outcomes (Gower et al., 2021). The third tier should provide more in-depth video-based therapy provided by registered practitioners once individuals have been matched with a practitioner that meets their needs and has adequate knowledge of the client's culture.

Secondly, telehealth enables expanded practitioner diversity and identity-based matching, which is associated with stronger therapeutic alliance and improved engagement (Gower et al., 2021). Rural youth, particular those who belong to marginalized communities such as LGBTQ+, are Indigenous or members of other ethnocultural minorities, report difficulty accessing culturally safe services within their local communities (Gower et al., 2021; Kingsbury & Arim, 2023; Tranchese & Suguira, 2021). By removing geographical restrictions, telehealth increases opportunities for culturally responsive care and reduces barriers related to disengagement. As such, this proposed telehealth model for rural Canadian youth should seek to employ a diverse group of practitioners to meet the needs of the diversity within rural Canada's youth population.

Third, although telehealth reduces travel requirements, rural broadband instability and lack of private space remain barriers (CPA, 2023). Embedding telehealth access points within

school, primary care clinics, and community youth organizations may mitigate these barriers. Canada's ACCESS 24/7 program uses a similar integrated model to provide care that connects with local hubs, often within medical settings, which has shown to aid in accessibility (Malla et al., 2019). School-based collaboration has been shown to strengthen early identification and increase service uptake, youth engagement, and therapeutic alliance (Church et al., 2020; Dove & Costello, 2017; Read et al., 2023).

Ethical teletherapy practice remains central to this framework. The *Canadian Code of Ethics for Psychologists* (CPA, 2017) emphases respect for dignity, responsible caring, integrity, and responsibility to society. Telehealth can mitigate dual relationship risks common in small communities by allowing youth access to providers outside of their immediate social networks (Hagen et al., 2022). However, practitioners must ensure informed consent processes address privacy limitations, digital security, and emergency response planning specific to rural settings. Further, the fourth principle within the *Canadian Code of Ethics for Psychologists* ascertains that Canadian psychologists should "have responsibilities to the societies in which they live or work and to the welfare of all human beings in those societies" (CPA, 2017, p. 31). As such, providers must maintain knowledge of the communities their clients are located within, even if the provider does not live there themselves. Ethical teletherapy also requires transparency regarding technological risks, though practitioners must make efforts to secure data and use the Canadian Personal Information Protection and Electronic Documents Act compliant software when meeting with clients (CPA, 2023).

Advocacy is also embedded within this telehealth model at the practitioner level. Clinicians have an ethical obligation to promote equitable access to care, and by providing virtual services to rural Canadian youth, are promoting greater accessibility of care (CPA, 2017).

Within this framework, advocacy may also include supporting rural broadband expansion, interprovincial licensure flexibility, and equitable funding models for telehealth, as well as school-based telehealth partnerships. Rather than functioning solely at the clinical level, advocacy can then branch into facilitating structural change and reduce systemic inequities that limit access.

Stigma reduction should also be integrated into this telehealth model. Rural communities often value self-reliance and social visibility, contributing to fears of gossip, judgement, and reputational harm (Ferris-Day et al., 2021; Hagen et al., 2022). This telehealth model offers discreet access to services through video, text-based, and digital forums. When confidentiality improves, rural Canadian youth experience less fear when seeking or accessing mental health supports (Friesen, 2019). Digital psychoeducation can further mental health discussions and improve mental health literacy, reducing further stigma and misinformation regarding mental health concerns (Church et al., 2020; Read et al., 2023). Practitioners using this proposed telehealth framework should also take care to use nonjudgemental and culturally responsive language to further prevent reinforcement of stigma-based narratives (Gower et al., 2021).

If implemented effectively, this integrated telehealth framework may increase service utilization among rural Canadian youth by reducing travel burdens, expanding provider availability, and strengthening cultural matching (CIHI, 2024c; Gower et al., 2021; Hagen et al., 2022). Increased modality flexibility may improve engagement, particularly among youth hesitant to seek in-person services (Hilty et al., 2020). Early identification through school and primary care partnerships may also improve continuity of care and reduce escalation to crisis services (Dove & Costello, 2017; Malla et al., 2019). Collectively, these elements support improved accessibility, engagement, and potentially stronger treatment outcomes.

Despite these proposed successes, however, telehealth remains a partial solution. Persistent digital inequities, inconsistent broadband access, limited private space, and technological literacy challenges may restrict equitable participation (CIHI, 2021; Friesen, 2019). Telehealth does not eliminate broader structural determinants such as poverty or community-level stigma. Some youth may experience difficulty forming therapeutic alliance virtually, and interjurisdictional regulatory barriers may limit cross-provincial service delivery. Additionally, telehealth cannot replace culturally grounded, land-based, or in-person healing approaches valued within some Indigenous communities (Mushquash et al., 2024).

Reflections on Personal Learning

Engaging in this capstone has contributed significantly to my professional development, particularly in deepening my understanding of the systemic inequities that shape mental health access for rural Canadian youth. Through analyzing barriers across Bronfenbrenner's (1977) ecological levels, I gained a clearer appreciation of how entrenched these accessibility challenges are and how they interact across micro-, meso-, exo-, macro-, and chronosystem domains. This recognition highlights that meaningful improvements in accessibility require multifaceted, coordinated responses rather than isolated, individual-level interventions. As a mental health practitioner, this understanding reinforces the importance of engaging not only in direct client work but also in broader forms of advocacy, community collaboration, and systemic support. Such an approach aligns closely with the values and responsibilities outlined in the *Canadian Code of Ethics for Psychologists* (CPA, 2017), particularly those related to Responsible Caring and Responsibility to Society.

This project also encouraged me to reflect on my positionality. Growing up in a rural environment has provided me with personal insight into the cultural norms, community values,

and structural limitations that influence mental health experiences in these settings. However, this capstone expanded that understanding by demonstrating the diversity that exists across rural Canadian contexts. Although rural communities share many overarching challenges, each locale possesses unique cultural, geographic, and structural characteristics that shape youth experiences differently. Recognizing this variation has strengthened my awareness of how cultural humility and context-sensitive practice are essential components of ethical and effective mental health care.

Finally, the work completed in this capstone has underscored the value of integrating ecological awareness into my future clinical practice. Understanding mental health through a systemic lens enhances my ability to provide holistic, client-centered care that considers the full complexity of the environments in which youth live. Incorporating ecological principles into assessment, treatment planning, and advocacy will support more responsive and sustainable therapeutic interventions.

Conclusion

This capstone demonstrates that barriers to mental health service access for rural Canadian youth are multifaceted and interconnected across ecological systems. As such, this capstone examined themes of structural, geographical, and sociocultural barriers rural Canadian youth face when accessing care that is prevalent within the existing literature. Further, this capstone explores how telehealth-based interventions may help reduce these inequities. The literature demonstrates that rural youth experience disproportionate challenges related to geographic isolation, practitioner shortages, stigma, confidentiality concerns, and limited culturally responsive services (CIHI, 2021; Church et al., 2020; Hagen et al., 2022; Moroz et al.,

2020). These barriers are not isolated but interconnected, operating across systemic levels and contributing to delayed or foregone care.

In response, this capstone proposed an ethically grounded, advocacy-oriented telehealth framework that integrates stepped-care digital access, culturally responsive provider matching, and community-embedded telehealth hubs. When implemented intentionally, telehealth has the capacity to reduce travel burdens, expand practitioner diversity, mitigate dual relationship concerns, and provide discreet access points that may lessen stigma-related hesitancy (Gower et al., 2021; Hilty et al., 2020; Mushquash et al., 2024). However, telehealth is not a comprehensive solution. Persistent digital inequities, regulatory constraints, and broader social determinants of health continue to shape access to care. As such, telehealth should be understood as one component within a broader system-level reform of rural mental health services.

Despite enduring barriers, the future of mental health service accessibility for rural Canadian youth shows that recent innovations are providing ways of mitigating these barriers and increasing overall accessibility for youth. Technological advancements, such as telehealth platforms, social media, and wellness apps, offer new avenues for early intervention and support (Mushquash et al., 2024; Myers, 2019). These tools have the ability to reduce geographical barriers of travel burdens and increase anonymity, which are both advantages for rural youth facing stigma or limited transportation options (Hilty et al., 2020). Shifting generational attitudes also contribute greater openness toward discussing mental health, which may help reduce community stigma over time (Church et al., 2020; Knight & Winterbotham, 2020). Community-based programs such as ACCESS Open Minds further illustrate how integrated models can meaningfully enhance early engagement and intervention (Malla et al., 2019). Policy developments also signal growing recognition of rural disparities. Federal initiatives aimed at

improving rural infrastructure and economics lay the groundwork for sustainable mental health services in rural Canada (Government of Canada, 2024). Overall, a more equitable future for rural Canadian youth depends on multilevel collaboration across ecological systems, from individual efforts to systemic policy reform. By aligning technical advancements, cultural change and community engagement, rural Canada can shift toward a model of mental health care that meets the needs of youth regardless of their level of rurality.

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