

Parents' expected barriers to psychosocial care for children with complex problems

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Funding information

ZonMw, Grant/Award Number: 15901.0005

Abstract

Background and objective: Even though children with complex problems frequently need psychosocial care, two thirds does not receive treatment. Various barriers, particularly expectations of barriers, can hinder effective access of care. Our aim was to assess the practical barriers expected by parents, and the child, family and need factors associated with these expected barriers.

Methods: We sent web-based questionnaires to parents of a random sample of children known to have or be at risk of having complex problems (response = 77%). We used backward regression analyses to examine which factors were associated with expected barriers for children using psychosocial care, or no care at all.

Results: Seventy-three percent of all parents expected practical barriers. Parents of children using psychosocial care expected more barriers than when using no care at all. For children who used no care, parents of girls expected more barriers (regression coefficient 0.54; 95%—confidence interval 0.16, 0.92) as did families having less social support (−0.30; −0.50, −0.11). When children used psychosocial care, parents expected more barriers when their child was of school-age (0.38; 0.01, 0.75), of non-western origin (vs. native) (0.52; 0.17, 0.88), when parents were older (i.e., 36+ years) (−0.77; −1.12, −0.42), experienced more adverse life events (0.29; 0.13, 0.45) or had less social support (−0.17; −0.34, 0.00).

Conclusion: Even when their child is already receiving treatment, parents continue to expect practical barriers to psychosocial care. Psychosocial care services and their gatekeepers should address these concerns. Access to psychosocial care can be improved by removing practical barriers, especially if children already receive psychosocial care, or when parents have a limited network or belong to an ethnic minority.

KEYWORDS

access to care, general practice; barriers to care; mental health services

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1 | INTRODUCTION

Children with complex problems, who have a mix of chronic physical, developmental, behavioural or emotional disorders, typically have a great need for psychosocial care services, because their interacting problems enhance vulnerability (Denholm et al., 2013; Goerge & Wiegand, 2019; Lucas et al., 2008; Stith et al., 2009; Tausendfreund et al., 2016; Visscher et al., 2022). These children need the support of different professionals to meet their demands in various areas of their lives. On top of this, their parents or other siblings often need support because of health or psychosocial problems. In Western countries the proportion of families having a child with complex problems is estimated 5%. Moreover, the population of children at risk for complex problems is estimated 10% of the families in the general population (Goerge et al., 2010; Morris, 2013; Van den Berg & De Baat, 2012). Children with complex problems run a high risk of poor mother-child attachment and of developing behavioural and emotional problems (Denholm et al., 2013; Lucas et al., 2008; Stith et al., 2009). Unfortunately, only about one-third of children known or suspected to be at risk of complex problems successfully enrol in psychosocial care (Girio-Herrera et al., 2013; Owens et al., 2002). These services have a need for more insight into barriers for treatment to improve the children's enrollment in order to help these children and their families.

Theories on access to care and help seeking behaviour describe the process before a child receives treatment, in which parents have to recognize their child's problems, decide to seek help and select and reach the right service (Eiraldi et al., 2006; Levesque et al., 2013). In this process, gatekeepers of psychosocial services, such as preventive child health care, local social teams and family practitioners, play a vital part in supporting parents to go through the stages of help seeking. We elaborate on the local context of The Netherlands in the Method section. Psychosocial care services and their gatekeepers need more insight into the barriers in all stages of help seeking to improve the referral of children and their families in need of help (Nanninga, Reijneveld, et al., 2016). Literature shows that child and family characteristics like ethnicity, family socioeconomic status, enabling factors like social support, and need for care impact the likelihood that parents will access treatment for these children (Andersen & Newman, 1973; Nanninga et al., 2018; Nanninga, Reijneveld, et al., 2016; O'Brien et al., 2016; Pannebakker et al., 2018; Pletcher et al., 2010; Radez et al., 2021; Roberts & Bernard, 2012; Verhulst & Van Der Ende, 1997; Zuckerman et al., 2013). Nonnative families, families with a lower socioeconomic status and families with low social support are less likely to access treatment.

Roughly half of parents who decided that their child should get help by psychosocial care services experience some type of barrier (Sayal et al., 2010; Kazdin et al., 1997; Kazdin & McWhinney, 2018; Kazdin & Wassell, 2000). Building on the earlier work on barriers to treatment model by Kazdin, a well-used way to cluster these barriers regards a categorization into (Charest-Belzile et al., 2020; Hurley et al., 2020; Nanninga, Jansen, et al., 2016, 2018; Reardon et al., 2017, 2020; Walz et al., 2019): (1) Barriers related to perceptions about psychosocial problems, such as parental denial of the

severity of the problems and perceived irrelevance of the treatment; (2) barriers related to perceptions about treatment and service providers, such as a possible problematic relationship with the therapist or stigma related to receiving help; (3) practical barriers caused by family circumstances or the health system, that is, logistic obstacles like transportation problems or inconvenient services. A recent national survey of Australian children between the age 4 and 12 years showed that the commonly reported barriers by parents reflected this typology (Schnyder et al., 2020). In this paper we focus on practical barriers to care such as transportation or arranging a babysitter because they need the attention of the parents, irrespective of whether they have already entered the care system or not. These barriers need to be solved, with or without assistance of the parents' social network or psychosocial care services and their gatekeepers (Reardon et al., 2020; Schnyder et al., 2020). Lowering or removing the other two types of barriers related to perceptions about psychosocial problems or about treatment and service providers, will need extensive interference of professionals. We therefore focused on perceived practical barriers to be solved primarily by the parents.

Research on practical barriers to care usually focuses on barriers actually experienced by children already using care services. A gap exists in information about perceptions of parents of children in the community who are not in care, possibly because of anticipated insurmountable barriers (Reardon et al., 2017). Our study adds to the knowledge on the differences in expected barriers between children known to have or be at risk for complex problems using psychosocial care, those using other types of treatment, or those using no care at all during the past 6 months. The aim of our current study is to assess: 1. the expected practical barriers to psychosocial care for all three subgroups, and 2. the child and family factors associated with expected barriers for children using psychosocial care or no care at all. Families with children with complex problems are often in demanding circumstances, so we hypothesize that they especially expect barriers to meet the added demands of visiting services for treatment. We thus anticipate that parental expectations of barriers to care are more frequent for the subgroups of children who have experience in using care than for the group who does not use care. Furthermore, we foresee that expectancies of barriers impacting psychosocial care use will be in line with earlier research on actual experienced barriers. These are associated with family and child factors like socioeconomic status, enabling factors like social support, and need factors like parenting concerns. The insights of our study can benefit access to psychosocial care.

2 | METHODS

We performed a cross-sectional study, embedded in a longitudinal study on children known to have or be at risk for complex problems, and their parents, living in an urban setting in the Netherlands (Pannebakker et al., 2018, 2019). We were particularly interested in how background, enabling and need factors impact their care use. This study consisted of two waves, the first in 2013 and the second 12 months later. In the second wave we focused on the practical

barriers to care which formed the basis of this paper. The study was conducted according to the Helsinki regulation; the Medical Ethics Committee of Leiden University have confirmed that Dutch law requires no further assessment for this study (C12.041).

2.1 | Setting

In the current care system for children and adolescents in the Netherlands, access to care is organized via roughly three gatekeepers to care: (1) preventive child health care or well-child clinics, (2) local social teams and (3) family practitioners. These gatekeepers provide primary care to children with mild psychosocial problems. In case of more severe problems, they refer children to specialist care. Children with psychosocial problems are referred to child and adolescent mental health or social care, entailing psychologists, psychiatrists and specialist social workers as main professionals. Underlying economic and social problems like poverty or housing problems are dealt with by municipality services community care as provided sometime directly connected to local social teams. Children with physical health problems are referred to hospital-based care. Most services are financed by the local government, but the general practitioner and hospital-based care are financed by health care insurance companies.

The data for this study have been collected before a reform of psychosocial services in 2015; before that reform, psychosocial care was financed by more types of funders than currently (Ministry of youth and health care, 2023). The reform in particular aimed to limit increases in costs of that type of care, and to improve quality and efficiency. System challenges arising after this reform probably did create more practical barriers though, for example long waiting lists appeared which could have compelled parents to travel further for the first available treatment (Dutch institution for children and youth, 2023). Another challenge is the staff shortages in child care services, which could affect parent's possibilities to accommodate siblings when taking the child with CP to treatment.

2.2 | Sample and procedure

To obtain a wide range in use of care services we used two samples. First, we used a community sample of children with complex problems or at risk of developing them, using or not using care in the past 6 months, and identified during well-child visits ($n = 239$). In the Netherlands these well-child visits are provided by well-child clinics and have a high attendance rate of 95% (CBS Statistics Netherlands, 2014). We secondly used a sample of children with complex problems ($n = 33$) who were using care with high intensity. This sample consisted of children enrolled in specialized ambulatory child and family services, that is, care to which they were referred by primary care. Almost all respondents met three or more inclusion criteria (97%), that is, were parents of a child with complex problems or at risk of developing them.

Families with children between 18 months and 12 years were included if they met at least two of the following inclusion criteria:

(1) Elevated total score on the parent-reported Strengths and Difficulties Questionnaire (SDQ) or Brief Infant Toddler Social Emotional Assessment (BITSEA) (Briggs-Gowan et al., 2004; Goodman, 1997); (2) one or more major adverse life events during the past year assessed using the standard screening questionnaire of the well-child clinics; and (3) care utilization by the child or parent in the past 6 months. For the community sample a fourth criterium was added: persistent parenting concerns reported by the well-child care worker and/or parents. For both samples, the inclusion procedure consisted of two steps: (1) The nurse, doctor or social worker identified parents based on the inclusion criteria that were part of their standard screening questionnaire. When they met the criteria, they were provided oral and written information about the study, and the parents were asked permission to be called by a research assistant. (2) The research assistant asked informed consent for participation in the study.

A total of 272 parents who participated in the second wave of a cohort study into use of care by children at risk for complex problems were asked to fill in questions on barriers (response = 76.8%). Data were collected in a digital questionnaire, although parents could also opt to be interviewed by trained research assistants by telephone in the language of their preference. Parents were reminded three times to fill in this questionnaire and received a gift certificate of 20 euros when they did. The informed consent procedure was carried out carefully, with oral as well as written information and formal informed consent. Participants could opt out at any moment. Parents who dropped out were significantly more often parents of sons, more often of non-western origin, and more often from a neighbourhood with a lower socio-economic status (Sociaal Cultureel Planbureau, 2015).

2.3 | Measures

We assessed the level of barriers expected by parents by using the subscale 'stressors and obstacles that compete with treatment' from the questionnaire Barriers to Treatment Participation Scale- Expectancies (Nanninga, Reijneveld, et al., 2016). This questionnaire was developed in several focus groups of therapists. This resulted in a shortlist of relevant barriers. Parents then selected the most relevant barriers by using parent report questionnaires (Kazdin et al., 1997; Nanninga, Reijneveld, et al., 2016). This led to a shortlist of relevant barriers that were included in the parent report subscale we used in our study. Examples of items are 'We do not have transportation (car, truck, taxi) to travel to treatment' and 'Getting a babysitter so I can come to treatment with my child will be a problem' (See Table 1 for an overview of all items). The questionnaire does not allow to list other expected stressors or obstacles that compete with treatment. The Scores were on a five-point Likert scale. They were added into a total score of the level of expected barriers (Cronbach's $\alpha = 0.89$).

Children's service use in the past 6 months was measured with the Questionnaire Intensive Care for Youth, a questionnaire measuring use of a pre-set list of types of Dutch services (Bouwmans et al.,

TABLE 1 Background characteristics of the overall sample, and of children using no care, other types of care, and psychosocial care (with or without other types of care).

	Total N (%)	No care use n (%)	Other types of care n (%) [^]	Psychosocial care n (%) [^]
Total	266 (100)	89 (33.5)	53 (19.9)	124 (46.6)
Predisposing factors				
Child's gender				
Boy	150 (56.4)	50 (56.2)	28 (52.8)	72 (58.1)
Girl	116 (43.6)	39 (43.8)	25 (47.2)	52 (41.9)
Child's age				
Pre-school	104 (39.1)	37 (41.6)	30 (55.6)	37 (29.8)
School-aged	162 (60.9)	52 (58.4)	24 (43.4)	87 (70.2)
Child's ethnicity				
Native	154 (58.3)	49 (55.7)	31 (58.5)	74 (60.2)
Non-native: Western	23 (8.7)	8 (9.1)	5 (9.4)	10 (8.1)
Non-native: non-Western	87 (33.0)	31 (35.2)	17 (32.1)	39 (31.7)
Parental gender				
Man	26 (9.8)	6 (6.8)	6 (11.3)	14 (11.4)
Woman	238 (90.2)	82 (93.2)	47 (88.7)	109 (88.6)
Parental age				
<36 years	115 (43.7)	43 (49.4)	20 (37.7)	52 (42.3)
≥36 years	148 (56.3)	46 (50.6)	33 (62.3)	71 (57.7)
Parental education				
Low/medium	135 (51.1)	46 (51.7)	20 (37.7)	69 (56.6)
High	129 (48.9)	43 (48.3)	33 (62.3)	53 (43.4)
Family composition				
Two-parent family	131 (50.0)	45 (50.6)	34 (64.2)	52 (43.3)
One-parent family	108 (41.2)	35 (39.3)	19 (35.8)	54 (45)
Other	23 (8.8)	9 (10.1)	0 (0)	14 (11.7)
Mental health of the parents, mean (SD)	1.9 (2.7)	1.6 (2.6)	1.5 (2.4)	2.2 (2.9)
Number of life events, mean (SD)	2.5 (2.2)	2.2 (2.1)	2.0 (2.0)	2.9 (2.3)
Enabling factors				
Social support partner, mean (SD)	9.6 (5.8)	10.5 (5.5)	10.5 (5.2)	8.6 (6.0)
Social support family/friends, mean (SD)	38.3 (7.8)	38.8 (7.2)	39.4 (7.3)	37.6 (8.4)
Care parent				
Yes	120 (45.1)	24 (27.0)	24 (45.3)	72 (58.1)
No	146 (54.9)	65 (73.0)	29 (54.7)	52 (41.9)
Need factors				
Chronic condition				
No/low impact	207 (77.8)	81 (91.0)	41 (77.4)	85 (68.5)
Yes, high impact	59 (22.2)	8 (9.0)	12 (22.6)	39 (31.5)
Psychosocial problems				
Yes	108 (41.5)	21 (24.7)	17 (32.1)	70 (57.4)
No	152 (58.5)	64 (75.3)	36 (67.9)	52 (42.6)
Parenting concerns, mean (SD)	3.8 (2.9)	2.7 (2.7)	3.2 (2.7)	4.9 (2.8)

Note: This study is part of a longitudinal cohort study. Background characteristics were measured at first wave (2013); other factors measured at T2 1 year later (2014). Values expressed as n (%) or mean (SD).

2012; Jansen et al., 2013). This list has been adapted to the setting of care for youth from the valid and reliable Questionnaire for costs associated with psychiatric illnesses and care use (TIC-P) (Bouwman et al., 2012; Jansen et al., 2013). We adapted this listing of types of psychosocial care services to our target population by using the names of well-known local psychosocial care services, which this standard questionnaire allows for. We also left out items that were not relevant for our population, such as adult care services. Moreover, respondents had the opportunity to add services we did not list. Services are defined as any care provider or group of care providers. We identified three subgroups of respondents based on their use of care: (1) Children who used no care during the past 6 months; (2) children who used psychosocial care during the past 6 months (care delivered by a developmental-behavioural paediatrician, child psychiatrist, child and family services, or school social services); and (3) children who used other types of care during the past 6 months (i.e., not psychosocial care, but care from the [para] medical domain, such as medical specialist or physiotherapist). If children used both 'psychosocial care' as 'other care', they were assigned to the 'psychosocial care' group.

We used validated questionnaires if available and assessed their reliability in the sample under study. We assessed determinants of use of care based on Andersen and Newman's behavioural-health model of access to care, consisting of predisposing, enabling and need factors (Andersen & Newman, 1973). This comprehensive model addresses the intrapersonal and environmental factors explaining an individual's/population's use of care. In the newest version of this model, expectations of barriers to care are also stressed as enabling factors that can impact care use for their child (Andersen & Newman, 2008; Babitsch et al., 2012). We followed the classification of the major components predisposing, enabling and need factors using the systematic review of Babitsch et al. (2012). Predisposing factors involved the child's age and gender, parental age and gender, the child's ethnicity, parents' educational level, family composition, and adverse life events they had experienced. Child's age was specified as pre-school: 15–47 months, and school-aged: 4–12 years. Child's ethnicity was specified as (1) native; (2) non-native: Western: children of parents originating from an industrialized country resembling the Dutch population in socio-economic and socio-cultural position; and (3) non-native: non-Western: children of parents originating from other countries (Wingerd, 2013). Parents' educational level was specified in three categories: (1) low level: no primary or lower secondary education; (2) average level: upper secondary education or post-secondary non-tertiary education; and (3) high level: tertiary education. Life events such as unemployment or loss of a loved one in the past 12 months were measured on the life-events scale of the Brief Instrument Psychological and Pedagogical Problem Inventory or KIPPPI (Cronbach's $\alpha = 0.79$) (De Wolff et al., 2013). An example of a question is 'Did you suffer the loss of a family member or loved one?'

Enabling factors included social support and use of care by another family member. To measure social support we used the

subscale 'social functioning of the family' from the Dutch Family questionnaire (Cronbach's $\alpha = 0.91$) (Wingerd, 2013). An example of a statement used in this questionnaire is 'We can count on our neighbors if we need help'. Parental care use was also based on the TIC-P (Jansen et al., 2013).

Need factors included a child's chronic condition, emotional and behavioural problems, parenting concerns, and parents' assessment of problems in their relationship with their child. Questions measuring a child's chronic health were as follows. 'Does your child suffer from one or more chronic health conditions—such as asthma, diabetes, ADHD or autism—for which treatment is or has been needed? What is the impact of this condition on your child's daily life?' (Wingerd, 2013). We measured child behavioural and emotional problems using the BITSEA for children from 18 months to 3 years and the SDQ for children from 3 to 12 years (Briggs-Gowan et al., 2004; Goodman, 1997). An example of a statement of the BITSAE is 'my child obeys rules'. An example of the SDQ 'my child often has temper tantrums'. The validated Dutch versions of both were found to be reliable (Kruizinga et al., 2012; Theunissen et al., 2013). Cronbach's α 's as measured in this study were for the SDQ 0.74 and for the two BITSAE subscales 0.67 and 0.80. We measured parenting concerns using the following question: 'Did you have concerns about your parenting during the past 12 months?' (Reijneveld et al., 2008). Finally, the parental assessment of their relationship with the child was measured using the validated Dutch Parenting Load Questionnaire (Cronbach's $\alpha = 0.83$) (Vermulst et al., 2012). An example of a used statement is: 'I feel happy when my child is near me'.

2.4 | Analysis

First, we described the background characteristics of the respondents and their association with care use for the total population and three subgroups: (1) 'No-care group': children who use no care during the past 6 months; (2) 'Psychosocial care group': children who used psychosocial care during the past 6 months; and (3) 'Other-care group': children who used other types of care during the past 6 months. If children used both 'psychosocial care' and 'other care', they were assigned to the 'psychosocial care' group. Second, for the three subgroups, we assessed the expected practical barriers to care. Third, for the subgroups 'no care' and 'psychosocial care' we assessed the associations of predisposing, enabling or need factors with the sum score of the number of expected practical barriers to care, using univariate and multiple regression analyses. From these analyses we excluded parents of children using other types of care because of small numbers. In the multiple regression analyses we used stepwise backward selection procedures on factors that were univariately related to barriers to care within the subgroups at $p < 0.10$, using as criterion a p -value < 0.10 to retain variables. All statistical analyses were performed in SPSS version 20.0 for Windows (IBM corp., 2011).

3 | RESULTS

3.1 | Background characteristics of respondents

Half of the children had used psychosocial care, one-fifth another type of care, and one-third no care at all during the past 6 months (see Table 1). Children using psychosocial care differed from the other groups of children on several predisposing, enabling and need factors. In line with our expectations, children in psychosocial care were more often affected by their chronic conditions, had more often psychosocial problems, and had more parenting concerns than children using other types of care or no care at all.

3.2 | Expected practical barriers to care

Of all parents, 63% expected one or more practical barriers to psychosocial care (see Table 2). The two most frequently expected barriers were (1) 'My time is limited: I will not have time for the assigned work', and (2) 'Scheduling appointment times for treatment would be difficult'. Parents of children using psychosocial care expected significantly more barriers than parents of children using other types of care or no care at all. The expected barriers: 'Scheduling appointment times for treatment would be difficult', and 'Treatment will just add more stress to my life' occurred significantly more often in the group of parents of children using psychosocial care.

3.3 | Factors associated with expected barriers to care

For the associations of predisposing, enabling and need factors with expected barriers we focused on the two subgroups of children: those using psychosocial care, and those using no care at all (see Table 3). For both subgroups we found bivariate associations of predisposing, enabling and need factors with the number of expected barriers. When we used multiple regression analyses, however, need factors were not associated with the number of expected barriers. Parents of children using no care at all expected more barriers to care for their daughter, and more barriers when receiving less social support from their family and friends. Parents of children using psychosocial care expected more barriers to care when they themselves were younger, or when their child was school-aged or of non-native origin. These parents also experienced more adverse life events and received less social support from their family and friends.

4 | DISCUSSION

This study showed that three out of five parents expected practical barriers to psychosocial care. Parents of children using psychosocial care expected more barriers than parents with a child using other types of care or no care. The former especially expected more

problems with scheduling appointment times and managing the stress of treatment. Expected practical barriers to psychosocial care were associated with predisposing and enabling factors but not with need factors, regardless of whether a child used psychosocial care or no care at all.

We found a high prevalence of expected practical barriers among parents of children with or at risk of complex problems, even when already in treatment. This finding is in line with earlier studies (Hoagwood et al., 2000; Kerkorian et al., 2006; Nanninga, Reijneveld, et al., 2016; Radez et al., 2021; Schnyder et al., 2020). An explanation for this high prevalence may be that parents have trouble navigating within the health care system, for example, because of limited health literacy (Radez et al., 2021; Sanders et al., 2009; Visscher et al., 2022). Because interventions to improve health literacy skills for adults seeking mental health care have been shown to be effective, professionals need to pay more attention to such interventions (Frauenholtz et al., 2015; Hurley et al., 2020). A review by Hurley et al. (2020) shows parental health literacy interventions should best be provided to parents of children already receiving treatment (Cutler et al., 2018). For instance, local social teams and family practitioners who refer children to care systems support parents in improving their health literacy skills needed for the various stages of help seeking for their child. These parents of children already receiving treatment do not necessarily feel they will find their way to treatment a next time and will be able to continue to cope adequately with challenges caused by their child's use of care, such as time to care for the remaining children. Supporting care enrollment continues to require attention of gatekeepers even when parents already have experience navigating the health system, interventions to improve health literacy skills of parents could help.

This study showed that a child's age, gender, parental age, number of adverse life events and amount of social support by family and friends are associated with the number of expected barriers to psychosocial care. Previous research has shown these factors to be determinants of barriers already experienced by parents, and of actual use of psychosocial care by children with complex problems (Kazdin & Wassell, 2000; Verhulst & Van Der Ende, 1997). Expectations may thus be a good indicator of actual barriers to psychosocial care, implying that the worries and expectations of parents expressed to a gatekeeper to psychosocial care services are thus real concerns which should be addressed. This requires further study though. However, the current study does add several predisposing and enabling factors to the scarce body of knowledge on expectations about barriers to psychosocial care.

We found that parents with limited support of family and friends expected more practical barriers, both for children using psychosocial care or no care at all. More studies found a link between low social support and actual use of psychosocial care by children at risk for complex problems, indicating that expectations of practical barriers is only one piece of the puzzle in understanding successful care enrollment (Nanninga et al., 2015; Sanders et al., 2009). Need factors are known to be the most important drivers behind care enrolment, and thus outweigh the burden of expected practical barriers (Andersen,

TABLE 2 Expected practical barriers for all children, and for children using no care, other types of care or psychosocial care (with or without other types of care).

	All children N (%)	No care use n (%)	Other types of care n (%)	Psychosocial care n (%)
Total	266 (100)	89 (33.5)	53 (19.9)	124 (46.6)
0 barriers	100 (36.8)	41 (46.1)	23 (43.4)	34 (27.4)
1–4 barriers	89 (32.7)	23 (25.8)	15 (28.3)	49 (39.5)
More than four barriers	83 (30.5)	25 (28.1)	15 (28.3)	41 (33.1)*
We do not have transportation (car, truck, taxi) to travel to treatment	44 (16.6)	8 (9.1)	10 (18.9)	26 (21.0)
My child is involved in other activities (sports, clubs, music lessons) that would make it hard to come to a session	40 (15.0)	17 (19.1)	4 (7.5)	19 (15.3)
Scheduling appointment times for treatment would be difficult	67 (25.3)	16 (18.2)	11 (20.8)	40 (32.3)*
Treatment would conflict with other activities in which I am involved	53 (20.1)	13 (14.8)	10 (18.9)	30 (24.4)
I experience too much stress in my life to participate in treatment	44 (16.6)	11 (12.4)	9 (17.0)	24 (19.5)
My personal health problems or illness would stop me from getting treatment for him or her	37 (13.9)	12 (13.5)	7 (13.2)	18 (14.5)
My child's health problems or illness will stop me from getting treatment for him or her	28 (10.5)	8 (9.0)	6 (11.3)	14 (11.3)
Crises at home will get in the way	45 (16.9)	12 (13.5)	8 (15.1)	25 (20.2)
Treatment will just add more stress to my life	57 (21.4)	10 (11.2)	16 (30.2)	31 (25.0)*
Bad weather will prevent us from coming to treatment	37 (13.6)	11 (11.7)	5 (9.3)	21 (16.9)
My time is limited; I will not have time for the assigned work	68 (25.7)	24 (27.0)	12 (22.6)	32 (26.0)
My child will never be home long enough to do the homework assigned	35 (13.2)	12 (13.6)	4 (7.5)	19 (15.3)
Family health problems or illness in our home will stop me from getting treatment for my child	24 (9.1)	9 (10.1)	6 (11.5)	9 (7.3)
Getting a babysitter so I can come to treatment with my child will be a problem	65 (24.7)	19 (21.6)	12 (23.1)	34 (27.6)
Parking at the treatment agency will stop me from getting treatment for my child	39 (14.7)	16 (18.0)	8 (15.1)	15 (12.2)
Members of my family would stop me from getting treatment for my child or they would disagree with me about whether we should come to treatment at all	24 (9.0)	6 (6.7)	4 (7.5)	14 (11.3)
I am too tired after work to go to sessions	46 (17.3)	14 (15.7)	8 (15.1)	24 (19.4)
My job schedule is too hectic	58 (21.8)	22 (24.7)	12 (22.6)	24 (19.4)
Treatment would take time away from spending time with my children	52 (19.7)	16 (18.4)	10 (18.9)	26 (21.0)
I have trouble with other children at home, which would make it hard to come to treatment	40 (15.0)	11 (12.4)	9 (17.0)	20 (16.1)

Note: Values regard n (%). Chi-square tests were conducted to analyse differences between groups.

* $p < 0.05$.

2008; Babitsch et al., 2012). In turn, these need factors are also likely to add stress to families in need leading to more expected barriers (Andersen, 2008; Eiraldi et al., 2006; Levesque et al., 2013). Such social support may thus continue be a factor in accessing care, for example, regarding the provision of help with transportation, or care for other children while the parent visits the care provider. A proper inventory of supportive resources available to a parent may thus be key to maintaining a sustainable care relationship.

Finally, in line with earlier findings, we found that need factors were not associated with expected practical barriers for children known to have or be at risk for complex problems, regardless of whether they used psychosocial care (Hoagwood et al., 2000). The fact that greater needs are at least associated with equal access is a positive indicator for accessibility, although it would be even more favourable if, when accessing psychosocial care, parents of children with greater needs could expect fewer practical barriers than those of

TABLE 3 Associations of predisposing, enabling and need factors with expected practical barriers to psychosocial care for children using no care at all and for children using psychosocial care.

	Expected practical barriers to care			
	No use of care		Use of psychosocial care	
	Crude B (95% CI)	Adjusted B (95% CI) ^d	Crude B (95% CI)	Adjusted B (95% CI) ^e
Predisposing factors				
Child's gender				
Boy	0	0	0	
Girl	0.56 (0.16;0.95)*	0.54 (0.16;0.92)*	-0.17 (-0.53;0.20)	
Child's age				
Pre-school	0		0	0
School-aged	0.14 (-0.28;0.55)		0.15 (-0.24;0.55)	0.38 (0.01; 0.75)*
Ethnicity of child				
Native	0		0	0
Non-native: Western	0.57 (-0.13;1.26)		0.61 (-0.04;1.26)	0.27 (-0.37;0.90)
Non-native: non-Western	0.12 (-0.30;0.53)		0.58 (0.19;0.96)*	0.52 (0.17; 0.88)*
Parental gender				
Male	0		0	
Female	0.01 (-0.77;0.79)		0.13 (-0.44;0.70)	
Parental age				
<36 years	0		0	0
≥36 years	-0.20 (-0.59;0.20)		-0.51 (-0.87;-0.16)*	-0.77 (-1.12; -0.42)*
Parental education level				
Low/medium	0		0	0
High	-0.08 (-0.48;0.33)		-0.04 (-0.40;0.33)	-0.32 (-0.67;0.03)
Family composition				
Two-parent family	0		0	
One-parent family	-0.18 (-0.61;0.25)		0.35 (-0.03;0.74)	
Other	-0.04 (-0.74;0.66)		0.50 (-0.10;1.10)	
Mental health of parent				
Adverse life events	0.16 (-0.06;0.37)		0.27 (0.10;0.43)*	0.29 (0.13; 0.45)*
Enabling factors				
Social support partner	-0.11 (-0.31;0.09)		-0.26 (-0.42;-0.10)*	
Social support family/friends	-0.30 (-0.52;-0.09)*	-0.30 (-0.50;-0.09)*	-0.24 (-0.40;-0.08)*	-0.17 (-0.34;-0.00)*
Care parent				
Yes	0		0	
No	-0.49 (-0.94;-0.05)*		-0.15 (-0.51;0.21)	
Need factors				
Chronic condition				
No/low impact	0		0	
Yes, high impact	0.09 (-0.62;0.80)		-0.24 (-0.62;0.15)	
Psychosocial problems				
Yes	0		0	
No	-0.61 (-1.08;-0.14)*		-0.18 (-0.55;0.18)	
Parenting concerns	0.20 (-0.02;0.43)		0.18 (0.00;0.37)*	

Note: NALL Bs are standardized. Adjusted R^2 : psychosocial care = 0.28; no care = 0.15. ^d $n = 89$; during the backward stepwise regression analysis the variables were removed in the following order: mental health of the parent, care parent, chronic condition, psychosocial problems, parenting concerns, parental gender, child's ethnicity, child's age, family composition, social support partner, parental education, parental age, number of life events. ^e $n = 120$; during the backward stepwise regression analysis the variables were removed in the following order: child's gender, social support partner, mental health of the parent, parental gender, parenting concerns, care parent, family composition, chronic condition, psychosocial problems. In all backward stepwise regression analyses, the criterion for removing a variable from the model was set at p -value < 0.1.

* $p < 0.05$.

children with lesser needs. Even more, our finding that non-native parents expected more practical barrier is in line with other research and indicates a particular inequity in accessibility (Tambling et al., 2022). Non-native parents experience particular inequity in accessibility of psychosocial care.

4.1 | Strengths and limitations

A strength of our study is its community-based design with oversampling of children in care, ensuring the inclusion of parents who had not recently used psychosocial care for their child. This gave us insight into the expectations of parents who may not have accessed services during the last 6 months because of practical barriers. Moreover, we were among the first to use a validated questionnaire to measure expected barriers in this group, a factor which highly enhances the quality of the information in this study (Andersen & Newman, 1973; Kazdin & Wassell, 2000).

Our study also has limitations. We included a group which fairly represented the ethnicity of the general population, but with some overrepresentation of parents with a high educational level, and greater numbers of drop-outs of non-natives and families with lower social economic status. This may have led to some underestimation of barriers, with which better educated parents are probably more skilled to cope. Finally, we used a cross-sectional design so the direction of effects or causality remains unclear.

4.2 | Implications for practice

We found that the majority of parents expect practical barriers, even when their child is already using psychosocial care. We would advise psychosocial care services and the gatekeepers to this type of care, like social workers, preventive health care nurses and general practitioners, to address expected practical barriers with all families when referring them to psychosocial care, but also, and especially, with families already using psychosocial care. Parents play a key part to overcome practical barriers like finding a babysit or asking for a leave from work to attend treatment, but that is not always easy when your family is under strain because of the demanding needs of a child with complex problems. The gatekeepers to psychosocial care services can motivate parents to take initiative to overcome the barrier, which could be challenging when you have to meet the several demands of a child with complex problems. The use of motivational interviewing techniques to support parents in navigating the local psychosocial care system could help to overcome these barriers.

We found that parents, regardless of whether their child was using psychosocial care, expected fewer practical barriers if they were receiving social support. This implies that when advising parents with a limited social network to consider psychosocial treatment, the referring gatekeeper of care service should pay particular attention to expected barriers. Moreover, improving the social network of parents with children with complex problems typically requires long-term

attention (Radez et al., 2021; Visscher et al., 2022). Research shows that professionals struggle to make sustainable changes in the quality of social support (Nanninga et al., 2018). Taking into account the limited training and time assigned to gatekeepers to offer this attention, assistance of community psychosocial services could help. However, parents' acceptance of these services may be complicated by the perceived barriers found in this study. To overcome such practical barriers to needed treatment, short-term help can also be offered by local volunteer initiatives, like buddy projects.

This study aimed at practical barriers to psychosocial care that need to be addressed primarily by the parents in the community population themselves, with or without the help of a social network or professionals. However, systematic gaps in the conditions for effective care use hindering access to psychosocial care, such as absence of public transport or lack of childcare facilities, exceed the responsibility of parents and families and require adequate policy making on the issue local networks of care organizations and governments. This may hold even more given the increased length of waiting lists after the collection of our data, despite reforms of the Dutch system such as the responsibility of local governments for financing the system and positioning mental health advisors at general practitioners and schools.

4.3 | Implications for research

Having added several predisposing and enabling factors to the scarce body of evidence on expected barriers to psychosocial care, we found that need factors play only a minor role. More research is needed to confirm these findings, as dealing with expectations of barriers should be a core component in future efforts to provide better access to child psychosocial care. This research should also include other types of care, for example, health care services, so all care services active in families of children with complex problems can improve their referral rate and better meet the various needs of these families. More research, preferably with a longitudinal design, is needed to better understand how anticipation of unsurmountable practical barriers impacts care enrollment (Reardon et al., 2020).

This study further indicated that the level of expected practical barriers is affected by parents' ethnicity. Additional study of the mechanisms involved can help to explain why children of non-native parents, and their families, underutilize psychosocial treatment. A qualitative design could provide the in-depth information needed to understand these mechanisms.

4.4 | Conclusion

Many parents expect practical barriers when seeking care for their child known to have or at risk for complex problems and they expect more future barriers when their child is already using psychosocial care than when not. We also found that expected barriers were associated with predisposing and enabling factors, and not with need

factors. We advise psychosocial care services and referring professionals, such as social workers, and general practitioners, to discuss possible practical barriers with all parents with children known to have or at risk for complex problems. We furthermore advise these services and professionals to be particularly aware of barriers expected by parents whose child is already using psychosocial care, or who have a limited social network or belong to an ethnic minority.

ACKNOWLEDGEMENTS

First and foremost we thank the parents for participating in this study. Thanks for recruiting them are due to the preventive healthcare workers at the Preventive Child Health Care services in The Hague and to the caseworkers at BKK, MEE and Bureau Jeugdzorg in the Hollands Midden region. We thank research assistants Ellen Westhoff, Jasper Boerrigter, Sophie Wins and Rosanne Schoorl for their work on this project, and Yvonne Schonbeck for her support with project organization. Finally, we thank Meinou Theunissen for her help with the analysis of data and Mascha Kamphuis for project management.

CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest to declare.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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How to cite this article: Pannebakker, N. M., Reijneveld, S. A., Numans, M. E., & Kocken, P. L. (2023). Parents' expected barriers to psychosocial care for children with complex problems. *Child & Family Social Work*, 1–12. <https://doi.org/10.1111/cfs.13093>