Access to Mental Health Supports and Services in Rural Nova Scotia: Perceptions and Experiences of Young Women

by

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Dedication

This thesis is dedicated to the community of Pictou County, Nova Scotia, including the students, families, school administration, teachers and staff, as well as healthcare professionals, who work tirelessly to promote mental health in their work and personal lives.

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Abstract

Although a growing number of Canadian youth live with diagnosed and undiagnosed mental health issues, only one in six youth has access to mental health services and supports. Existing literature suggests there may be numerous barriers and facilitators to accessing mental health supports and services in rural communities. However, there is little research on how youth experience access in rural Canada and virtually no literature on rural Nova Scotia (NS). This study addresses how youth in one rural NS community perceive and experience access to mental health services and supports. The lived experiences of seven young women were collected using semi-structured interviews and analyzed using conceptual ordering. Barriers and facilitators at the individual, family, school and community levels were identified. Youth also suggested ways in which access could be improved in their community. Findings from this study will contribute to the literature and may inform policies and programs in rural communities.

List of Abbreviations Used

ASIST	Applied Suicide Intervention Skills Training
CBPR	Community Based Participatory Research
CIHI	Canadian Institute for Health Information
CMHA	Canadian Mental Health Association
CRRF	Canadian Rural Revitalization Foundation
ED	Emergency department
GAD	General Anxiety Disorder
GSA	Gay Straight Alliance
HPS	Health Promoting Schools
LGBTQ*	Lesbian, Gay, Bisexual, Transgender, Queer, + (inclusive of other identities)
MHCC	Mental Health Commission of Canada
NS	Nova Scotia
NSHA	Nova Scotia Health Authority
PHAC	Public Health Agency of Canada
RA	Research Assistant
SBS	School-based services
SEAK	Socially and Emotionally Aware Kids
SEL	Social and emotional learning
SES	Socioeconomic status
WHO	World Health Organization

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Chapter 1: Introduction

Background

Mental health issues are a growing epidemic among Canadian youth (Mental Health Commission of Canada, 2013). Mental health is used in this study as an umbrella term to describe the spectrum of mental and emotional health that a person may experience, including good to poor mental and emotional health, and diagnosed mental illness. It is estimated that approximately 15 percent of Canadians under the age of 18 are diagnosed with a mental illness, such as a mood disorder, anxiety, eating disorder or other psychiatric condition, and many others live with undiagnosed mental and emotional health concerns (Cloutier, Cappelli, Glennie, & Keresztes, 2008). Mental health issues often result in complex biopsychosocial concerns for those living with the issue and their loved ones, including physical health concerns, decreased productivity at school and work, and increased expenses associated with healthcare (MHCC, 2015). Individuals living with a mental health issue often require personalized care (i.e. counseling, medication, recreational therapy) to manage the varying biopsychosocial aspects they may encounter (Latham, 2012). Alarmingly, only one out of every six Canadian youth living with a mental health issue has access to mental health supports and services (Cloutier et al., 2008).

The meaning of access has evolved over the past several decades from being a purely physical phenomenon to encompassing a more nuanced experience (Fortney, Burgess, Bosworth, Booth & Kaboli, 2011). Fortney and colleagues (2011) describe two strands of access: *actual access* and *perceived access*. Actual access is conceptualized as "directly-observable and objectively measurable dimensions of access," while perceived access is "self-reported and subjective dimensions of access" (Fortney et al., 2011, p.10). Perceived access is important for

the design of person-centered health care services because it can offer insight into 'hidden' issues of access, such as affordability of care and its appropriateness. As a tool of measurement, Levesque, Harris and Russell (2013) introduced five system-level factors of access: approachability (i.e. transparency and outreach), acceptability (i.e. values and culture), availability and accommodation (i.e. location, operating hours), affordability (i.e. direct and indirect costs), as well as appropriateness (i.e. coordination and continuity). These five factors, along with five corresponding service user abilities (the abilities to perceive, to seek, to reach, to pay and to engage), are meant to offer greater insight into perceived access to health care. Gaining an understanding of these factors can help us to better understand access from service users' perspectives and adapt service delivery accordingly.

There are ongoing debates in the literature concerning the barriers and facilitators to accessing mental health supports and services in rural Canada. Known barriers to access for the general population in rural Canada include individual-level barriers (i.e. limited awareness of local services), and community-level barriers (i.e. lack of specialized physicians, inadequate community services, lack of privacy and travel barriers) (Anderson & Larke, 2009; Boydell et al., 2006; Cloutier et al., 2008; Haggarty, Ryan-Nicholls & Jarva, 2010). However, Caxaj and Gill (2016) suggest that living in a rural community adds a sense of belonging and connectedness, which may encourage an individual with a mental health issue to seek help. Jackson, Unruh, and Donahue (2011) also indicate that rural dwellers often experience a better quality of life because of perceived community support, which may result in better access to mental health supports and services.

Understanding access to mental health supports and services in rural communities is critical for Atlantic Canada, including the province of Nova Scotia (NS). More Atlantic

Canadians live in rural locations than other Canadians, with NS being one of the most rural Canadian provinces, and there is a higher prevalence of diagnosed mental illness, such as depression and anxiety, in this area of Canada compared to other provinces (Latham, 2012; Statistics Canada, 2011). The mental health of Atlantic Canadians is thought to be heavily influenced by a number of factors, such as an aging population, socioeconomic status (SES), and working conditions (Latham, 2012). Because of the historic rise and decline of primary industries within the Atlantic region, many youth are moving away from the area to find work. Youth outmigration contributes to the poor economic health of the province and can result in a decrease of supports and services, including those for mental health (Latham, 2012). The population of NS is also aging. By 2030, 25 percent of the population will be 65 years or older (NS Department of Seniors, 2017). As a result, there may be conflicting beliefs regarding where to invest the most money or which population should be a priority: youth or our aging population.

Under the umbrella of mental health issues, depression is the most commonly diagnosed mental illness in Atlantic Canada. In particular, the Public Health Agency of Canada (PHAC) notes that the number of young Nova Scotians reporting living with diagnosed depression and symptoms is higher than other young populations in Atlantic Canada (Latham, 2012). The *Nova Scotia Student Drug Use Survey*, administered by Dalhousie University and the Department of Health and Wellness, is one of the only tools to have measured patterns of substance abuse, gambling behaviours and symptoms of mental illness among Nova Scotian youth (Asbridge & Langille, 2013). This last administered survey found that 24.4 percent of NS students in grades seven, nine, ten and twelve reported "somewhat elevated depressive symptoms" and 8.7 percent of students reported having "very elevated depressive symptoms" (Asbridge & Langille, 2013, p.

8). Both figures had increased slightly compared to the 2007 figures of 20.5 percent and 5.8 percent, respectively (Asbridge & Langille, 2013, p. 8). Interestingly, students surveyed in Northern NS, a highly rural area, reported poorer mental health than their peers in other areas of the province and poorer mental health than the national average (Asbridge & Langille, 2013, p. 42). The help seeking behaviours of students were also measured provincially using this survey. On average, 45 percent of students reported wanting help for depressive symptoms; however, only 16.4 percent of these students actually received help (Asbridge & Langille, 2013, p. 43). Based on this information, there is an unmet need for accessible mental health supports and services for NS youth.

The Research Problem

A fair amount of research has been dedicated to understanding barriers and facilitators to accessing mental health supports and services in rural communities around the world. However, there is relatively little literature on rural areas in Canada. The majority of literature on rural access to mental health support and services in Canada focuses on Western and Central Canada, with very few studies on access to mental health supports and services in rural NS. Further, the existing literature primarily focuses on the opinions and voices of adults living with mental health issues, and healthcare providers. There is virtually no work published on the perceptions and experiences of access to mental health supports and services for youth living in rural NS. It is important to capture this information so that we can better understand the reality for youth who live with mental health issues in rural NS and so that these youth, and future generations, can experience better access to mental health supports and services.

Context and Significance of Study

  This study took place in Pictou County, a community situated in Northern NS, approximately 130 kilometres from the provincial capital of Halifax – the nearest metropolitan centre. In 2011, Pictou County had a population of 43,748 which had decreased 4.2 percent since the last census in 2011 (Statistics Canada, 2018a). In 2011, approximately 8,855 residents were under the age of 19 or could be considered as being "youth." This figure accounts for 20.2 percent of the total regional population (Statistics Canada, 2018a).

  Like many other rural communities, health care is being restructured in Pictou County to respond to the population's changing size and needs. In a national context, restructuring has resulted in fewer doctors in rural areas in Canada. Although twenty percent of Canadians reside in rural areas, only ten percent of physicians and two percent of specialists practice in rural Canada (Islam, 2014). Likewise, the Aberdeen Hospital, the only hospital in Pictou County, has experienced a number of changes to its mental health services. In 2015, the Nova Scotia Health Authority (NSHA) announced the closure of the hospital's inpatient mental health unit due to staffing problems and, in late 2017, the area's only psychiatrist retired (Henderson, 2016; Musick, 2018). For those in the community who are experiencing less severe instances of mental health issues, there are other mental health services in the community. These services include community mental health services and programs offered through the local health authority, as well as treatment from other health professionals, such as social workers or private psychologists. However, the details concerning the community-based services and the number of psychologists and social workers providing mental health services in the community are not publicly available. Lack of mental health services are problematic for the community because of the few family doctors in the area and the need to travel to other areas of the province to receive

care. For many reasons, youth may rely on other informal supports provided within their community, including friends, teachers, school guidance counselors, or online resources.

Purpose

The study's main purpose was to understand the perceptions and experiences of access to mental health supports and services of rural Pictou County youth who live with a mental health issue. In order to achieve this purpose, the study's main research question asked: How do youth living with a mental health issue in one small rural community in NS perceive and experience access to mental health supports and services? Pictou County is of specific interest because of the high rates of mental illness and reduced specialized mental health service delivery. Ideally the findings will serve to inform policy, community-based interventions and support and service delivery within Pictou County. However, some of the knowledge gained from these lived experiences may be transferable to other areas of NS and Canada.

Overview of Study Design

This study used a qualitative research design with elements of grounded theory and community based participatory research (CBPR). Qualitative research allowed for a greater understanding of individuals' thinking, feelings and experiences than some quantitative methods (Creswell, 2013). Using elements of grounded theory allowed for the research to move beyond "armchair theorizing" to develop a conceptual understanding of access, based on actual community data and the incorporation of the first voice (Corbin & Strauss, 2015, p.6). Incorporating elements of CBPR, in the form two student research assistants (RA), allowed two youth to contribute to the study. Giving space for the first voice was important to allow youth to be the driving force behind the potential development of youth-centered mental health supports and services.

Perceptions and experiences of access were collected from seven female rural high school students in the community, who were between the ages of 16 and 18 years, using individual semi-structured interviews. Purposive sampling was used to recruit the students. Interview guides were created with the help of existing literature, my thesis committee and two student research assistants (RA). Interviews were held at the school with the option of being audio recorded or having notes taken. Interviews were transcribed and analyzed through Atlas-ti using conceptual ordering based on modified grounded theory. Themes from the data will present how the participating students perceive and experience access to mental health supports and services.

Key Terms

Mental health. The dual continua model is used to understand mental health and mental illness in this study (Keyes, 2002). Traditionally, mental health and mental illness are thought of as being on a single continuum. If individuals are mentally ill, they are at one end of the continuum. As their mental health improves, their position on the continuum changes. Therefore, when using the traditional model, it is impossible for someone with a mental illness to ever simultaneously obtain good mental health. However, the dual continua model (Figure 1) states that mental health and mental illness should both be thought of as being on two perpendicular continua (Keyes, 2002). In other words, it is possible for an individual to live with a mental illness, yet still experience good mental health.
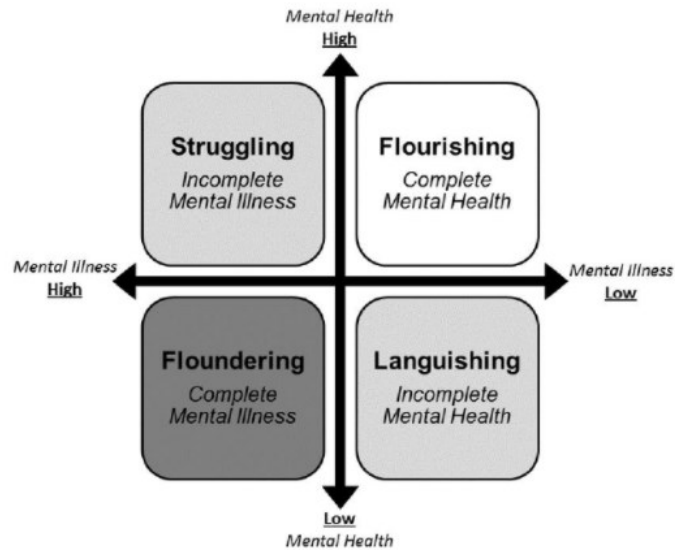
Figure 1 Keyes' (2002) Dual Continua Model (as cited in Teng, Venning, Winefield & Crab, 2015)

Using this model of mental health better represents the flourishing and languishing of mental health and the complexities of living with a mental illness.

I will be using the term "mental health issue" in this study, instead of mental illness, as it represents both the diagnosed clinical illness, as well as symptoms of mental health, and also recognizes the importance of emotional health. As explained earlier, mental health is used in this study as an umbrella term for describing mental and emotional wellbeing and mental illness. PHAC defines mental health as "a positive sense of emotional well-being that allows us to realize our full potential and to cope with the stresses of life," with an understanding that "determinants of health including biological, psychological, social, cultural and environmental factors interact and affect mental health over the course of a person's life" (Latham, 2012, p. 5). Emotional health is often forgotten when talking about mental health and mental illness. Jenkins, Johnson, Bungay, Kothari and Saewyc (2015) describe emotional health as "thoughts and emotions" which fall outside a "diagnosable category of mental health" (p. 105). Anxiety can be

used to illustrate the difference between mental health, emotional health and mental illness. An individual may be diagnosed with General Anxiety Disorder (GAD), which is a mental illness. However, based on the dual continua model, he/she may be in good mental health, meaning that he/she is managing their anxiety and, despite a diagnosis, is mentally well. At other times, the individual may have low mental health and high mental illness, which would mean he/she is struggling to manage their GAD diagnosis. On the other hand, there may be individuals who experience anxiety some of the time or who have fewer clinical symptoms and are not diagnosed with GAD because they do not meet the criteria. Although they do not have a diagnosed mental illness, they are still experiencing some degree of emotional distress.

The incorporation of both mental and emotional health issues in this study may have allowed for a greater diversity of individuals and their experiences with access, particularly those who are not diagnosed with a mental illness but who are struggling with low mood or high stress. It is important to understand the perceptions and experiences of these youth, since emotional distress can be a precursor to mental illness. With the normalization of anxiety and depression, some youth may also be using services for emotional health issues despite not having a formal diagnosis.

Rural. Existing literature suggests that there is no precise definition of rural. Kelty (2007) found that there are over 40 different definitions of rurality in Canadian academic journals and reports. The variety of definitions can be both inclusive, but problematic. By creating several definitions of rurality, communities are more likely to see themselves in these definitions and multiple definitions represent the diversity of these communities. However, having too many definitions can come at the peril of having a thorough understanding of what rural means. Typically, most definitions of rural focus on the population or population density. In

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Australia, where there is a large body of rural health research, rural communities are commonly defined as "areas outside of larger regional areas but with access to services locally"; however, there has been an international movement to begin recognizing that rurality also encompasses a "social representation or a culture and a way of life" (ACYS, 2015, p.19 as cited in Ontario Centre of Excellence, 2016a; Moazammi, 2015, p.5 as cited in Ontario Centre of Excellence, 2016a). I will consider both the physical and cultural aspects of rurality in this study.

Youth. The United Nations defines youth as being "a period of transition from dependence of childhood to adulthood's independence" (United Nations Educational, Scientific and Cultural Organization, 2017., p.1). The term "youth" has typically been defined by age, specifically the ages of 15-24 years old (UNESCO, 2017). More holistic definitions of youth may incorporate education status, income or psychosocial development. The relationship and transition between youth and adulthood is also being reconceptualised. Arnett (2000) suggests that adulthood may not begin until the mid-twenties, as youth are prioritizing education and travel over traditional markers of adulthood, such as marriage and children. Instead, Arnett (2000) suggests that there is a stage in development that exists between youth and adulthood: emerging adulthood. For the purpose of this study, I am using an age-based definition that envisions youth as being under the age of 18 and under the care of parents or guardians because I am working with a school-aged population.

Supports and Services. Services are defined as any formal institution, organization or program which is mandated to offer resources or treatment that have the potential of improving an individual's mental health. Services are often thought of as being part of the tiered model which suggests that the majority of effort should be placed on mental health promotion for the entire population, with fewer individuals being referred to (and fewer resources being devoted

to) acute care (Short, 2016). There is an overreliance on hospital-based or acute services, when often, the mental health of many individuals can be treated in other ways (Leader, 2016). Supports are considered to be informal methods (outside of formal services) used by youth as a means of improving their mental health. This term is more difficult to define because it will be the experiences of youth which define these supports. However, potential examples of informal supports could be friends, teachers, online discussion space, or in-school supports (e.g. guidance counselor).

Implications for the Field of Health Promotion

The completion of this study holds implications for the field of health promotion and health promoters within Canada. The World Health Organization (WHO) (2016) defines health promotion as being "the process of enabling people to increase control over, and to improve, their health" through the examination of "a wide range of social and environmental behaviours" (n.p.). By understanding the perceptions and experiences of youth, this study may help to create a platform for youths' voices and inform policymakers, health care providers and community members about youths' perceptions and experiences. By sharing the experiences of youth, this study may act as an advocacy tool by encouraging changes to policy and programming through the understanding of the first voice. Sharing the findings with the greater community, including Pictou County residents, parents, and politicians, may also inspire community action and potentially improve the accessibility of supports and services. Ideally, this study will inform changes in policy and programs being offered in Pictou County for youth with mental health issues. However, it is also hopeful that the study's findings will be transferable to other rural communities in NS and Canada, as they see appropriate.

Summary

Access to mental health supports and services is a noted problem for all Canadians living with a mental health issue. Further, marginalized populations, such as youth and those living in rural communities, tend to have even greater difficulty accessing appropriate mental health supports and services. Despite knowledge that youth in rural Canadian communities experience a higher prevalence of diagnosed mental illness and have less access to mental health resources, little research has been done to better understand their experiences. This study seeks to better understand the perceptions and experiences of youth in rural Pictou County concerning access to mental health supports and services. The research will inform policy and programs, and contribute to the body of literature on rural access to services.

Chapter 2: Literature Review

Understanding Mental Health

The concept of mental health is conceptualized differently by many organizations and stakeholders within the healthcare field. The WHO (2014) defines mental health as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (n.p.). PHAC suggests that mental health should be considered as "the capacity of each of us to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face" (Latham, 2012, p.5). Canadian Mental Health Association (CMHA) (2016a) furthers this notion of mental health as being holistic and encompassing good mental health, by reiterating that it is "not only the avoidance of serious mental illness" (n.p.). Outside of the traditional notion of mental health is the concept of emotional health. Jenkins et al. (2015) defines emotional health as the "thoughts and emotions" which fall outside a "diagnosable category of mental health" (p. 105). It is important to consider emotional health in conjunction with mental health because so many individuals live with emotional health issues, such as low mood or high stress, which can be mistakenly equated to and treated as mental illness.

Recent literature urges health professionals and researchers to envision mental health as being more than just the psychological counterpart to physical health, but rather the starting point of "whole health" (McLoughlin, 2016). I use Keyes' (2002) dual continua model to conceptualize mental health and mental illness. This model examines mental health and mental illness from two perpendicular continuum, and is commonly used in mental health promotion. Based on this model, the flourishing and languishing of mental health can be better understood

from the perspectives of both individuals who live with a mental illness and those who do not (Keyes, 2002).

 The burden of mental illness. Mental illness is considered to be "characterized by changes in mood or behaviour that cause distress and impair the ability to function in daily life" (Latham, 2012, p. 29). Examples of commonly diagnosed mental illnesses include depression, anxiety, and eating disorders. The complexities of mental illness in Canada have resulted in severe socioeconomic burdens at the individual and systems level. By the year 2030, mental health issues are expected to be the leading cause of disability in Canada (Ungar & McDonald, 2012). Ungar and McDonald (2012) note that in 2012, mental disorders cost the Canadian economy $51 billion. Approximately, $21 billion was lost to care costs, while the other $30 billion was due to lost productivity, such as missed work days. Missed school and work days are also a part of the larger social burden caused by mental health issues in Canada. Youth who are experiencing poor mental health are impacted by changes in behaviours, thinking, feelings and physical health (CMHA, 2016a). If left untreated, youth will have difficulty socially and academically functioning, and may not be able to fully contribute to their communities as adults (MHCC, 2015).

 The stigma associated with living with a mental health issue can also be burdensome for the individual and their loved ones. Stigma can be thought of as "the negative beliefs and attitudes held about mental illness, which can to public prejudice, stereotyping, and discriminatory behaviours" (Charbonneau et al., 2010, as cited in Davis, 2013, p. 60). Often, those living with a mental health concern describe stigma as being worse than the actual mental health concern (Thornicroft et al., 2016). Similar experiences have been captured in the addictions literature (Corrigan, Sachiko, & Kuwabara, 2009). Stigma may be experienced on two

macro levels: public stigma (stigma from those around the individual) and self-stigma (negative beliefs and attitudes from the individual them self), although there are many subcategories of stigma within these two levels (Corrigan & Watson, 2002). Both levels of stigma may dissuade the individual from disclosing they are living a mental health issue and prevent them from seeking out care (Judge, Estroff, Perkins, & Penn, 2008). For those who do disclose their mental health issue, stigma may prevent them from socializing with others, fully engaging with mental health care, and is associated with low self-esteem (Livingston & Boyd, 2010).

Applying the social-ecological framework to mental health. PHAC notes that "biological, psychological, social, cultural and environmental factors" interact to influence an individual's mental health (Latham, 2012, p. 5). Brofenbrenner's (1979) social-ecological framework (Figure 2) outlines the importance of thinking of health as being influenced by individuals, relationships, community and society. Individual level factors may include things that directly impact an individual, such as age, income, and socioeconomic status (SES). Relationship level factors may include the level of support an individual has from family and friends. Community level factors include school, workplace and greater community level indicators of health, like belonging, social isolation and school setting. Finally, societal factors include larger social norms and policies that govern a community and what goes on within the community (McLeroy, Bibeau, Steckler & Glanz, 1988). The model outlines how each of these layers of the environment inform each other to influence health.

Figure 2 Brofenbrenner's (1979) social-ecological model (as cited in CDC, 2018)

Most literature within the field of mental health focusses on the social determinants of mental health at the individual and relationship-level. Maggi, Ostry, Roberts, D'Anigiulli and Hertzman (2013) and Wilson, Wilson and Usher (2015) suggest that not much is known about mental health outcomes in relation to community and societal factors, particularly in rural communities, since research traditionally examines the individual and family factors of mental health. However, Wilson et al. (2015) outline that poor youth mental health is related to all levels of the social-ecological model. Wilson et al. (2015) coined the term "rural social ecology" as a way of framing the importance of rural community-level factors when thinking about mental health and appropriate supports and services in rural communities (p. 412).

Youth mental health. Understanding the psychosocial development of youth is particularly important because of the early onset of many mental health issues. It is estimated that up to 70 percent of mental illnesses among Canadian youth occur before the age of 18 (CMHA, 2017). Early life experiences are commonly linked to adult mental health issues. Key determinants of youth mental health issues include lack of attachment to their parent or primary caregiver, trauma, and incidences of abuse or neglect (Latham, 2012). The majority of mental

health issues typically appear in adolescence - a period where youth are developing socially and emotionally (Fagg, Curtis, Cummins, Stansfield & Quesnel-Valée, 2013). Youth living with mental health issues may experience changes in behaviour and thinking, such as low self-esteem and disengagement from school, which could impair their development (CMHA, 2016a). These symptoms are concerning because of the ramifications on the individual themselves. However, youth are also important members of society because they are considered to be the future of many communities through their contributions to its economic development, culture and workforce (NHS England, 2013).

The developmental period of being a youth is associated with Erikson's psychosocial stage of identity and role confusion. Erikson argues that teenagers experiencing this developmental stage are at a time where they are trying to develop their own identity while negotiating family values and the influence of peer groups (Gray, Ispa & Thornburg, 1986). It is ordinary for some youth to experience some mental distress during this time; however, excessive distress may disrupt normal development. Likewise, pre-existing mental distress may create barriers to normal healthy development (CMHA, 2017). Traditionally, the flourishing and languishing of mental health is thought to mostly occur during the teenage years during the identity and role confusion stage (Gray, Ispa & Thorburg, 1986). However, new literature has emerged which indicates that brain development is still ongoing until an individual is in his or her late twenties. From this information comes a new developmental stage termed "emerging adulthood" by Arnett (2000). Arnett (2000) suggests that emerging adulthood, "a distinct period demographically, subjectively, and in terms of identity explorations," occurs between the ages of 18 and 25 (p. 469). Unlike previous generations during this age, current 'emerging adults' face increasing pressures to become self-sufficient in a globalizing world. This priority is ranked

much higher than being married or obtaining a permanent job (Arnett, 2000). Globalization is used to refer to a complex process of the internationalization of state economics, which has in turn transformed a number of economic and social practices around the world. Due to globalization, many youth are uncertain about entering the labour market and starting a family (Blossfield, Klijzing, Mills, & Kurz, 2005; MacLeod & Browlie, 2014). Because of youths' uncertainty about their future, this developmental stage can be accompanied by increased problematic substance use and onset of mental health issues (MacLeod & Browlie, 2014, p. 78).

Youth mental health in Canada. In Canada, about 14 percent of youth between the ages of four and 17 years have been diagnosed with a mental illness (Butler & Pang, 2014). However, it is estimated that many other youth are living with undiagnosed mental health issues (Cloutier et al., 2008). Further, Canada has the third highest youth suicide rate among industrialized nations (CMHA, 2016a).

In particular, there are certain subpopulations of Canadian youth who are at higher risk of developing mental health issues, including young females, Indigenous youth, racial minorities, those who identify as being LGBTQ* and those who live in rural communities. Being a member of two or more of these communities may increase the risk of developing mental health issues due to an increase in minority stress, or the stress experienced by stigmatized populations from "inferior social status" (Lehavot & Simoni, 2011, p.2). On average, suicide rates within Canada have been declining, but the rate of suicide among young females has been increasing (Latham, 2012). Suicide rates are also much higher among young Indigenous people in Canada (Elias et al., 2012). It is estimated that suicide rates among Indigenous youth are, on average, three to six times higher than the rest of Canada. It is also estimated that suicide rates among Inuit youth are up to eleven times higher (Centre for Suicide Prevention, 2013). Other racial minority groups

also report poor mental health outcomes due to a lack of belonging in their neighbourhood and community (Xu & McDonald, 2010). Data shows that Canadian LGBTQ* youth are more likely to live with mental health issues than their hetero counterparts, yet they are also less likely to have satisfactory encounters with mental health professionals (McIntyre, Daley, Rutherford & Ross, 2011). There are also concerns about the mental health of Atlantic Canadian youth in relation to their sense of place and belonging (Latham, 2012). Several reports have noted the higher level of youth depression within NS compared to other Canadian provinces, but not much is known about why such high prevalence rates exist (Asbridge & Langille, 2013; Ungar & McDonald, 2012). Some hypotheses point to rurality and poor economic development as being key determinants to poor mental health in this region (Latham, 2012).

Rural Canada and Mental Health

The determinants of rural life in Canada. Approximately, 19 percent of Canadians live in a rural area; however, NS is one of the most rural Canadian provinces, with approximately 43 percent of residents living in a rural community (Statistics Canada, 2011). Despite the many definitions for rural, no single definition is used in the literature; however, most studies agree that rural areas have less than 10 000 residents and are not within commuting distance of major metropolitan centres (Boydell, Stasiulis, Barwick & Greenber, 2008; Haggarty et al., 2010; Statistics Canada, 2016). The multiple definitions of rural can be limiting because they do not easily facilitate the comparison of rural health studies and often overlook sociocultural differences (Canadian Institute for Health Information, 2006). Recently, there has been an international movement to begin recognizing that rurality also encompasses a "social representation or a culture and a way of life" (ACYS, 2015, p.19 as cited in Ontario Centre of Excellence, 2016a; Moazammi, 2015, p.5 as cited in Ontario Centre of Excellence, 2016a).

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Despite not having a global definition, 'rural' is relatively well understood in literature in contrast to urban communities (Kelty, 2007). As Kelty (2007) presents, the spectrum between rural and urban communities "can also be defined by the functional relationships that develop between people and the space and place they live in" (p. 1). In short, the physical, cultural, social and economic environments tend to differ between rural and urban communities and these differences are what render place, in the context of rural living, as a social determinant of health.

Rural Canada is demarcated by its importance to the national economy. Typically, agrarian, mining, fishing and forestry industries are found in rural Canada (Canadian Rural Revitalization Foundation, 2015). However, climate change and the rise of globalization have deeply impacted the productivity of these industries (Cunsolo-Wilox et al., 2012; CRRF, 2015). In many rural areas, job loss is causing residents to move to urban areas in search of good-paying jobs and further education (Jackson, Tirone, Donovan & Hood, 2007). Within NS, most areas of the province have experienced a population decrease, except for the city of Halifax, which experienced a population increase of 3.3 percent in 2016 (Statistics Canada, 2018b). Because of these changes to the physical and economic environments of rural Canada, the determinants of rural life are also changing.

The relationship between mental health and rural life. It is important to understand mental health within rural Canada for many reasons. There is evidence that rural populations typically experience poorer health outcomes than their urban counterparts. Although, it is well known that rural Canadians have lower life expectancy, higher infant mortality rates and higher rates of disability and chronic disease, little is known about the mental health of rural communities, including among youth (Ministerial Advisory Council on Rural Health, 2002; Maggi et al., 2013). The relationship between mental health and rural living is highly debated.

Some literature suggests that rural life can be a barrier to positive mental health, while other literature suggests that rural life can promote good mental health (Aisbett, Boyd, Francis, Newnham & Newnham, 2007; Kelly et al., 2011; Monette, 2012). The literature suggests that access to mental health supports and services are correlated with rural living; however, whether rurality produces barriers or facilitators to access is debated (Anderson & Larke, 2009; Caxaj, 2016; Hardy, Kelly & Voaklander, 2011). To better understand any potential correlation between rural life in Canada and mental health, it is important to consider access within the multiple rural environments.

Physical environment. The physical environment is one of the most recognizable aspects of rural communities. Herbert (2007) stresses that rural communities emphasize "community, the land, land utilization, and cultural aspects that build on rural tradition" (p. 2). As previously discussed, the importance of land translates into the importance of primary resource industries in rural Canada (CRRF, 2015; Herbert, 2007). Generally, the physical environment of rural Canada is thought to be protective of mental health because of reduced noise, pollution and crowds compared to urban areas (Monette, 2012). In most definitions, rural communities are presented as being isolated from surrounding metropolitan centres. The degree of isolation varies depending on the community and the definition of rural; however, in most cases rural communities are not within commuting distance of a central metropolitan zone. This isolation can directly influence the accessibility of health care in rural Canada (Aisbett et al., 2007).

The isolating nature of many communities means that physical and temporal access to appropriate mental health supports and services can be difficult for residents. Generally, rural communities are thought to have limited access to mental health services. Anderson and Larke (2009) explain that rural communities in Canada are often underserved and local family

physicians are typically overworked. Although this is the same for many physicians in urban areas, rural family physicians may experience greater stress due to professional isolation and heavier workloads (Szafran, Woloschuk, Torti & Myhre, 2017). If an individual is experiencing a mental health issue, their only avenue of care may be through a family physician. In general, these family physicians may not have intensive mental health training and additional referrals to a psychologist or psychiatrist outside of the community may be needed for those with a greater need.

As a response to the fall of the welfare state and rise of neoliberalism, most Canadian provinces have begun to restructure and regionalize healthcare services (Caxaj, 2016; Pinch, 1997). Key aspects of health care regionalization in Canada include the development of provincial health authorities, the integration of services, and aligning community needs and resources (Lewis & Kouri, 2004). Initially, it was thought that restructuring and centralizing services in key regional areas would help to reduce costs; however, the move has proven to be costly for service users and rural communities (Church & Barker, 1998; Caxaj, 2016). There is evidence that the regionalization of healthcare has caused issues with physician retention and rural depopulation. There is also an increased competition for specialists, who are often stationed in larger regional centres (Lewis & Kouri, 2004). Service users in rural areas may be forced to pay for travel and lodging when attending appointments outside of their community (Boydell et al., 2008). There is also evidence that the regionalization of healthcare has resulted in greater reliance on volunteers and private sector care (Milligan & Power, 2010; Skinner, Joseph & Herron, 2016). Heightened wait times for services in larger communities means that rural residents must attend every appointment, or risk being placed back on the waiting list. Although the same practice happens for urban residents, it can be problematic for rural residents in

particular because they must reorganize travel to and from the appointment, which may involve extended time away from work or school.

Cultural and social environment. The cultural and social environment of rural Canada may act as a protective factor through community support. Community belonging, or the sense of 'fit' within the community, is thought to be one of the key determinants behind reduced stress and positive mental health outcomes in rural Canada (Caxaj & Gill, 2016). Kitchen, Williams and Chowhan (2012) suggest that community belonging in rural Canada is an indicator of social attachment and "social engagement and participation within communities," which also indicates positive mental health (p. 104). Statistics Canada (2016) also suggests that belonging "supports an "upstream" approach to preventing illness and promoting health." The correlation between mental wellbeing and community belonging is important, but relatively understudied (Kitchen et al., 2012).

Economic environment. In general, rural Canadians typically have less education and lower household income than those in urban Canada (CIHI, 2006, p. 3). Rural Canada was once rich with primary industries; however, many of these industries have folded with the rise of globalization (McGrath as cited in Jackson et al, 2007, p. 481). Job loss in these regions may be associated with increased stress (Latham, 2012). As Adler and Snibbe's (2003) psychosocial theory points out, stress can act as a pathway between SES (measured by levels of income and education) and poor mental health. It is important to understand the economic environment of rural communities because of the association between economic concerns, related to globalization, and mental health concerns for youth and emerging adults (MacLeod & Browlie, 2014).

The Importance of Access

The concept of healthcare access has been reconceptualized over the last several decades (Fortney et al., 2011). Levesque et al. (2013) define healthcare access as "the opportunity or ease with which consumers or communities are able to use appropriate services in proportion to their needs" (p.1). In recent developments, Fortney et al. (2011) propose the idea of actual and perceived access. Actual access is defined as "directly-observable and objectively measurable dimensions of access," while perceived access is defined as "self-reported and subjective dimensions of access" (p. 641). Fortney et al. (2011) argue that perceived access is more relevant from a service user's perspective because it offers greater insight into the service user's experience which may not always be visible to researchers or care providers. Perceived access is more indicative of person-centered care, which focuses on the service user's "preferences, needs and values" (Morgan & Yoder, 2012, p.8). Perceived access allows decision makers to better understand factors that are not always evident to a health care provider, including financial, cultural or social barriers.

Levesque et al. (2013) developed a patient-centered access framework, as a way of measuring perceived service user access to healthcare services. In the framework, Levesque et al. (2013) propose five 'A's of access: approachability, acceptability, availability & accommodation, affordability and appropriateness (Figure 3). Each 'A' of access describes how health services may be made more accessible through system-level and service user-level factors. Each 'A' of access is chronologically ordered according to how an individual typically experiences access to health services (e.g. from need to outcome). *Approachability* means that the service should be transparent and provide outreach to the community, while the service user needs the ability to perceive care (i.e. health literacy and beliefs). *Acceptability* is comprised of

the cultural and social aspects used to measure whether the service is acceptable for the service user. Likewise, service users need the ability to seek out appropriate care in accordance to their own beliefs and values. *Availability and accommodation* are measures of actual access and include the physical and temporal accessibility of the services (e.g. where services are located and wait times). Accordingly, service users need to have the ability to reach a service through transport and social support. *Affordability* speaks to the financial barriers which may prevent someone from accessing care and corresponds with the ability to pay. Finally, *appropriateness* is described as how well a service user's needs fit within the scope of the service and promotes the service user's ability to engage through adherence and empowerment (Levesque et al., 2013).
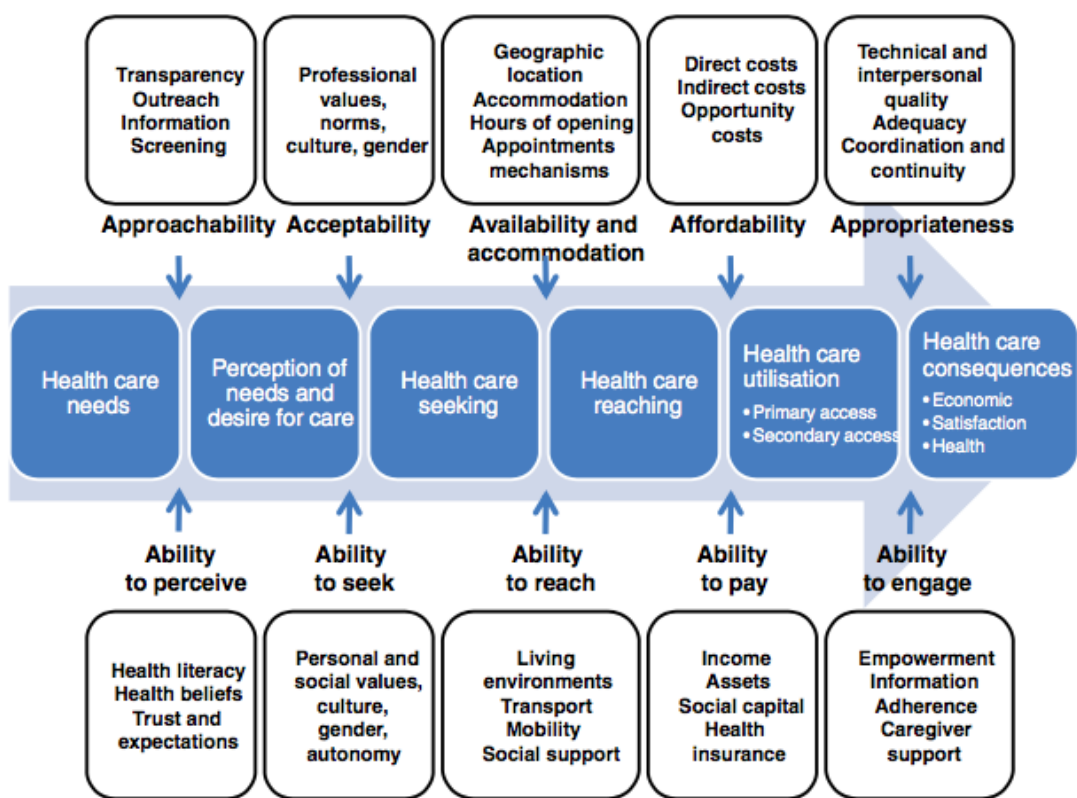
Figure 3 Levesque et al. (2013) patient-centered access framework

In order to effectively respond to poor mental health and varying degrees of mental illness, and to promote good mental health, access to appropriate mental health supports and

services is paramount. Access to appropriate care is critical for youth, so that they can develop

mentally and socially, and contribute to their communities (MHCC, 2016). Care that is

considered to be 'appropriate' is always evolving. Caxaj (2016) stresses that care systems need

"to involve multiple sectors and social pathways that account for unique relationships to the land,

different views of family and community and different challenges in relation to diverse identities

(i.e., ethno-cultural, sexual orientation, gender norms)" (p. 30). This concept of appropriate care

is especially true in rural areas, where populations are often thought to be homogenous and

service delivery is targeted to that perceived population (Boydell et al., 2008; Haggarty et al.,

2010). However, there are diverse subpopulations within rural communities (e.g. differences in

gender, sexual orientation and race) whose accessibility to services may be limited to do the

assumption of homogeneity within the rural population.

Youth Access to Mental Health Support and Services in Rural Canada

Based on existing literature, we know that the following factors may influence youth access:

      Physical access to care. Youth in particular have extra challenges to accessing services

in rural areas. Many youth cannot drive because of their age or associated costs (i.e. vehicle,

license, driving test). Because many rural communities do not have public transit, many youth

must depend on a trusted adult to take them their appointment (Forchuk, Jensen, Martin, Csiernik

& Atyeo, 2015). This relationship between the youth and an adult is not always feasible because

of the stigma surrounding mental illness, as well as the costs associated with traveling for

appointments (e.g. gas, car maintenance, lost work days) (Forchuk et al., 2015). Traveling to

appointments outside of their community can also mean missed school days, which may further

disadvantage their academic progress.

Community belonging. Typically, Canadian rural youth between the ages of 12 and 17 years report a strong sense of community belonging, which decreases between the ages of 18 and 29 years (Statistics Canada, 2016). This decrease in sense of belonging may be due to the transient nature of this age period (i.e. moving away for school or work); however, no explanation is given. A sense of belonging can encourage youth to open up about mental distress. Nevertheless, the social atmosphere of the community can also be stigmatizing because of the lack anonymity and culture of gossip (Davidson, Kutcher, Manion, McGrath & Reynolds, 2011). Belonging and sense of community may differ within subpopulations and can give further insight into the culture of rural Canada.

Gender. While young Canadian females are more likely to be diagnosed with a mental illness, there is no indication that young males experience a greater sense of community belonging (Pearson, Janz & Ali, 2013; Statistics Canada, 2016). Within Canada, approximately two thirds of both women and men experience a sense of community belonging (Statistics Canada, 2016). However, perceived lack of community belonging is found to have a greater negative impact on the social and psychological health of women (Kitchen et al., 2012). On the other hand, young males with mental health issues are more likely to be stigmatized in their community due to the perceived lack of masculinity associated with mental health issues (Davidson et al., 2011).

Sexual orientation. In general, youth who identify as LGBTQ* often experience greater mental health issues, including higher risks of depression and suicide than their hetero counterparts due to minority stress (Lehavot & Simoni, 2011; CMHA, 2016b; Rainbow Health Ontario, 2013). Attachment to school can be a way of facilitating community belonging; however, many LGBTQ* youth experience stigma and discrimination from their peers, which

can make school feel unsafe and mitigates their connection to the community (Langille, Rasic,

Kisely, Flowerdew & Cobbett, 2012; McCreary Centre Society, 2007). Gay-Straight Alliances

(GSA) within Canadian schools have been useful in creating a stronger sense of community

attachment; however, one study notes that many rural GSA do not have access to the same

resources as urban GSAs (St John et al., 2014). Likewise, family rejection can impede

community belonging and is strongly correlated with poor mental health (Rainbow Health

Ontario, 2013). The stigma surrounding LGBTQ* youth can negatively influence sense of

community, as well as access to mental health services (McIntyre et al., 2011).

Racial minorities. Both Indigenous youth and other racial minorities face barriers to

community belonging. Over half of the Indigenous population in Canada are considered to be

youth, and suicide and self-harm are the leading cause of death for this population (Centre for

Suicide Prevention, 2013). For Indigenous youth, place traditionally plays a large role in their

identity. However, as Cunsolo-Wilox et al. (2012) note, the majority of Indigenous youth reside

in rural and remote places, where the loss of place to climate change has a huge impact on their

physical and mental health (p. 544). While climate change directly impacts the physical

environment of place, the change in environment results in a "psychological process and socio-

cultural process" within the individual called "solstalgia", as their sense of community belonging

is also changing (Cunsolo-Wilox et al., 2012, p. 539.) The lack of access to culturally appropriate

supports to help facilitate self-expression and exploration can further distress Indigenous youth

(Centre for Suicide Prevention, 2013).

Literature on the mental health of young new immigrants and racial minorities,

particularly in rural Canada, is quite limited (Caxaj & Gill, 2016). However, Khanlou (2010)

suggests that youth are subjected to increased stressors as they negotiate their own identity and

help their parents transition to a new community. Khanlou (2010) also believes that young female migrants may have a more difficult time forming community connections because of traumatic pre-migration situations. Despite notable barriers, Caxaj and Gill (2016) cite that ethnic diasporas can create a sense of community within the greater geographic area, as proven with the Indian-Canadian population in British Columbia.

Socioeconomic status. Poor economic development in some rural communities means that many youth must leave their community for further education or to secure well-paying jobs, which can be very stressful. Youth who stay in their home community may experience the loss of their support system if friends and family move away for work (Jackson et al., 2007). Kitchen et al. (2012) recognize that youth who come from households with a family income of $80,000 or greater, usually experience a greater sense of community because of higher potential of social mobility compared to households with less than $20,000 or headed by a single parent. Overall, very little is known about the impact of SES on rural youth mental health, as most studies focus on adult residents who are responsible for contributing to household income and paying for rent and other necessities (Fagg et al., 2013).

Support of family and friends. There is little published literature available on how rural youth may experience the support of family and friends. From a family perspective, one rural Ontario study suggests that parents view themselves as the "squeaky wheel" and are often vocally advocating for access to services for their youth (Boydell et al., 2006, p.185). Rural living can be a barrier for parents when searching for mental health supports and services for their children because of distance to urban centres; however, the small geographic area allows for parents to gauge the credibility of existing services (Boydell et al., 2006). There appears to be

relatively no published literature on whether youth in Canada choose to use their parent or family member as a support system, and the factors behind this choice.

In terms of support from a friend, the existing literature focuses on an organizational level and the role of self-help (i.e. youth supporting other youth regardless of experience or knowledge) (Hall, 2007). Virtual self-help (i.e. using social media and the internet for support), is also thought to be common for individuals without access to formal services or face-to-face contact with peers (Naslund, Aschbrenner, Marsch & Bartels, 2016). Although there is little literature on peer support in rural Canada, rural areas of other industrialized countries, like Australia and the United States, are focusing on peer support programs to bolster existing mental health programs. Peer support is thought to beneficial for those living with a mental health concern because "peer workers know what it is like to experience mental illness and can share experiences of personal recovery with consumers" (NSW Mental Health Commission, 2014, p. 100, as cited in Gray, Davies & Butcher, 2017). In a pilot study done in Australia, it was found that the lived experiences of peer workers made them a valuable part of mental health programs; however, more training and formalization of the role needed to take place (Gray et al., 2017). In the United States, peer workers have also been used to provide support for members of the LGBTQ* community living with mental health concerns (Willging et al., 2016).

Youth access to care in Nova Scotia. Research indicates that there are significant health disparities between Atlantic Canada (e.g. New Brunswick, Newfoundland and Labrador, NS and Prince Edward Island) and the rest of Canada (Haggarty et al., 2010). PHAC notes that Atlantic Canadians are more likely to experience mental health issues than other Canadians because of the higher prevalence in the rural population (Latham, 2012). Access to care for youth is infrequent, despite indications that youth are actively seeking help (Asbridge & Langille, 2013;

Davidson et al., 2011). PHAC also suggests that lost jobs, economic decline and lost sense of community could be contributing factors to poor mental health in the Atlantic provinces (Latham, 2012).

Within Atlantic Canada, NS has the highest prevalence rate of diagnosed youth depression (Latham, 2012). The *Nova Scotia Student Drug Use Survey*, which monitors self-reported rates of substance use and mental health among NS high school students, has found similar findings as the PHAC report (Asbridge & Langille, 2013). In general, NS students, particularly those in rural areas, are reporting higher levels of depressive symptoms and suicidal behaviour than the national average (Asbridge & Langille, 2013). In response, the Province of NS launched a mental health task force which released a recommendations report and made it clear that access to services is a provincial priority: "[E]very Nova Scotian has a right to expect equitable access to mental health and addiction services" (Ungar & McDonald, 2012, p. 5). Although it can be assumed that youth in rural areas of NS experience the same barriers and facilitators of access as other rural Canadian communities, there is very little literature outlining how exactly youth in rural NS may perceive and experience access.

School-Based Services

Rural schools. Much of the literature on rural mental health supports and services focuses on formal mental health services, like psychiatry or inpatient units. However, for many rural communities, local schools can be key resources. Historically, rural schools in Canada were deemed to be for "cognitively deficient" students because there were fewer resources being invested in them and it was believed that promising students would be sent to urban schools to prepare for a specific occupation (Thompson, 2011, p.7). Because of the divide between rural and urban, there has always been an "othering" of rural students; particularly in terms of

research, as most research on education and student outcomes have come from urban institutions. Further, the literature that does exist on rural schools is often from urban scholars (Thompson, 2011).

Since the rise of globalization, there has been declining enrollment in many rural schools, forcing closures in many small Canadian communities in order to accommodate the values of efficiency, productivity and the ability to compare students on an international scale (Stromquist & Monkman, 2000). However, the rise of rural school closures has resulted in a movement within rural communities to prevent further closures. Campaigns associated with this movement have cited rural schools as being more than just settings for education, but rather community hubs (Clandfield, 2010; People for Education, 2017). Community hubs are defined as "the focus of activity for neighbourhood families finding diverse needs catered to in one public site" (Clandfield, 2010, p. 9). Many rural communities in Canada, particularly in British Columbia, Ontario and NS, where rural school closures are high, are now turning to the community hub model in order to preserve historical buildings and community resources.

School-based services. Many rural public schools are considered to be community hubs because of the inclusion of school-based services (SBS), which are "those delivered by school-employed or community-employed providers in school buildings" (Doll, Natasi, Cornell & Song, 2017, p.1). SBS are thought to be potentially successful mental health services for prevention and treatment (Macklem, 2014). SBS may include services such a mental health services, nursing services or community services (i.e. judicial). Within North America, SBS were primarily implemented because of the growing data concerning the rise of mental health concerns among school aged children. Multiple studies have shown that students with mental illness are less likely to have academic success (Doll et al., 2017). However, from a community standpoint,

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there has a been an increasing focus on implementing SBS that will be able to serve not only students currently enrolled in the school, but community members after school hours (Province of NS, 2016). Having SBS may promote better access to mental health services by simply having services in the school; however, there are also concerns regarding who actually accesses SBS, who provides the services and whether SBS are effective in preventing and responding to youth mental health issues (Macklem, 2014; Gahagan, Jason & Leduc, 2012).

School-based services in Nova Scotia. Within NS, there has been a strong political movement among public school teachers to improve classroom conditions for their students. This movement includes a work-to-rule strike during the 2016-17 school year when teachers were legislated back to work by the provincial government (SaltWire Network, 2017). NS public school teachers have suggested one key classroom improvement involves providing resources for students struggling with mental health concerns (The Canadian Press, 2017). In response to these concerns, the Province of NS has committed to creating "wrap around classrooms" to better connect students with necessary health resources, although it is unclear at this time what this looks like (Glaze, 2018, p. 31). Their other initiative has been implementing the SchoolsPlus program in schools around the province.

The SchoolsPlus program was created in 2008 by the Department of Education in collaboration with the Departments of Community Services, Health and Wellness and Justice, as part of the *Our Kids Are Worth It* strategy (Halifax Regional School Board, 2017). This program aims to provide "comprehensive, collaborative [and] seamless delivery of services" within schools that respond to community needs, including youth mental health (Province of NS, 2016, n.p.). Targeting youth mental health through schools is supported by the provincially-commissioned report on mental health, entitled *Coming Together*, which states that schools

should be the focus of future mental health promotion activities (Ungar & McDonald, 2012). The program sees that existing infrastructure (e.g. schools) is used to improve the well-being of the community. Ideally, a SchoolsPlus site will house a variety of services, such as health services and recreational programs, that will be available to students during the school day, as well as the greater community after school hours.

Summary

A review of the literature has found numerous gaps in rural mental health research. The majority of literature on access to mental health supports and services in rural Canada focuses on the experience of adults. Virtually no literature focuses on the experiences of Canadian youth when accessing mental health supports and services. The majority of what is known comes from a heteronormative perspective and depicts rural Canadian populations as being homogenous. Finally, very little research addresses youth mental health in NS, let alone from a rural perspective.

Moving forward, more research needs to be conducted on the accessibility of mental health supports and services for youth in rural Canada. Ideally, future research will also incorporate the lived experiences of youth and will address areas of Canada which are not the focus of existing research, including Atlantic Canada (Boydell et al., 2008). Focusing on youth populations is beneficial for population health, as the Province of NS's mental health task force states: "Research shows that the strongest return on investment in health promotion efforts is for programs focusing on children and adolescents" (Ungar & McDonald, 2012, p. 23). Ultimately, this study on the perceptions and experiences of youth access in rural NS will incorporate the lived experiences of youth, in order to address these gaps in literature, as well as inform future policy development and programming.

Chapter 3: Study Design and Methods

This study asked: How do youth living with a mental health issue in one small rural community in NS perceive and experience access to and use of mental health supports and services? A series of sub-research questions were used to answer the main research question, including: 1) What do youth living with mental health issues in this community perceive as the key barriers to accessing mental health supports and services?; 2) What do youth living with mental health issues in this community perceive as the key facilitators to accessing mental health supports and services?; and 3) What mental health supports and services (existing in the community or not) do youth living with a mental health issue perceive as being the most valuable, and why?

Conducting Qualitative Research

This study used a qualitative approach rooted in social constructivist theory to capture the lived experiences of youth within the study community. A qualitative research design was the most appropriate approach to this study as it best captured the lived experiences of youth due to its focus on exploration. As Creswell (2013) explains, "[w]e conduct qualitative research because a problem or issue needs to be explored" (p. 144). Creswell (2013) goes on to note that qualitative research is especially useful when we want to "hear silenced voices" and "empower individuals to share their stories" (p. 144-145). As Creswell (2013) puts forth, "the goal of the research, then, is to rely as much as possible on the participants' views of the situation" (p. 91).

The study drew from social constructivist theory because the purpose was to gain a better understanding of how youth in a specific community setting perceived and experienced access to mental supports and services. Social constructivism suggests that "[individuals] develop subjective meanings of their experiences – meanings directed toward certain objects or things"

(Creswell, 2013, p. 74). The developed meanings may vary according to the individual and usually have social or historical significance (Creswell, 2013, p. 74). According to Creswell (2013), there are a number of ways in which social constructivists validate their research, including placing emphasis on the "specific contexts in which people live and work in order to understand the historical and cultural settings of the participants," as well as being reflexive about their own positionality (p. 92). To this end, the lived experiences of students within the study community were gathered through interviews and presented using quotations in order to generate knowledge about the study community and students' perceptions and experiences of access to mental health supports and services within the study context.

      Grounded theory. Elements of grounded theory were used to guide the study. Grounded theory is a qualitative methodology developed by Glaser and Strauss (1967) to construct theory rooted in collected data. Grounded theory can be useful in the reducing "armchair theorizing" (Corbin & Strauss, 2015, p. 6). As Corbin and Strauss (2015) posit, the methodology can "demonstrate how logic and emotion combine to influence how persons respond to events or handle problems through action and interaction" (p. 11). Normally, data are collected in order to create themes, through conceptual ordering, which can be used to build a theory. Conceptual ordering "refers to the organization of data into discrete categories…" (Corbin & Straus, 2015, p. 61). Concepts arise during data analysis and are not defined beforehand. Grounded theory can be used to understand different perspectives of a situation, such as access, through the use of data. In this study, I only used conceptual ordering to help develop themes from the data. I decided not to develop a theory from these concepts because of the small sample size and because conceptual ordering could best answer my research questions.

One of the strengths of grounded theory is its reliance on data, in order to generate concepts and, eventually, a theory. This study emphasized the inclusion of the first voice and sought to understand the perceptions and experiences of youth. Choosing a methodology which also emphasized the first voice was critical to the success of the study. One of the unique aspects of grounded theory is the interconnectedness of data collection and analysis. Grounded theory relies on constant comparison and a set procedure in order to generate concepts. Therefore, the resulting concepts are more objective than a pure description of the data. This quality exists because the concepts are evidence-based and are not just the interpretation of the researcher (Corbin & Strauss, 2015). Although data collection and analysis procedures were informed by the grounded theory procedures, it was modified for the purpose of the study. Typically, data are constantly being collected and compared to emerging concepts, resulting in large volumes of data. Because of the timeline for this study, data collection only occurred once; but during the analysis process, there was a constant comparison between emerging concepts.

Community Based Participatory Research. This study incorporated elements of community based participatory research (CBPR). Minkler (as cited in Federal Reserve, 2014) describes CBPR as "using a community-based approach to data gathering and translation [and] can significantly improve the "relevance, rigor and reach" of data-driven practices" (p. 244). In an effort to work with the community, two student RAs from the study school were recruited to assist with the study. Avard, Black, Samuel, Griener and Knoppers (2012) suggest that "[i]f minors are to benefit from qualitative research, greater effort is needed to involve minors as key stakeholders in all stages of the research, from planning, to interviewing, to analysis" (p. 40). Although, the RAs were not able to participate in all aspects of the research due to ethical concerns, they had a role in providing feedback on the interview guides and will assist with

knowledge dissemination in the community. The RAs were also helpful in providing suggestions on how best to communicate with youth. The purpose of this role was not only to have community feedback at multiple stages of the research, but to also give the RAs valuable research and community action experience, which otherwise might not be available through the school. A small honorarium of $150 was provided to students at the end of the study activities to thank them for their help and input.

Setting

Pictou County, situated in Northern NS, is a geographic area consisting of five towns, a rural municipality and a First Nations community. In 2016, Pictou County had a population of 43,748 which had decreased 4.2 percent since the last census in 2011 (Statistics Canada, 2018a). The majority of residents have a European heritage and the area is well known as being the first landing place of Scottish settlers in Canada (Hector Heritage Quay, 2018; Statistics Canada, 2018a). Historically, the area was reliant on primary industries, such as mining and fishing, as a main economic driver and was considered to be the industrial heart of Atlantic Canada with over 107 industrial companies employing well over 5500 people (McCulloch, 1981). Many of these industries began in the 1800s at the peak of national mining and rail industries and resulted in the area being considered as Canada's Birthplace of Steel (Councils of Pictou County, 1916). Historical records show that in the 1980s, residents of the area were making at least $35 a week more than any other community in NS, including Halifax (McCulloch, 1981).

Since then, almost all coal mines have closed in the area, including the infamous Westray mine, which received international attention after a 1992 explosion killed 26 miners underground (Richards, 1996). The last remaining coal mine, Pioneer Coal, still operates in the Town of Stellarton, but is expected to close in the next few years after the area has been

completely mined (Beswick, 2013). Due to the demise of primary industries, the area has been

economically struggling and has been considered one of the worst places to live in Canada for

the last number of years (Moneysense, 2017). As of 2018, the area has a relatively low economic

status compared to the provincial average. The median household income, regardless of

household size is $56, 066 compared to the provincial average of $60, 674 (Statistics Canada,

2018a). Approximately 19 percent of the population is considered to be low income, after tax

(Statistics Canada, 2018a).

Health care services are being restructured in the community, much like other rural

communities in Canada. This restructuring has resulted in the closure of the local hospital's

mental health in patient unit and the retirement of the area's only psychiatrist (Henderson, 2016;

Musick, 2018). The restructuring of services means that many residents must now travel outside

of the community for specialized mental health care. The next closest hospitals are located in the

towns of Truro and Antigonish, approximately 60 kilometres away (NSHA, 2016). However,

there are accounts of patients being sent as far away as Yarmouth, approximately 460 kilometres

away, to seek treatment and support. Between August and December 2015, 143 people accessed

the emergency department (ED) of the Aberdeen Hospital for mental health services. Of those

143 patients, seventeen patients were transferred to another hospital for in-patient treatment

(Henderson, 2016). Those with a diagnosed mental illness who do stay in Pictou County and

require specialized treatment have limited options for treatment. Youth can access community

mental health services, such as group therapy or programming through NSHA; however, a

referral is needed from a family physician or parent or guardian (Pictou County Health

Authority, 2016). Although referral-based services may prevent individuals from seeking

unnecessary care, this system is problematic for youth without a family doctor. As of November

2017, 37,339 Nova Scotians are on a provincial wait list to get a family doctor (Ray, 2017). Approximately, 1600 of those registrants are from Pictou County (The News, 2017). Although there are private psychology practices available in the community, a poor economy means that not every resident has the financial means to access these services.

The SchoolsPlus program has been another way of providing mental health supports and services in the community. The Province of NS (2016) describes SchoolsPlus as being "a collaborative interagency approach supporting the whole child and their family with the school as the center of service delivery" (n.p.). Within this model, a SchoolsPlus facilitator and community outreach worker are employed within participating schools to help students and their families navigate, connect and access health and social services within their community. At the regional level of Centres for Education (formally known as school boards), there are advisory councils which include representatives from government departments, including Education, Justice, and Health and Wellness. At the beginning of the program, three schools within Pictou County were selected to participate: one at the elementary, junior high and high school level. However, all schools were located within the Town of New Glasgow, where most other community health services are located (Jess, 2014). While this location may encourage collaboration between existing services, it also means that community members living in rural areas of the community are still not being served because there is no public transit in Pictou County. In March 2017, the Province of NS announced that it would be investing an additional $4.4 million by 2019-2020 in the SchoolsPlus initiative (Palmeter, 2017). Additional funding means that the SchoolsPlus program will be implemented in more schools in the future, potentially benefiting more students and families. Currently there are very few SchoolsPlus sites in rural NS, especially in Northern NS, which is the orange region of the map (Figure 4).
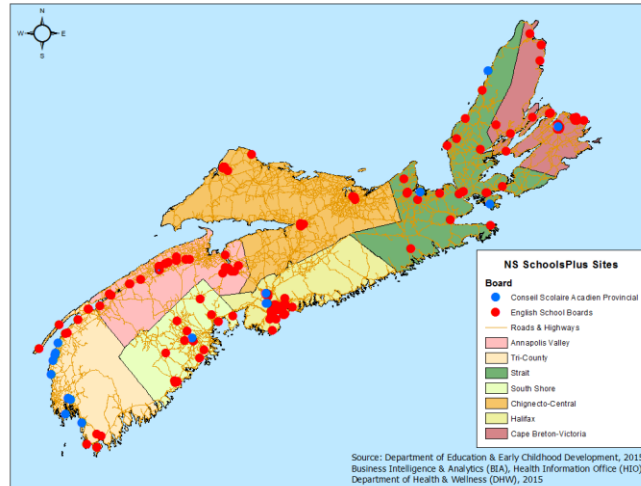
Figure 4 Map of NS SchoolsPlus Schools (Province of NS, 2016)

Researcher Reflexivity

An important aspect of this study is my positionality as a researcher. I was raised and attended school in Pictou County. During my senior year of high school, I was diagnosed with major depression by my family doctor. Although I had been living with a mental health issue for several years, I was not knowledgeable on mental health and I was unaware of where I could go for help in my community. It was not until I left Pictou County to attend university in Ontario that I began to seek out supports and services for my mental health. Because of my mental health experiences, I have an understanding of what it may feel like to live with a mental illness in Pictou County. However, because I was formally diagnosed at the end of my time in the community, I do not fully understand the experience of access to services and supports.

My lived experience of mental illness has guided many of my educational and volunteer endeavours. While completing a Bachelor of Arts (Honours) in Global Development Studies at Queen's University, I was heavily involved with mental health initiatives in the local community. I chaired the university's mental health awareness committee, where I helped

develop an award winning lived experience workshop for first year students. I also held a managerial position with the campus Peer Support Centre, where I undertook SafeTALK and ASIST training to better assist the hundreds of students who received support each school year from the service. Now, I volunteer with Kids Help Phone as a Crisis Text Responder. These experiences have helped me develop better communication skills and knowledge on how to interact with youth who are experiencing mental health issues in ways which validate their experiences and provides an open space for dialogue. Having these experiences and related skills helped facilitate the research process, such as facilitating interviews through active listening.

Insider-outsider positionality. My personal and professional experiences relating to the study community and mental health have influenced how I am positioned in the research process. There is a large body of literature which describes the insider-outsider researcher position. Insider research occurs "when researchers conduct research with a population of which they are also members" (Kanuha, 2000, as cited in Dwyer & Buckle, 2009, p.58). Within the category of insider positionality exist three types of researchers: peripheral members, active members and complete members. Peripheral members are researchers who are a part of the population, but do not participate in the same core activities as the rest of the group. Active members are researchers who are involved with central activities of the group, but who do not fully share the same values. Complete members are researchers who engage in the same core activities and share the same values as the rest of the group (Adler & Adler, 1987, as cited in Dwyer & Buckle, 2009, p.55).

However, the insider-outsider position is no longer viewed as being simply binary (Milligan, 2016). Current research argues that positionality and researcher identity should be thought of as a "liquid identity" (Milligan, 2016, p. 240). The concept of the liquid identity

emphasizes the hyphen in "insider-outsider," by examining this space as "the space between" or a space of tension (Dwyer & Buckle, 2009, p. 60). Milligan (2016) argues that it is no longer the role of the researcher to position themselves as an insider or outsider. Instead, the researcher must acknowledge the fluidity of their identity based on how research participants view their relationship with the researcher. The only control the researcher has over this positioning is the ability to make choices in the research design, which could alter their positionality.

Based on the literature surrounding the insider-outsider position and the liquid identity, I view myself as an peripheral member researcher with insider positionality; however, I acknowledge that I have a liquid identity, which means that my identity could have been interpreted quite differently by the school community than how I interpret it. Because of my age and having lived outside of the community for the last several years, it is possible that I was viewed as an outsider. Since I was unable to predict exactly how I would be perceived by the students, I acknowledged early in the research process that I would need to build continued trust with the students by sharing my positionality with the students. Since moving back to NS to work on my master's degree, I have spent time volunteering in the school and surrounding community, as a way of re-integrating myself into the community.

Participants and Recruitment

Study population. The focus of the study was to capture the perceptions and experiences of rural NS youth living with a mental health issue when accessing mental health supports and services. Participants were youth, between 16 and 18 years of age, currently enrolled in grades ten, eleven, and twelve at one rural high school in Pictou County. This study population was purposively recruited because the perspectives and experiences of rural youth were desired, and

evidence suggests that NS students are most likely to be living with a mental health issue around the time they are in grade ten (Asbridge & Langille, 2013).

Inclusion and exclusion criteria. Inclusion criteria for the study was any current student at the study school in grades ten, eleven or twelve, between the ages of 16 and 18, who was experiencing self-reported perceived poor mental health (e.g. depression, low mood, anxiety, eating disorders,) and who had been a resident of Pictou County for at least one year. These criteria were selected, so that service and support utilization in the community could be reliably captured. Eligibility for the study was based on self-reporting. A formal diagnosis was not required as lack of a family doctor or other barriers may have prevented them from seeking care or a formal diagnosis. Therefore, no screening instrument was used other than the student self-identifying as being eligible.

Sampling and study size. There is debate surrounding the recommended number of participants for a qualitative research study. Guest, Bruce & Johnson (2006) and Sandelowski (2000) do not recommend a specific sample size for qualitative studies. On the other hand, Patton (1990) suggests that ten to fifteen participants are feasible for purposeful sampling strategies. As Al-Busaidi (2008) suggests, the recruitment strategy is based on the available human, financial and temporal resources available, as well as study objectives (p. 15). For this study, seven students were recruited. Before the data collection stage, I had hoped to recruit between six and ten students. I was unable to reach the maximum number of participants due to time constraints. The recruitment period coincided with the Christmas break and high school exam period, which made it difficult to recruit high numbers of participants due to the busyness of the school.

Recruitment strategies. Multiple strategies existed for student recruitment. To begin, two student RAs, one male and one female, were recruited from the school community. Their responsibilities were to provide feedback on the interview guide and knowledge translation activities in their community. The students involved received a small honorarium to thank them for their work. To recruit the student RAs, the school's Student Services was provided with the position description (Appendix A). The position was shared internally through a staff email, through posters and through the school's morning announcements (Appendix A). Students were able to "apply" for the positions by submitting a paragraph stating their interest to Student Services. Student Services was used as the contact point for this position, since they are the main source of the school's co-curricular and extra-curricular information. For similar student opportunities (i.e. co-op positions, student leadership programs), students apply through Student Services and the staff select a deserving student who best fits the opportunity and who would benefit the most. Having Student Services involved was important because they knew the student applicants best.

The main source of participant recruitment was through the school. Morning announcements, posters, and newsletter inserts were used for recruitment (Appendix B). A homogenous purposeful sampling strategy was used because it specifically targets the recruitment of a group of people with many of the same characteristics (Patton 1990, p. 173). Interested students were asked to send me an email stating their interest in participating. Once I received their email, I provided more details about the study, confirmed that they were eligible to participate and sent them a copy of the informed consent form (Appendix C). Once any questions that they had were answered, I scheduled an interview time. Students were offered a small honorarium to participate. At the time that their interview was scheduled, students were able to

select their choice of a $20 gift card to either Cineplex, Sportchek, or Indigo. These options were selected because they are businesses in the community that are popular among youth.

Data Collection

The importance of gathering lived experiences. Lived experiences (i.e. the access related experiences of youth living with mental issues) were collected using semi-structured interviews. Recent international studies show the importance of lived experiences to the development of program and policies, as well as quality improvement within the mental health care system (Borg, Karlsson, Lofthus & Davdison, 2011). The first voice allows for advocacy to occur because the wants and needs of the population are vocalized in their own language, through the use of quotes.

Corbin & Strauss (2015) suggest that unstructured interviews are key methods for data collection using grounded theory (p. 38). For the purpose of this study, I used semi-structured interviews. I decided to use semi-structured interviews rather than unstructured interviews because of limited time for data collection (i.e. one hour over lunchtime) and in order to purposefully probe participants. Semi-structured interviews are commonly used in health research because their flexible open-ended nature can generate more information about an individual's experiences (Al-Busaidi, 2008).

Data collection setting. The data was collected at a rural high school in Pictou County, NS. Semi-structured interviews were held on school property during lunch hour in a private office. The office could be locked and had window coverings to ensure maximum privacy. It was located in a quiet hallway away from most foot traffic. Interviewing over the lunch hour was selected because it ensured that additional transportation before or after school was not an issue for students who were interested in participating. Recognizing that there is a high level of

extracurricular student activities that happens over the lunch hour, all interested participants were able to select the day of the week (Monday through Friday) that they wanted to be interviewed. Giving this choice to the youth allowed them to select a day that would not interfere with their schedule, which may potentially "out" them as having participated in the study. I was the only researcher participating in the data collection process. The student RAs did not participate in data collection because some participating students may have felt as if that their privacy and confidentiality were threatened, which could have influenced how they answered questions.

All meetings with the student RAs were also held in a private room. During the course of the study, I met with the student RAs in-person four times, but frequently communicated with them over email and sometimes by phone. During these meetings, I would contact the Acting Principal of the school and he would find a private space on school property to meet. Due to space limitations, this space varied from a private guidance counselor office to the principal's office. It was important to meet in a private space to ensure confidentiality of study information and to maintain the privacy of the student RAs.

Interview process. A semi-structured interview guide was developed for this study based on literature reviews, and input from my committee and student research assistants (Appendix D). To prepare for the interviews, I met with the student RAs once in the fall (October 2017) and communicated with them over the phone and email several times leading up to the interviews. During this time, I explained more about the study and their roles. We also spent time going over the interview guide and time was given for them to provide feedback on the guide. Based on their feedback, it was deemed that the questions included in the initial interview guide were appropriate for the final interview guide. However, their feedback did influence the types of probing questions and language that were used.

A week before a scheduled interview was to occur, as well as the day before the interview, I contacted the student participant to remind them of their interview and its location. The student met me at the beginning of the lunch hour at the private office. The informed consent discussion was held, and the student signed the informed consent form. The student was given their choice of gift card as a thank you for participating. Students were given this thank you before the beginning of the interview in case they decided to withdraw from the study at any point of the interview. I signed an honorarium form noting the day, location and participant number for once the student has received their gift card (Appendix E). Students were given the option of receiving a pamphlet of mental health resources in Pictou and Colchester Counties, as a safeguard for their mental health after the interview (Appendix F). No students opted to receive the pamphlet. Each interview lasted approximately one hour. After all of the questions were discussed, I ended the interview and thanked the student. I briefly explained what would happen with the information they provided me and how the final report would be disseminated. Students were not able to review a transcript of their interview due to time constraints and difficulty of follow up during the school year.

During the interview, students were given the option of having their interview audio recorded and having direct quotes used. If they did not want their interview audio recorded, I took notes by hand. Only one of the seven students interviewed did not want to be audio recorded. This individual still agreed that direct quotes could be used. During the interview, I took general notes about the student's experience. Whenever the student mentioned something that I thought may be a useful quote to include, I wrote down what they said verbatim and after they finished answering that specific question, I checked with them to make sure the quote represented what they said. I only did this for short quotes (i.e. ten words or less). Because it was

challenging to take detailed notes while interviewing, this practice did not happen often and very few direct quotes from this participant are included in the results.

During the data collection and analysis process, I kept a small journal in which I noted my thoughts as memos. This journal allowed me to reflect on time spent working with the student RAs and organize my thoughts during data collection and analysis. Keeping a journal helped me to better understand my positionality as a researcher. During the interview process, journaling helped me debrief after each interview and prevented me from interjecting with my own thoughts, which could have dictated the direction of the interview or resulted in response bias. It also helped me note patterns between interviews and during coding and note anything that surprised me during analysis.

Data Analysis

Data were analyzed using conceptual ordering, a modified version of grounded theory. Conceptual ordering allows the researcher to understand and present data a step further than only description but does not involve the creation of a theory (Corbin & Strauss, 2015). I decided to use conceptual ordering because I wanted to develop a conceptual understanding of youths' perceptions and experiences, but the study was exploratory in nature, so a developed theory was not possible. After data collection, all interviews were transcribed, ensuring that all personally identifying information was removed. Transcripts of the interviews were coded using Atlas-ti. Invivo coding was used to create preliminary codes from the data. Invivo coding was used because it captured the participants' own words, which were very rich and conceptualized their experiences (Corbin & Strauss, 2015). After invivo coding, I collapsed the initial codes (i.e. axial coding) into fewer groups. Through constant comparison, I was able to inductively develop key themes from these codes. Key themes were identified based on codes which had appeared in the

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majority of interviews (i.e. four or more). However, some of the experiences shared by participants were so unique that there was little overlap with other codes. In this case, these experiences were used as examples, but were not necessarily considered to be a theme. My supervisor went through the anonymized transcripts after they were coded in order to check whether they were coded and themed properly.

Ethical Considerations

Submitting to ethics. At all stages of the research, I sought to uphold the three main tenants of the Tri-Council Research Ethics Board: "respect for persons, concern for welfare, and justice" (Government of Canada, 2014, p. 6). This was a higher risk study because it addressed a vulnerable population's experiences with accessing mental health supports and services. This study also took place at a public high school, which required additional ethical consideration to ensure students' privacy and wellbeing were maintained. This study received a full board review through the Dalhousie University Health Sciences Research Ethics Board in July 2017 (Appendix G). Additionally, a letter of support from the school's acting principal was collected and submitted to the Chignecto Central Centre for Education (formally known as the Chignecto Central Regional School Board), the governing education body in the area (Appendix H). School board approval was necessary because the research was occurring in the school. The study was given approval by the school board in September 2017 (Appendix I).

Risks and benefits. The risks associated with this study, included psychological harm in the form of distress, discomfort, mental fatigue, and the "triggering" of past experiences during discussion. There was also a risk of social harm to participants, such as the stigma associated with mental illness and participating in a study on mental health. This risk was heightened because the interviews took place on school property in the vicinity of their peers.

The risks were minimized by allowing participants to skip any questions that they did not want to answer. They could also take a break at any time. Participants were able to withdraw from the study at any point during the interview or up to two weeks after their scheduled interview. Data analysis did not start until two weeks after the last interview was collected. Students were also given the option of taking the pamphlet with a list of community mental health resources. This was optional as it was recognized that having a pamphlet in their possession may "out" the student as having participated in the study, and, therefore, as having a mental health concern. School based services, such as guidance counsellors, were also aware that interviews were happening at the school and were available to provide support if needed, although the names of participants were not shared. Finally, all information that was used in the final sharing of results was anonymized (e.g. personal information excluded/bracketed from transcripts).

Participating in this study may not have directly benefited the participants; however, there are some people who may find it helpful to share their experiences in a supportive and safe space (Pennebaker & Seagal, 1999). There are several indirect benefits to the study, including potential contributions to scholarly works on rural youth mental health. The study may also inform future programs and policies, which may help youth in the community.

Working with vulnerable populations. The participants in the study, youth with mental health issues, are considered to be vulnerable (Government of Canada, 2014). However, it was necessary to include this population in the study to collect information on their experiences, given that so little is known about how youth access to mental health supports and services in rural NS. I was careful not to create further vulnerable circumstances through the careful selection of the language being used to talk about mental health and mental illness in the study

(i.e. no slang or colloquialisms that could be misinterpreted). Further, I requested that I be

reviewed for a current criminal record check and vulnerable sector search that was available to

the school administration at their request by the beginning of data collection. Working with

student RAs may have also helped mitigate some of the challenges working with a vulnerable

population because they had a greater insight into how to effectively work and communicate

with this population.

Informed consent. Informed consent was "free, informed and ongoing" (Government of

Canada, 2014, p. 202). It was important that all study participants had time to fully and freely

consent to participation. Aside from Dalhousie's informed consent protocol, informed consent

also needed to follow school board protocol (e.g. passive consent). The school board policy was

that passive consent was collected from parents or guardians. As per school policy, passive

consent was gained by notifying parents or guardians electronically about the study (i.e. through

school, website, Google classroom) (Appendix J). Passive consent gathered electronically is now

common practice for the school which has since moved all letters, newsletters and notices online,

instead of providing paper form. Parents or guardians who did not want their child participating

in the study were asked to email me and I would keep track of students' names. Parents and

guardians had one week from the time of notification of the project to the beginning of data

collection to opt their teenager out. No parents or guardian contacted me to opt their student out

of the study.

When an interested student contacted me, she was forwarded the informed consent form

for her own perusal. Having the student give her own consent was important because it

maintained her right to confidentiality. Being able to speak to the researcher without having their

parent/guardian present may have also minimized any response bias. On the day of the study, I

discussed the informed consent form with the student. The student was asked questions to make sure she know what she was signing. She was able to withdraw from the study at any time during data collection and up to two weeks following data collection by emailing me.

Privacy and confidentiality. Talking about a stigmatizing topic, such as mental health, can raise privacy and confidentiality issues. As a researcher, I did everything in my capacity to create a safe space, where students could express themselves freely. For example, the room was locked, so that others could not enter the room, but the student could leave at any time. The blinds were drawn on the windows for the privacy of students. Potential privacy breaches were minimized using several strategies. First, study communication was through the student's personal email and the subject line did not disclose their participation in the study. Secondly, during the interview, students were told that confidentiality would only be broken for legal obligations, such as if there was suspicion of abuse or neglect of a child, an individual was at risk of harming themselves, or there was concern that someone else is in immediate danger of being harmed. Participants had the option of having their interview recorded, as well as having direct quotes used in the final results. Finally, I anonymized lived experiences and excluded personally identifying factors in data analysis and dissemination. Privacy and confidentiality measures articulated through the informed consent form may have also comforted participants and helped in creating a safe space for discussion.

Storage of data. All data and consent forms were securely stored. During data collection in Pictou County, paper copies of the consent forms were stored in a locked briefcase with the key to the briefcase kept on me at all times. The briefcase was only used while in Pictou County and while transporting the documents back to Halifax. Once in Halifax, the consent forms were taken to the supervisor's office as soon as possible and stored in a locked filing cabinet.

Identifying information was stored separately from the collected data. If the student consented to having her interview audio recorded, it was done using a handheld audio recorder. The audio recorder was transported between the school and my family home in Pictou County using a locked briefcase. Once I arrived at my family home in Pictou County from the school site, I immediately transferred the audio files from the audio recorder to two external hard drives. Both external hard drives were password protected and were also labeled with my name and phone number (but not the contents of drives) on the front of each hard drive. The audio files were immediately deleted from the audio recorder. The external hard drives were transported back to my house in Halifax in a locked briefcase, where I stored both of the hard drives in a locked filing cabinet in my house in Halifax. As each interview was transcribed, I deleted the corresponding audio file.

If a student decided that they did not want their interview recorded, I maintained a separate journal that only indicated the study ID and notes from the interview. One student did not want their interview audio recorded, so I used this journal for one interview. This journal was secured in a locked bag while in Pictou County and while traveling to Halifax. Once in Halifax, the journal was kept in a locked filing cabinet in my house. Once the interview notes were transcribed digitally, I destroyed the journal.

A master list of participant names and study IDs were maintained for two weeks after the data collection (the amount of time participants had to withdraw). After this time, participants were unable to withdraw from the study, so there was no need to link the study ID back to the master list. The master list was stored on a password protected memory stick which was kept in a locked filing cabinet at all times. The memory stick was destroyed once the withdrawal period and recruitment were over.

The research journal was completed when I returned to Halifax and reflected on my time in Pictou County. It was also used as I transcribed and analyzed the interviews. No names or identifying information were recorded in the journal. This journal was kept in a locked filing cabinet in my house in Halifax.

Transcripts were stored in digital form on two password protected hard drives. Data will be kept for five years in my supervisor's office at Dalhousie University. After five years all study data will be securely destroyed by dismantling the hard drives and shredding paper documents as mandated by Dalhousie University. Only my supervisor and I have access to all of the data information. My thesis committee had access to quotes from the transcripts, as needed, and the student RAs did not have any access to the data or names of the participants.

Conflicts of interest. Because I was conducting research in the school community I grew up in, I was aware there may be a number of conflicts of interest. A potential interpersonal conflict of interest was that two of my siblings attend the study school and I am familiar with many of the students. This conflict of interest was managed by not speaking about the study to my siblings to ensure privacy and confidentiality for all involved. Having siblings in the school may have also impacted recruitment, both negatively and positively. Some students may not have wanted to participate in the study because they were familiar with my family and may have been worried about their privacy. On the other hand, the sense of familiarity may have encouraged some students to participate because there was a sense of comfort in sharing their experiences with someone from the community. The impact on recruitment ultimately depended on students' individual perceptions of myself.

The student RAs also had a large conflict of interest, as their peers were being recruited to participate in the study. To limit this conflict and privacy risk, the student RAs were not

involved in any data collection or analysis. They only gave feedback on the interview guide, reviewed preliminary results (no quotations) and suggested how findings should be disseminated. They were not given access to the names of participants or any identifying information.

Research team roles. As lead researcher, I was responsible for the initial research design, REB submission and correspondence, engaging relevant stakeholders, working with the student RAs, recruitment, data collection, data analysis, and knowledge dissemination. The supervisor and committee members were involved with offering feedback on the research design, data analysis (i.e. reviewing quotes as needed), and ways of knowledge dissemination. The supervisor and committee members will also be authors on future publication and conference presentations. The student RA assisted with the development of the research questions and dissemination of knowledge.

Trustworthiness. The rigor of this study was carefully attended to by addressing the four key tenets of trustworthiness in qualitative research: credibility, transferability, dependability and confirmability. *Credibility* is considered to be the measure of how realistic the findings of a study are. To enhance the credibility of the findings, I followed a number of suggestions outlined by Shenton (2004) including the adoption of methods from similar studies, prolonged engagement with the community, using tactics to ensure honesty, iterative questioning, frequent debriefing (after every interview with supervisor and as needed with school administration, RAs and committee members), employing reflective commentary, and subjecting the findings to peer scrutiny (i.e. committee meetings and defence). The *dependability* of the findings is closely tied to credibility and is typically thought to entail the replicability of a study. However, in qualitative research, it is unlikely that replicating a study will produce the same findings. Instead, I have made sure that the study design is clearly outlined so that the study itself, but perhaps not the

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findings, could be replicated (Shenton, 2004). The *confirmability* of the findings has been ensured through a series of check and balances, including frequent meetings with my thesis supervisor, the admission of my own beliefs and assumptions, and the recognition of study boundaries. Finally, the *transferability* of the findings is not necessarily something that the researcher can expect to control. However, by focusing on the other three aspects of trustworthiness, perhaps the trustworthiness of the study will allow for the findings to be transferable. Findings may be transferable to other schools (rural or urban), areas of Nova Scotia, Canada and beyond depending on how these knowledge users see the findings fitting within their needs and context.

Summary

The sensitive and personal nature of lived experiences, particularly those of vulnerable populations, can contribute valuable information to research. The use of elements of grounded theory and CBPR allowed for the collection of the lived experiences of youth in a way in which showcased their voice and highlighted their experiences and perceptions of mental health supports and services which currently exist in their community. The use of semi-structured interviews created an environment where youth were able to freely express their personal experiences in safe and supportive environment, while contributing to development of knowledge in the field of rural youth mental health. However, there were also challenges and risks associated with the nature of this research, which were mitigated and negotiated along the way. The inclusion of two student RAs provided a valuable research opportunity to youth interested in research and gave insight into the ways in which the lived experiences of youth can be best collected, thought about and presented. This study has implications for the field of health promotion, as it contributes to the greater body of literature on mental health and access to

supports and services in rural NS, and has the potential to inform practical changes in policy and

program delivery in rural NS.

Chapter 4: Results - Barriers and Facilitators of Access

This results chapter serves as an introduction to participant demographics and community context, as well as an exploration of the key themes concerning barriers and facilitators to accessing mental health supports and services. Key themes were identified through the analysis of interviews with youth in the study community and will be presented as four levels aligning with much of the socio-ecological model: individual, families, school and greater community.

Introduction to the Students and the Community

Demographics. A total of seven participants were interviewed as part of this study. Participating youth were not asked explicitly about their identity; however, some chose to share parts of their identity as they answered questions. All participants identified as being females. Of the seven female participants, one identified as Indigenous and two identified as being from immigrant families. The other youth did not specifically identify their ethnic or cultural background. Three participants were born outside of the study community and moved to the area as young adults. The other four participants were born and raised in Pictou County and had generations of family history in the community. SES and sexuality were not factors of identity which were explicitly identified by the participants during their interviews.

The purpose of this study was to better understand access to mental health supports and services in a rural NS community. Because the emphasis was placed on experiences of access, I did not ask about youths' diagnoses, duration of diagnoses or severity of diagnoses. Although this aspect of their mental health was important and may have informed the support or service they were utilizing, given that this was an exploratory study, I wanted the emphasis to be placed on their perceptions and experiences of access and did not want the youth to feel as if they were being labelled or categorized based on a diagnosis. I also did not want to collect personal health

information that was not necessary for answering the research question. It is acknowledged that the need for different types of interventions and the process of accessing a support or service can be quite variable depending on an individual's diagnosis or the severity of the diagnosis. For example, an individual living with a more "severe" mental illness, such as diagnosed schizophrenia, is more likely to be given priority to services over an individual who has mild symptoms of anxiety. In fact, there may even be specific supports or services targeted for that individual given the severity of their mental illness. Had information on diagnosis been collected, the participants may have revealed the exact type of service or program that they were accessing, thus offering some sort of understanding of how diagnosis may affect access and fast-tracking to services. Despite not asking directly about these aspects of mental health, they were usually mentioned by youth when being interviewed. In general, the youth who participated spoke about living with anxiety, depression and eating disorders. The onset of these issues ranged from elementary school to high school; however, they all spoke about support and service use during their time in high school. These supports and services ranged from friends, parents and teachers, to SBS (Student Services for guidance counselors and Teen Health Centre for nurse-provided health care) and to community health services (i.e. family doctor, community mental health and private therapy).

Conceptualizing mental health. As an icebreaker question at the start of the interview, youth were asked how they define mental and emotional health. Asking this question allowed for myself, as the interviewer, to have a better understanding of how each youth perceived mental health. It also helped ease into the more personal questions about perceptions and experiences of access. Youth had mixed opinions on what mental health "means." Some youth considered mental health to be very negative, such as "things you struggle with every day or in your whole

life" (P1), or very positive, such as "…being a good person to make yourself happy and do[ing] what you can to be happy" (P5). However, the majority of youth viewed mental health as being a mix of both negative and positive experiences and more generally described mental health as a holistic term. These youth also emphasized the importance of mental health to overall wellbeing:

I think mental health is…. It's kinda like… your health includes all aspects of yourself, so it's like your emotional state, your physical state, your mental state. I think it's important to take care of those and I think it's important that we're taught to maintain that balance (P7).

A journey of access. All participants had accessed both a mental health service (i.e. individual or group therapy, family doctor) *and* support (i.e. family, friend, teacher) in their lifetime. All youth were still receiving support from family or friends at the time of the interview. The majority of youth (four) were still using services in the community or school, although three youth had stopped using formal services for a variety of reasons. It should be noted that their reasons for stopping service use were all access-related issues and not related to improvement in their mental health.

All youth described a common "journey" to accessing mental health supports and/or services. This journey aligned well with the Levesque et al. (2013) patient-centered access framework. Although all youth were able to access a support and service, access to these supports and services seemed to be quite challenging, especially when reflecting on the five A's of Access. When considering access using this framework, Levesque et al. (2013) suggest key abilities that service users must have and key factors that the service must develop. Youth most commonly identified barriers related to all service factors, except for affordability. The youth also identified barriers related their ability to perceive health care (i.e. mental health literacy),

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their ability to reach a service (i.e. transportation), and their ability to engage with the service

provider (i.e. adherence to plan). Many of the barriers identified by the youth were experienced

at multiple points in their journey and in different contexts (i.e. in the school and the

community). To this end, the barriers and facilitators of access are organized according to the

socioecological model (individual, family, school and community level). A summary of these

barriers and facilitators are provided in Table 1.

	Barriers	**Facilitators**
Individuals	• Internalized stigma • Lack of knowledge	none identified
Family	• Parent attitudes • Reduced agency	• Observational parents • Lived and professional experience • Gatekeepers to services • Desire to please parents
School	• Stigma • Lack of support (friends and teachers) • Delivery of SBS	• Role of supports (friends and teachers) • Uniqueness of SBS
Community	• Rural life • Stigma • Privacy • Location • Service delivery	• Rural life • Role of supports (friends and community members) • Flexible service delivery

Table 1   Summary of Barriers and Facilitators

Theme 1: Individual Barriers and Facilitators

Barriers.

Internalized stigma. Exposure to stigma in the community and school settings and within

personal relationships resulted in some youth internalizing stigma associated with mental health.

This stigma resulted in most youth having difficulty admitting that they needed help, which acted as a key initial barrier to accessing supports and services. One youth stated that she had a very hard time opening up to her parents because of a history of family trauma and the fear that she would be adding to that trauma (P1). Another youth shared that at first, she did not want to share her experiences with her family because she didn't want to become another burden: "It was one of those type of things where… you don't want to bother them with your problems because they're busy people…" (P6).

Internalized stigma was also detrimental for youth even when they had accessed a support or service due to feelings of embarrassment and shame. These feelings prevented some youth from fully sharing their concerns with healthcare providers:

I would just get super anxious and then I had depression because I was so anxious all the time that I was scared and then I got really sad and everything. And I wouldn't tell anyone about it and I'd been to the doctor a bunch of times for like other things and I never mentioned it. And then it was just… a little over a month and a half ago, we were there for like something else, like fainting spells and stuff [nervous laughter] and my mom was the one who brought it up. And the doctor was like "Is this true?" and I was [snickers] like "Well Yes" [nervous laughter]. And I always freaked out, like even going I'd be pretty much crying just because I didn't want to talk, I hated doctors, like I hated talking to any of them, so I was always scared to go get help too so… (P2).

Another youth echoed this experience and shared how her friends interacted with healthcare providers: "And some people feel that they're embarrassed when they go and I think that's the reason why people try to stay and lean back" (P4). Although youth specifically used the term "stigma," these experiences may be related to not wanting to complain or to act tough.

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Lack of knowledge of supports and services. Lack of knowledge of mental health supports and services in the community and the school was another key barrier to access. All youth stated that they did not know the supports and services available to them in the greater community and that knowledge of where to go is a major barrier to accessing supports and services: "People don't know what's out there" (P1). Some youth mentioned that they believed there were very few services available in the community, which may be why they have little knowledge on supports and services: "Well, I know there's not much out there, but I haven't really like reached out to a service because I'm not really sure what *is* left out there" (P4). In contrast, some youth believed that communication and marketing were factors in their lack of knowledge: "I don't think a lot of people know about the services that are available because a lot of them are hidden. Like the service I went to – it wasn't something you know about unless you were to search it up" (P6). There were also misconceptions around where youth could receive supports and services in the community. One youth explained how she recently found out that mental illness could be treated like a physical illness:

I never knew that the hospital offered like mental health services. I thought it was only like a place for like, like treating illnesses and stuff like that. And when I told my friends, they were also weirded out. Like "Why does the hospital deal with that kinda stuff?" (P5).

A few of the youth who were interviewed said they were aware of SBS, but did not know they could access them for mental health related purposes. For example, some youth knew there was a nurse at the Teen Health Centre, but did not know that the nurse could be consulted about mental health: "I didn't know all the things that a nurse could do" (P7). Some youth knew about Student Services, but thought the service's only focus was on post-graduation support. One

youth did not know that she could access it for mental health support until she had no other option: "Like, I didn't know that Student Services would help me. That's just all that was left. Like there was no one else in the school I could talk to" (P4).

Further, most youth had mixed opinions on whether their peers would know where to go for supports or services. Within the community, most youth thought their peers would also not know where to go: "No, I feel like it's not widely spread throughout Pictou County. Like my age, like, not a lot of people know where to go for help, like at all" (P4). A few youths believed that their peers were more knowledgeable than them: "So, like, I'm sure tons of people do, but in my experience, I didn't and my friends didn't, so I just feel like from that, they - we don't really know a lot about it" (P5). However, some youth believed that students would probably be more knowledgeable about SBS than other resources in the community: "Like, I feel like the only option they would know about is really at our school" (P5).

Although the internet and social media were only mentioned by three youth, they believed that these resources were not the best way to develop knowledge. The only positive attribute that was mentioned about the internet was that it may help some people help find additional mental health services in the community: "I think probably some people have more experience, like, trying to find professional services. So, the internet is a great resource" (P7). One youth suggested that although using the internet kept her busy, it was not a good way to educate herself about her illness: "Yeah. I would look up a lot of stuff and how to cope and… that type of stuff. … I didn't find it too helpful, but, yeah. It kept me busy [laughter]" (P6). Likewise, another youth mentioned that many misconceptions about mental health and substance use were spread among students on social media, including that "marijuana is not a drug" (P4).

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Theme 2: Family Barriers and Facilitators

    Barriers.

    Parent Attitudes. Although this experience was uncommon, a few youths mentioned that they had experienced what they perceived to be stigma within their family. This stigma was a barrier to disclosing their mental health concern to a parent and, subsequently, using their parent as a support or finding an additional support or service. One youth said she had a difficult time sharing her mental health issue with her father because of the stigmatizing language he used to talk about anxiety: "I remember I used to have like anxiety attacks and he would call them like temper tantrums or stuff because he doesn't have like issues like that, so he didn't understand" (P2). One youth also stated that she perceived stigma from parents as being a barrier to accessing services for many other youth: "I just think that within families as well, because a lot of parents aren't really accepting that mental health is an issue. So that can be difficult for some kids who try to access services" (P7). It was unclear whether parents' attitudes were indeed stigma or whether it was a result of embarrassment or family shame.

    Reduced agency. Most youth relied on the knowledge of parents to find a resource. This reliance did not improve their knowledge of supports and services and resulted in a reliance on the parent for future support. Some youth mentioned that although they had accessed a service in the community, they still had no knowledge of what to expect from the service and, usually, could not remember the name of the service or where it was located (P3). Relying on someone else for knowledge may reduce the agency of youth. For instance, it may force a youth to disclose their mental health concerns to an adult if they want to access a support or service, but need an adult to help facilitate this process (i.e. transportation, referrals). One youth stated that she only talked about her mental health when her parents initiated the conversation, which

prevented her from continuing to access services: "…I wouldn't have a way to get there unless he [father] brought it up again. Or… it was one of the things we didn't really want to talk about. So…" (P6).

The youth whose parents helped facilitate access to additional community services commented that sometimes their parents were so involved with their care that they felt uncomfortable disclosing information to their healthcare provider. One youth's mom accompanied her to doctor's appointment which reduced her privacy: "It was kinda awkward because then she [the doctor] asked me about depression and stuff, and if I ever cried on my own or like had all these things. And I did. And I was like "Do I want to admit this in front of my mother…." (P2). Another issue that was identified was that some parents "forced" their youth to try services that they knew wouldn't work for them. In the case of the same youth, her mom "forced" her to try therapy: "My mom tried to make me go to a therapist this summer, but I didn't want to be there, so it was kinda a forced thing. So, it wasn't fun in any way" (P2).

Facilitators.

In their interviews, youth mentioned two categories of facilitators that were associated with their parents. The first were facilitators that made it easy to access their parents as a form of support. The second group of facilitators were those that parents provided which facilitated access to additional supports and services.

Facilitators to accessing familial support. Out of the youth who were interviewed, six relied on their parents for support. Four of these youths said that they did not initially approach their parents for support, but ended up relying on their parents as a source of support once their parents noticed a change in their behaviour. One youth's parents had noticed self-harm on her arm and encouraged her to seek counselling (P1). Another youth said that her parents confronted

her at a fast food restaurant about her eating disorder after noticing changes in weight: "They actually, I was trying to hide my eating disorder from everyone, but I went from 200 pounds to 130 pounds in a month [nervous laughter], so like they noticed that" (P5). Other youth also talked about their parents recognizing changes in mood: "Yeah, he noticed. Well, my mom noticed something was going on and said it to him and he said it would be a good idea for me to talk to somebody" (P6).

Other youth relied on their parents for support because they were more knowledgeable about mental health due to lived and practical experience. One youth relied heavily on her mom for support because she was a former health professional: "She does have like all the knowledge and the background of like *every* different, like mental illness, and she *understands* what everybody is going through. And how, to cope with it" (P5). Other parents were viewed as great supports because of their own lived experiences with mental illness. One youth relied on her dad for support because they shared similar challenges because of their immigrant background: "Yeah, mainly I think my father. Because he also suffers with mental health, so I feel very connected. Uh, yeah… I think [pauses] he struggles with things similar to I do, so I would say so" (P3). Another youth was able to share her challenges with an eating disorder with her stepmother who was also living with an eating disorder at the time:

> And they like, my stepmother also went for an eating disorder, since they're common. So, she supported me and helped me through the way. My father was also supportive and helped me. Like he suffers from post-traumatic stress, so he kinda knew that mental health can be really hard on people, so he's like trying to find out ways to help me with it and stuff like that (P5).

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Facilitators to accessing additional supports and services. Out of the six youth who used a parent as a support, five youth also stated that their parents were key facilitators in the accessing further mental health services in the community. Parents were seen as advocates by their youth – they were vocal and could ensure their youth received care in the community. They could also be trusted to quickly find a service or support in the community: "Well… I moved here and then about a couple months after, I told my dad I'm not feeling very well, and he set me up with a counselor…" (P3). In particular, this youth thought her father was more helpful at finding resources than Student Services in her school: "…[B]ut I found that in the school they weren't as helpful, as… um, going by myself with my parents or something to finding supports, I found" (P3).

Transportation by the parent to an additional service was also a key facilitator of access. Most youth identified transportation as being a barrier to access; however, they were able to access community services thanks to their parents. One youth noted that although her father was able to drive her into the main town to access services, the 30-minute drive was still difficult for her family: "Um, well… my parents were willing to drive me places, but like, being from, like, this area here, it's really hard to drive into [central town]" (P5).

Concern for their parents, as well as the desire to please their parents, were also experiences that facilitated access to seeking additional mental health services. One youth mentioned that she only went to a counselor because she could see "the worriedness" of her parents (P1). Another youth talked about how she did not want to seek out help, but her parents encouraged her: "…[B]ut… they wanted me to get some help. I wasn't really too keen on the idea of, like, going to talk to somebody, but… they encouraged it" (P6). Although these feelings of "people pleasing" encouraged and facilitated access to supports and services, this facilitator

could also be considered as a barrier from some perspectives if the youth did not want to seek help or were unlikely to engage with the service.

Theme 3: School Barriers and Facilitators

Barriers.

Stigma. Stigma in the school environment was deemed to be a major barrier for youth when deciding whether to disclose their mental health concern. In general, it was thought that there was more stigma within the school than in the greater community: "At school I think it's more like… you're a freak or something, like if you have mental health problems or something. Then in the community, it's more just… not talked about" (P2). When one youth was asked whether there was stigma in the school, she responded: "Yeah. Definitely, yeah. Because you never hear of someone that has mental health. It's all behind a black wall" (P4). This youth went on to explain that it was hard to form a community among those with similar mental health issues within the school because other students hid their mental health concerns: "I guess I haven't really… found somebody who was really struggling. I don't know cause there's such a stigma – stigma that people hide" (P4).

For a few youths, stigma in the school also prevented them from using SBS. One youth explained that seeing guidance counselors at the school is stigmatized because students do not fully understand their role. For example, many students think that going to a guidance counselor and sharing their concerns may result in the guidance counselor breaking confidentiality and sharing details of their visit with family members or emergency services: "People think they [guidance counselors] will rat on them [students] if they go" (P1). Many other youth agreed that there was stigma associated with going to the school's Teen Health Centre because it was associated with LGBTQ* health and sexual health:

I think of like the stigma around Teen Health Centre. I think also just like GSA. They

think more like Teen Health is more for like people like LGBTQ* and have like that stuff

– nothing wrong with that stuff. Just… yeah. (P2).

Other school-related issues of stigma came from stigmatizing language and jokes used by

other students at school. One youth explained that one of her friends had attempted to die to by

suicide but survived. This situation was joked about by other students: "For example, a girl I'm

just being friends with tried to commit suicide last week and a boy here came up and said,

"You're just doing it for attention" (P1). Another youth mentioned that mental health is often

trivialized by other students making jokes: "It's the people joking about, like, "I'm going to kill

myself" thing a lot of people say where it's not really appropriate, but it happens sometimes"

(P6). Events like *Bell Let's Talk* seemed to help reduce the stigmatizing language being used, but

the behaviour change did not long: "A lot of people get into it and they talk about how mental

health is so important, and then the next day it's like nothing happened" (P6).

The group of participating youth all identified as being female. Because of their similar

gender identities, it was difficult to fully understand the experience of access across a spectrum

of identities (i.e. gender, race). However, youth shared their perceptions on how youth who

identify differently than them may experience or perceive access to mental health supports and

services. All youth stated that accessing a service or support would be much harder for them if

they were male. Youth mentioned that males with mental health concerns were highly

stigmatized in the school and greater community because they were perceived as being "weak"

(P2) or "sensitive" (P3). Another youth explained that she believed one of her male classmates

clearly had disordered eating behaviours because his behaviour was very similar to hers when

she was living with an eating disorder. She was surprised to learn that males could even experience eating disorders:

> Like, it's kinda odd to hear that a boy has an eating disorder. Like, I didn't know that existed! But I know of one guy who has an eating disorder. But… he never told anyone. He only told… I only found out because I noticed [nervous laughter]. Like I kinda caught on (P5).

This youth went on to comment that social norms meant that males most likely found it harder to share their feelings or concerns with others: "I'm pretty open about what other people have, but I feel like for boys, people here are kinda like more old school. Like, it's like, "You have to be as tough as bricks"" (P5).

Lack of supports. The overt stigma among their peers prevented some youth from sharing their experiences with a friend. Most youth stated that they either did not tell their friends about their mental health or that they only told them limited information because they knew their friends wouldn't understand:

> I don't really… *bother* talking to them about it sometimes because they don't really have anxiety or anything or they definitely don't have it to the extent that I did or have. So, they don't really understand and they're like… they see me take my medications sometimes. In the mornings I take it or when I get to class and they're like "What's that for?" "Oh it's nothing… it's fine" (P2).

Another youth echoed the concern of peer mental health literacy. She shared an experience she had had when sharing her eating disorder diagnosis with friends. Although the matter was serious, her friends were unsure of how to properly support her because of their age and lack of knowledge on eating disorders:

But like, they couldn't, they didn't understand it well enough, especially since we're still young, so like. And we're not educated about eating disorders a lot, so like, they wouldn't know how to like help me through it unless they'd been through it personally, so. I took them one by one into a room and I told them and they were just like "Oh… it's gonna be ok" [laughter] [makes pat on the back motion] (P5).

They also perceived other youth as not wanting to share with their friends because they were worried about losing friends:

Some people don't want friends to know because their friends might think something of them. Like, oh, they have to act careful… about talking about some type of things. Or like some people will end up being supportive, but it's a fear of "What if they don't want to be my friend?" I find with a lot of people (P6).

Other barriers for using a friend or peer as a support included not knowing how to begin the conversation (P6) and being worried about reciprocating that support (P7).

In general, youth had mixed opinions on whether they could confide in teachers at the school. Some youth noted that sometimes teachers would take their personal issues into the classroom (i.e. stress or anger), which prevented students from wanting to confide in the teacher:

…[S]tress is a big part of it – a big factor and some teachers have bad days and some have good days. And… when a teacher has their bad day, the next day you come in and you're sort of scared and every day that happens, you get… just more distant from the teacher I find (P4).

This youth was also under the impression that some teachers may not fully understand the scope of mental health and substance issues that were occurring in the school, which made it difficult to provide support. She explained about a situation a classmate experienced where the teacher

did not understand how to deal with their concurrent substance abuse and mental health issue, which was causing them difficulties in school.

> Because the other day….he [classmate] was sitting with three, two other guys and doing his work because he doesn't understand what's going on. Because sometimes he skips class and whatever. [Teacher] particularly took him out and put him over at a desk by himself... And just ever since that one day, he always had to sit at that desk. And I think that's the reason why he all of a sudden dropped out. Even though it was kinda his fault, you know, for the drugs and stuff, he still was mentally not there and needed help (P4).

***Lack of education*.** All youth who were concerned about their knowledge of mental health and supports and services believed that their lack of knowledge was related to the school environment and lack of emphasis placed on mental health education and promotion. Many youth thought there should be some degree of education on mental health and/or supports and services offered through the school. When asked if they were aware of any initiatives that were happening in the school to address mental health, one youth said: "…. Not that I really notice" (P6). One youth commented that because there was little education happening in the school, their peers were receiving information from other less trusted sources, such as social media (P4). There were a few youths who did remember some initiatives in the school, like a school-board wide initiative called "What's in Your Backpack." "What's in Your Backpack" was a school-board wide initiative that sought to create conversation on healthy relationships and social justice. Students were encouraged to anonymously write factors of their identity on a piece of paper that was shaped as a backpack. These "backpacks" were then displayed in the school hallways in an attempt to highlight the diversity of students (P4). They all agreed that the

initiatives were only effective while they were running. After the event or campaign ended, students seemed to forget about the importance of mental health (P6).

   Delivery of existing SBS. Many youth believed that the SBS were hard to access and, therefore, "underutilized" (P7). Youth generally believed that SBS were hard to access because there was no clarity on the role of the supports and services. Although services existed in the school, very little was being done to share their role with students. One youth recounted that they were only told to visit Student Services when they were in crisis. However, the term "crisis" was never fully unpacked, which left several youth unsure of when they could visit them for other mental health concerns: "They go and talk to us about it. Like, they only say come down if you're having a major issue" (P5). A few youths spoke about the importance of having clear information about SBS so students did not need to out themselves:

> It's really hard to get information without coming up and being like "Hey I have
>
> depression! Here's a good place to help with that!" So it's kinda, like, really hard to get
>
> the word around that there's, like, services around (P5).

   One youth spoke about how they tried to access the Teen Health Centre one day but found the door was locked and no one was available to help them. This discouraged them from returning to the Teen Health Centre for further assistance: "I find it very, like the door is always locked and they're very, like you walk in and they're like "What are you doing in here?" (P2). This youth heard of similar experiences happening to other students and believed that it was a reason why very few students used SBS: "I don't think so. I don't think they do [use SBS]. I don't think *many* people do" (P2). Another youth said that they had never seen the nurse in the building, which made them uncomfortable going to the Teen Health Centre: "Yeah… I don't think I've ever met the nurse honestly [laughter]" (P7). One youth said that she thought

consulting her parents or even finding services on her own would be more helpful than going to Student Services (P3). However, one youth said she was not surprised that the supports or services were not always available in the high school because her junior high school had no services, even though that is when her eating disorder began to occur (P5).

Privacy was another barrier for youth who wanted to access SBS. Most youth were concerned with the current practice at the school that involves calling students out of class for their appointment with Student Services. Youth voiced their concerns that classmates would know that they needed extra help and that Student Services was not private enough. This was a concern because it meant that the youth may be "outed" about having a mental health issue when there is a lot of stigma in the school and community:

> It's one of those things because I know a lot of times they'll pull somebody out of class and then afterwards your friends ask, "Oh why were you out of the classroom?" You kinda feel awkward because you have people asking you and you don't really wanna come out and say that you have a problem (P6).

Youth were also concerned that students from other schools in the community would find out about their mental health concern because there was little privacy in their school: "So it's just like hard since we pretty much know everyone. Like we know people from other schools really well. Like… there's always a fear that, like, people will find out about it" (P5). Despite concerns about privacy in SBS, one youth did note that these concerns would likely still exist in larger schools in urban area – it was not a rural-specific issue: "Well, I think that [rurality] probably has a little bit to do with it, but I think even if you were in a bigger place, your friends at least would still, ask or notice" (P6).

Although there were a number of barriers associated with SBS, one youth gave the school the benefit of the doubt. As she relayed:

I think that it's difficult with school because the school is complex and there's so many other things going on and, unfortunately, I don't think mental health is the number one priority for them… Um, so I think that, yeah, less attention is put on that (P3).

Facilitators.

***Role of supports*.** Friends were considered to be a valuable support for the youth who were interviewed. Five out of the seven youth stated that they relied on friends at school for support. However, the extent of the support was quite variable. Living in a small community meant that it was easier to make friends for many of the youth and they felt more connected to those around them:

I guess you can get really close to friends here. You're not distant from many people. And you can really… interact with people because there's not many people in the community, unlike somewhere like Halifax (P4).

One youth who moved to NS from a major Canadian city shared that making friends in the community was a great support that helped her manage her mental health: "But you know, I have wonderful friends here and I'm very lucky in many ways, so I think I have definitely been doing better. I can say that" (P3). Youth were more likely to value the support of friends who had experienced a similar challenge or situation: "Yeah it was easier to share with someone who was going through the same thing at least" (P6).

Peer groups at school were also important supports. One youth spoke about how different student clubs at school helped to create a community of support in the school for those who were struggling with their mental health:

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Like we have Teen Health here, which is a club that also talks about it. And my friend went

to it and she said it was really good. They grew really close and they like, they had a lot of

fun. It got people to like, you know, be more comfortable (P5).

Overall, youth felt it was important to feel a part of the school: "It's really important in a school

this big to feel like you're included in something and have that support" (P7).

Most youth mentioned the positive role of teacher support, either for themselves or other

students. Overall, youth agreed that typically every student had one teacher that they trusted and

would confide in. Some youth mentioned that they rely on a specific teacher or staff member for

mental health support during the year (P7). Some youth talked about the positive classroom

environments created by teachers and how that greatly influenced how comfortable they felt in

school:

My [teacher] – she's always like going on about mental health issues and she hates it

when people say they have depression and anxiety, even though they don't... you know

how they joke about it? And she's like really supportive. Um, my teachers also, like

they're like "If you have anxiety, it just shows that you care about stuff" so they're like

making it seem like lighter and stuff like that (P5).

Uniqueness of SBS. Youth who successfully accessed SBS were satisfied with their

experience for a number of reasons. Some youth mentioned that the location of SBS is ideal

because they do not miss school time and do not have to consider transportation. One youth said

that even though she went to Student Services as a last resort, she thought it was convenient that

it was located in the school and she could just walk-in, especially since she had been

experiencing anxiety attacks related to academic pressure. She also found the guidance

counselors to be extremely friendly (P4). Another youth echoed these thoughts and said: "They

[Student Services] have a really good guidance counselor, so they're easy to trust" (P7). Finally, one youth said that she appreciated that she could talk to a guidance counselor at school without her parents knowing (P6). One youth also spoke of a community partnership that provided free transportation to the local gym after school two days a week to promote overall wellbeing (P7).

Theme 4: Community Barriers and Facilitators

Barriers.

Rural life. At the beginning of the interview, youth were asked about their experiences living in a rural place. Almost all youth commented that rural life has shaped some aspects of their mental health. As previously mentioned, only half of the youth had grown up in the community and the other half had moved to the area from other parts of NS and Canada. Because of these differences, there were several varying perspectives on how rural life had shaped their mental health. Most youth, regardless of where they were raised, explained that there were little opportunities for them which, in turn, led to negative mindsets and isolation: "…[A]nd, I feel like, um, there's less opportunity for youth to do things. Um… of course there are things, but I wish, I don't - I feel like I don't get enough opportunities to do things" (P3). Other youth agreed and said there were few opportunities or social activities for them to engage. Most activities were isolated (i.e. reading or listening to music) because of the rural nature of the community: "Not really much in the community, but reading, writing and listening to music type of thing" (P6).

Several youth commented on how they perceived the environment of their rural community. There were mixed views from youth on whether they found the community to have a positive or negative environment. Most people reported that they believed there was a negative attitude associated with the community. One youth who moved to the community believed that many of her peers held a negative outlook on life because of their community:

I just find that the youth here are more… have more of a negative outlook on living here.

They just don't see many opportunities and I think that's one of the key issues is that we

really need to start focusing on youth development (P7).

Another youth believed that negativity was experienced by not only youth, but by adults too. Her

family had lived in the community for many generations and she had seen a pattern in negative

behavior across generations:

They [youth] take a small community and sort of bash it to a point. Like the mental health

sort of went downwards and they take a small community for granted. They just sort of…

lean off on things. Do you know what I mean? There's a lot of people that are quite

negative, I guess, because there are adults who are negative 'cause there's not many jobs

in Pictou County. And… I guess youth don't like being here because it's known for lots

of drug and alcohol use (P4).

Stigma. Interestingly, some youth who were born and raised in the community believed

that there had been some changes in stigma over the last several years. They believed that mental

health was "more accepted than in the past," but there were still high levels of stigma (P6). This

sense of community stigma prevented youth from sharing their mental health concerns with

those around them. In general, youth who moved to the community and were not born in the area

believed that the community was more stigmatizing than those who were born and raised there:

"There's more stigma in Pictou County than anywhere else" (P1). Youth who had lived in the

area their entire life had similar perceptions of negativity in the community but believed it to be a

normalized part of living in the community: "It's just the way the community is" (P5). In

particular, youth shared that they believed normalized mental health concerns, such as anxiety

and depression, although still stigmatized, held less stigma than other mental health concerns,

such as self-harm or eating disorders. One youth who struggled with self-harming behaviours suggested that she felt uncomfortable sharing her mental health concerns because community members would think it was "attention-seeking" (P1). Another youth who was receiving treatment for an ongoing eating disorder believed that eating disorders were more stigmatized in the community, which prevented her from sharing her illness with others:

> And I feel like in this community, eating disorders are like criticized a lot, so I feel like "She has an eating disorder. She's bad. Stay away from her". Everyone's really open. Like you know friends, they're really open with their anxiety, with their depression. They're not hiding it! Like their teachers know about it, like, but like, nobody ever brings up eating disorders. Like at all (P5).

When asked why she believed eating disorders were so stigmatized in the community, she said: "Well, I don't even know why. It's just that, like, people think that girls with eating disorders are like bad. Like, it's just like, people don't like that kinda stuff" (P5).

One youth also made an interesting observation that stigma is worse for adults in the community than it is for youth:

> I think adults struggle just as much. I think the youth, youth definitely – you see it more because it's definitely more focused on. But adults you… I think there's more of a stigma around adults (P7).

Privacy. In general, youth believed there were major privacy concerns which acted as a barrier to accessing supports and services in the school and community. All youth commented that things were easily spread in the community: "Everyone knows everybody [so] easier to get things spread around" (P1). Some youth were concerned about rumours and misconceptions that were often spread in the community: "Usually, if someone knows something about you, *a lot* of

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other people know about it too… It's kinda difficult so rumours get spread… misconceptions"
(P5).

Along with the potential for rumours being spread, there were concerns that lack of
privacy may result in being judged by others in the community:

Um, it's really hard because you like kinda know everyone and they kinda have like a set

opinion about something. So, like if you have a different opinion or if you're going for

something that's not really accepted in your community, it's hard to bring that up because

there's not as many people, like you feel like there's sometimes not as many people who

will be there to support you (P5).

One youth was more concerned with privacy between her and her counselor, rather than other

people in the community finding out: "If I was to go talk to a nurse or anything here, they'd

come into [retail store] where I work and then they're there and they know and I just find that

awkward sometime" (P2). The youth who had lived in an Indigenous community before moving

to Pictou County commented that the need for privacy seemed to be greater here than in other

cultures: "Because people do value their privacy, especially in Canada I notice, like in other

cultures they're more open, but specifically in Canada, it's more reserved" (P7).

Location of Services. Transportation was a key barrier for youth when accessing a

support or service. Many youth shared that transportation was difficult in the community because

there was no public transportation in the area (P7). Many youth could not drive or had to share a

single vehicle with the rest of their family, which meant they had to tell their family where they

were going or had to wait for a vehicle to become available if they wanted to access a service

(P1). Alternate sources of transportation, like taxis, were deemed to be too expensive for

consistent use, especially for youth who lived in very isolated and rural areas of the community

(P5, P7). Five out of the seven youth mentioned that a parent drove them to a service or support in the community. While this facilitated access, there were concerns that this was a not sustainable practice. One youth commented that even though her father drove her into town to access services, it was "still hard" because they lived about 30 minutes away. She also shared that transportation became difficult for her father who had to sacrifice his personal time for her:

> Because, like, my father - I only lived with my father at the time and he like, found it really difficult because he wanted to do stuff… I mean he's retired, but if he had a job, he wouldn't have time to drive me during school because that's when most parents have to work (P5).

Likewise, another youth shared that relying on her parents for transportation did not work out for her because she was scared to tell her parents that she wanted to continue seeking help from a community service: "But it was like a transportation type of thing because like I thought of maybe trying it out again, but it was one of those… yeah… I wouldn't have a way to get there unless he brought it up again" (P6).

Another concern was related to the restructuring of the healthcare system in the rural community. Because the mental health inpatient unit in the community hospital closed, those who needed acute care were often sent to other inpatient units across the province. Although none of the youth interviewed experienced this situation, one of them did bring up that they realized it was an issue for some of their peers or other people they knew in the community:

> And I know that travelling… Me and my mom were talking about traveling to [neighbouring community] or [neighbouring community] and people don't have the money to go back and forth. They don't and they can't. They just don't have the money (P4).

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Finally, one youth mentioned that although transportation to services is important, it is also important to think about transportation to other health promoting places in the community. She was disappointed that she could rarely hang out with friends or go to the gym – all activities that would help support her mental health: "Yeah because I heard the gym really helps. Like going out and being more active really helps with mental health, but it's quite difficult" (P5).

Those who had to travel outside of the school to seek services shared that it was hard to get appointments outside of school hours (P1). Because of hours of availability, youth often "missed out on a lot of school work" (P5). Another concern was that inflexible hours meant that students were missing out on other school-related commitments that could promote good mental health, like being a part of sports teams or clubs:

And a lot of people are involved in school things, especially here. Everyone's at least involved in something intense it seems. And a lot of people have jobs, so it's difficult to find a balance between school, jobs and your own personal health (P6).

There were also concerns that the location of their school meant that students had a more difficult time accessing services than students at other schools in the Pictou County (P4).

Two other youth also shared that the built environment of services can greatly influence how accessible the space feels. One youth spoke about the "angular" feeling of the local hospital and the unwelcoming vibe it gave off: "…[E]ven at [local hospital], I find that even from the, kind of architecture, and to even like details like that, it's very angular kinda feeling when you're there and, um, I wish there'd be a more welcoming environment" (P3). Another youth spoke of the small physical space allocated to those needing mental health help in the ED of the local hospital (P4).

Service delivery. Youth reported several barriers related to service delivery in the community. Youth were concerned about wait times for most community services. Some youth preferred to rely on their supports, like parents or friends, because they knew the wait time for seeing a healthcare professional would be too long. Likewise, one youth said that she would never be able to see her family doctor for a mental health problem unless she was "really sick" (P4).

Because the community has an older age demographic, many health professionals are aging and retiring. These retiring health professionals are not being replaced, which is a barrier for several youth. One youth expressed her frustration about her long-term counselor's retirement. She had been court ordered to attend therapy due to family issues. However, when her counselor retired, she stopped receiving help for a few years because she found it frustrating to "share the same information over and over" with new counselors (P1). Another youth shared her concern that her family doctor may be retiring soon (P4).

Because of the limited services in the community, many youth expressed their frustration about services that did not provide them with the help that they needed. One youth explained that she tried several counselors but was getting frustrated by the way they addressed and belittled her mental health concern: "It was horrible, and I stopped. Then a couple months later, I was with another person and it did not click at all, and that counselor actually told me that I'm not depressed [sighs]. So I just stopped for a while" (P3). This youth went on to explain that the way she was treated in these therapy sessions made her feel guilty for using the valuable resources in the community: "So, I felt almost like I was wasting my time, or I was wasting their time. So, I felt quite ashamed that somebody else who *actually* has a mental illness should be taking this

spot [pauses]. That was the kind of feeling I had" (P3). Other youth believed that the skills they were being taught by their mental health service provider were not the skills they needed:

> Like the pros were, it did help me, um, develop more confidence at the time, how to cope with hard stuff… But it didn't help me, like, how to cope with my eating disorder at the time because like it was really big and it was getting really dangerous for me. My hair started to fall out…Nobody really helped me understand it well enough to really help me (P5).

Multiple youth commented on the lack of diverse identities of service providers. Most service providers who were mentioned during the interviews were female. Although female providers were preferred by the youth because of their own identities, a few youths mentioned that there needs to be more diversity among service providers in order to reach out to the greatest number of youth (P1). As this youth stated, there is a lot of pressure in the community to "act the same, just to seem the same," meaning that many youth are afraid to express themselves differently and would not necessarily be comfortable opening up to a heteronormative service provider (P1). Cultural diversity was also a key barrier for another youth who identified as being a second-generation immigrant. Upon moving to the community, she experienced a "big shock" and found it difficult to share her experiences with her counselor because they didn't understand (P3). Lack of understanding meant that she often relied on her father for support because he experienced "similar struggles" and she rotated through several counselors until she could find someone she felt comfortable with (P3). Although she appreciated her current counselor, she expressed that she is always afraid of being judged and mental health supports and services would be more accessible to her if there were more diversity among care providers:

Well, um [long pauses] as a person who looks [non white]… and that's one of the fears I experience – of being judged. The person – the people who I talk to, it's hard for them to understand, um, so I would if it was someone, for example, someone who was a second generation [immigrant] who I could talk to, that would probably be wonderful. Um, yeah, it's – I've met someone who's good to talk to but sometimes it's hard for them to understand (P3).

Facilitators.

Rural life. Although most youth mentioned there were few activities and opportunities available to them, some youth did mention that they were involved with many school-related extracurriculars, like a sports team or school club. One youth suggested that youth may need to search hard or create their own opportunities in the area:

I really enjoy this community. I think there is a lot of hidden opportunity. So, I think there needs to be more advertisement in that way. But yeah… if you look hard enough [nervous laughter] there are a lot of programs. There are some programs in the churches, even if you're not religious, some youth programs, which I think is cool. They have some theatre groups for youth in New Glasgow, and yeah, I just think there can be a lot. (P7).

Despite many youth stating that the community had a negative environment, some youth shared that the community was welcoming and had a positive environment. One youth spoke of a family environment that persists throughout the county. She liked the environment because of its familiarity and sense of comfort: "Um, it has a really family environment. I like the family environment because like, you can like, ask someone like "Hey do you know this person?" and "Yeah, they're my cousin!" [laughter]. Yeah. It's really nice like that" (P5). Another youth liked the quaint environment offered by a small community: "It's nice that it's not always big and

busy" (P6). Finally, one youth who moved from a major Canadian city commented that the natural environment and beauty of the community was beneficial for her mental health: "The nature is very beautiful. That's good for my mental health" (P3).

Many youth compared their experiences in Pictou County to what they believed their lives may be like in a larger city. Interestingly, most youth believed that access to mental health supports and services would be better in their own community than if they lived in a larger city, like Halifax. Most youth believed that having a smaller population was beneficial for many reasons, including shorter wait times for services: "Because I think there's more people in bigger communities. And if there are more people, there are more people with the problem" (P6). The youth who moved from a major Canadian city said that she had heard about struggles her friends had had in larger cities. She believed the small community atmosphere helped to connect youth to appropriate care much quicker:

> For example, if I was still living in [large Canadian city], I probably would have felt very stressed. And I remember my friend was telling me, who lives in a big city, was telling me that they really don't – that it's really hard to find somebody… because it's so big and vast, and I think there's more of a sense that everybody knows everybody, so it's easy to find what you need (P3).

Other youth spoke of being able to cope with living with a mental health issue much better in a close-knit community. She stated that although there were some issues with access in the community, she would not trade it for living in a larger area. Instead, she suggested that improvements needed to be made in the community:

> I feel like the smaller communities are easier to cope with. As compared to the city. I don't know. It's just like. I've never lived in the city, so I don't know that, but like I feel

like being in a small community has pros and cons and I wouldn't really change that to like try to find out what would happen if I tried to access something in the city. I feel like there should be improvements in our community to help with that (P5).

Supports. Other supports that were used were trusted adults in the community, such as doctors, church members, family friends and teachers. These supports were used less frequently than family or friends, but still played an important role. One youth recalled how her private music teacher helped her find a counselor in the community: "…[O]ne of my music teachers actually, not with the school, told me – knew a good person and I started talking to her" (P3). This youth also mentioned that she did not think the same level of community support would be found in larger cities: "Well, um, I have lots of nice people in my community and my church community who I have a lot of trust in. And [pause] they help me find support and I think that was really great, that you can't really find in a big city" (P3).

Even though there were major concerns about privacy in the community and school, some youth commented on how a lack of privacy in the community also meant that it was easier to make friends in the community and find support:

I just, I find that sometimes, I feel like I'm – I don't have the privacy I want because it's such a small town. Um, and sometimes I wish I did have a little bit more of that, but I think through that I did find a lot of people who I didn't expect would be suffering from mental health, who do, so um yeah. It's like this complex thing where it may be a good thing at the end of the day (P3).

Other youth also commented on how it was easier to make friends in the small community: "Um, I guess you… you don't know *everybody*, but you know most people. And you know how they act, how they interact and it's easier to make friends in the smaller area" (P4).

Flexible service delivery. A few youth shared ways in which flexible service delivery facilitated access to services. Aside from relying on parents for transportation, one youth mentioned a program that was funded by a larger provincial mental health organization and paid for a taxi when the youth had an appointment during the school day. This adaptation ensured that she was picked up from and dropped off to school, minimizing the amount of time that she missed in school. Her friend who lived in a very rural area of the community, about 40 minutes away from services, also was able to take advantage of the service which helped him access much needed help (P1). One youth shared that in order to prevent her from missing school work, a service that she was attending allowed her to make appointments after school and during the summer. Having this flexibility made the service more accessible. This youth also shared that she preferred to access SBS because it meant that she missed minimal amounts of time in school (P6). Several youth who were satisfied with their experience in the community commented on the ease of getting into the service. One youth mentioned that an immediate opening in one program encouraged her to go ahead and seek help. Wait times would have prevented her from attending the program (P5). Those who were satisfied with their experience using a service had more options in the supports or services they received. One individual mentioned that she was able to choose between group or individual counselling and then meet with three different counselors through one program before selecting the counselor that best suited them (P1).

Summary

All youth who were interviewed identified as being female and had accessed at least one support or service for mental health in their lifetime. Based on the information they shared, accessing supports was much easier than accessing services; however, they perceived and experienced a number of barriers for accessing both. The barriers and facilitators that were

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organized at individual, family, school and community levels. Overall, family-level and school-level factors appeared to be good facilitators of access, while more barriers were experienced at the community-level.

Chapter 5: Results – Youth Suggestions for Improved Access

After identifying the barriers and facilitators of access that they had perceived and/or experienced when accessing a service or support, youth suggested a number of ways in which access could be improved. These suggestions were mainly targeted to access at the school and community levels, although some of their suggestions may be transferable to barriers associated with the individual or the family. In general, these youth believed that addressing these main issues at the school and community level would improve overall access.

School-Level Suggestions

Education.

Mental health literacy. Most youth suggested that more educational opportunities need to be provided through the school. The inclusion of more education could improve their mental health literacy and the approachability of supports and services. Mental health literacy is defined as "understanding how to obtain and maintain good mental health; understanding mental disorders and their treatments; decreasing stigma associated with mental disorders; and enhancing help-seeking efficacy" (Kutcher, Wei, & Coniglio, 2016, p. 154). Some youth suggested that wider school assemblies should be held because mental health and addictions issues often begin in high school and would have an impact on the wider community as well:

> Especially around the school, because that's when the addiction and the mental health usually starts. And there are some people that do suffer, but they don't know where to go and even if they knew something, like a presentation or if their teacher could go over at the beginning of the year, like where could you get help for this, it would be very helpful to the community (P4).

This youth also suggested that presentations should be from local community resources and not just generic resources (i.e. a national helpline): "But I think that a huge assembly talking about the concept and where you can get help. Not overall, like "Call this number", but in your own community, you know?" (P4). These presentations could potentially improve youth knowledge of community and school supports and services.

Youth also urged the incorporation of mental health curriculum for all grade levels. Several youth suggested that knowledge of mental health was quite poor among students and that students were wanting to know more about mental health: "And more talk about it even in our education system. I remember somebody said: "Why do we get PhysEd but we don't get mental health class?". I think that's really important" (P3). The school was seen as the place where mental health education should be taught, compared to other outlets, such as the internet or their parents.

Support for supports. Although the majority of youth had a relatively easy time receiving support from at least one person, they suggested a few ways that other youth may be able to receive support for themselves. Some youth suggested that they would like to see peer support skills be taught in the school, so that they and their friends could support each other better:

> It [education] should be something I think because there's a lot of people who don't want to talk to someone and they would feel more comfortable talking to a friend. And so, if friends at least knew how to deal with it, it would be easier. Like if you have a friend who has the same sort of problem, or knows what you're going through, it makes it easier because they know how it feels. But if it's a friend who doesn't, they're not going to talk and they won't know what to do (P6).

More youth seemed to be using teachers as supports rather than going to the SBS. It was suggested that more resources and mental health training should be provided to teachers. so that they can provide support to their students: "I think teachers should be like, um, have some mental health background. I think that would help a lot, if you see a student that is suffering. You could tell and you could help them, or if you couldn't help them you could call somebody who could" (P4).

Addressing School-Based Services (SBS).

Desire for SBS. Surprisingly, youth supported having more services in their school, despite barriers to access, and said they would be more likely to use services in the school rather than in the community: "It is a good place to start" (P4). One youth suggested that the school would be more accessible for youth:

> I think that if it's just in the community, people, like the students, if they wanted to remain anonymous, they don't really have a way to get there sometimes without someone else knowing or if their parents don't support it, they have no other way to get there. So, I think it's important that there's something in the school that students could actually go to and its anonymous if they want to (P7).

One youth mentioned that it was important to invest in SBS because "you're comfortable in school, *most* of the time. Then at least if you have something at school, you can go" (P2). Most youth commented that there should be an increased investment in SBS because it would limit the number of issues they experience with transportation and time away from school. More SBS would also target the age group where mental health concerns primarily begin (P4). The school would also provide a space where youth could solely access services that were designed for youth in mind, which was another desire of many youth (P1). Another reason youth may have

wanted to access SBS is that they expressed concerns that their mental health issues were related to academic stressors: "[L]ike if you're really focused on school and you don't take any time for yourself, or to like take a break and like distance yourself, that's really stressful and you just kinda shut down" (P7).

Improving existing SBS. Despite barriers to accessing existing SBS, youth suggested that improvements could be made to facilitate access to the two existing services (Student Services and Teen Health Centre). Youth suggested that Student Services could play a larger role in resource referral and become a resource hub for students to seek out information on community mental health supports and services: "…[H]onestly, I feel like Student Services here would help it, like facilitate the process of finding out" (P5). Another improvement for Student Services would be to find a mechanism that would allow students to speak to guidance counselors without being called out of class. Although there are sometimes walk-in appointments available, most students must submit their name and wait to be called out of class. This method can cause issues with privacy which may prevent students from using the service (P6). In fact, several youth thought it would be better if no appointments were necessary to see a guidance counselor, which may prevent students from getting scared and skipping their appointment (P2).

Youth felt that improvements also needed to be made to the Teen Health Centre. One youth suggested that a dedicated mental health nurse needed to be at the Teen Health Centre more frequently. Currently there is a nurse at the school one or two times a week, but hours and days of service fluctuate (P4). Several youth pointed out that they have never seen the nurse at the school and that when they tried to access the Teen Health Centre during hours of operation, the door was locked (P7).

Promotion of existing SBS. Overall, youth felt that Student Services was, in general, effective and accessible. They were also confident in their ability to physically access supports and services; however, they believed there needed to be better promotion of supports and services to promote access for other students in the school. One youth suggested that it should be made clearer that Student Services is not just for academic and post-graduation concerns (P4). She also suggested that business cards should be provided at the beginning of the year for both Student Services and Teen Health Centre with hours of operation, so students could keep the service info in their wallets for future use (P4). Another youth agreed and thought more information should be given on what each SBS could be used for and what to expect when a student accessed that service (P7). Other promotional tactics that were suggested included posters (P1) and advertisements over school announcements (P5).

Creating a school community of wellbeing. Although most of the suggestions provided by youth were geared towards improving medical and psychological services, some students spoke about the importance of creating a school community geared towards social and emotional wellbeing. Several youth viewed school clubs and committees as being a valuable component in creating good mental health. One youth suggested that services should incorporate leisure activities, such as sports or being around animals, which may be more effective for students (P1). Another youth envisioned an informal student life area where students could chat with one another, complete school work and have access to guidance counselors in that area of the school when necessary. She thought the informal nature of the space would make talking to a guidance counselor more casual and may encourage students to rely on each other for support (P2). Other youth suggested that addressing the root of their mental health issue, academics, through extra help sessions and other academic supports could also be beneficial (P4). Overall, having a sense

of belonging in the school was deemed to be important for creating good mental health and facilitating access to SBS: "It's really important in a school this big to feel like you're included in something and have that support" (P7).

Community-Level Suggestions

Service Delivery. The overwhelming recommendation from many youth was to spread services into rural areas of the community, so that transportation and travel times were not large barriers. One suggestion was to focus on public transportation, so that the entire community could benefit:

> I think it would definitely be really beneficial. Especially for people who are like elderly.
> Not just the youth. Because they can't get to grocery stores and they have to rely on other
> people. So, I do think public transportation is wonderful and it cuts down on our
> emissions and our footprint (P7).

However, one youth did note that unless stigma and community attitudes were addressed, it was unlikely that transportation would make a noticeable difference: "Because if you aren't willing to go the extra mile to go there, transportation will be useless" (P5).

Another key aspect of service delivery was wait time. As a solution, one youth suggested that there should be more walk-in appointments available in the community and school to encourage youth to go when there is an issue: "Because you don't want to make an appointment and then people probably end up saying they don't want to do it like I almost did" (P6). Although almost all youth suggested increased investment in SBS, it was also mentioned by several youth that it is not enough to just focus on SBS because graduating students then leave the school and need quality supports and services as adults. Youth recognized the value of investing in community services in order to benefit them in the future: "I would say [to invest in]

the school because the addiction and mental illnesses start in school. But they raise up and you continue to have addictions when you're an adult. Community-based mental health would provide help for both adult and teenagers I guess" (P4). Another solution that was offered was addressing built environments to make them more welcoming. As one youth stated: "…I think for now, I think for now it's not more of a location issue… but more of an environment issue" (P3).

Decrease service costs. Although the cost of services was not a key barrier identified by the youth in this study, they perceived it as being a barrier for other youth, as well as adults, in the community. Because of long wait times for public health services, like community health services, family doctors and walk-in clinics, a few youth attended private psychology sessions. These sessions were either paid out of pocket or through insurance. Youth were aware of the financial burden that accessing these services caused their families and were hyperaware of this problem when the service did not work for them. One youth suggested that a trial period should be put in place so youth can try out a service to see if they like it before needing to pay: "When you go in and you, it's like, it costs money too and a lot of people don't have the insurance or they don't have the money. So, if there was something that you could at least drop in once for free and see if you like it" (P6).

More options. Youth commented that they would like more variety of options to choose from when seeking a support or service, "just so they have more than one option to go to, if it doesn't end up working out" (P5). Among these options, the majority of youth believed there should be programs and services directed specifically for youth. There were mixed beliefs on whether these services should be in the community or in school; however, youth believed that their peers would feel more comfortable talking about their mental health in an environment that

was geared for teenagers: "I think it should be just for youth, so that they can get used to it and everything because it's also hard sometimes admitting when you're a youth why you have to be there and everything" (P2). Finally, one youth shared that it was important that an inpatient unit at the local hospital be reopened, so that youth in crisis would not be sent outside of the community (P4). Other suggestions were that a greater diversity of care providers who may be able to reach out to diverse populations in the community were needed (P3).

General Suggestions

Aside from improvements that could be made to supports and services in the school and greater communities, youth also stressed the importance of an attitude change towards mental health within the community and greater society which may help reduce stigma.

Changing the meaning of mental health. The most commonly suggested solution to improving access was to remove stigma by "changing the meaning" of mental health (i.e. how mental health is perceived by members of the community) (P3). Some of the youth had different ideas of what changing the meaning of mental health might look like. When asked what needed to be improved in the community, one youth suggested that mental health needed to be thought of more broadly and not just as affecting a specific population: "Just, um…. [thinking] getting rid of the status quo idea and, um, yeah, changing what it means, the norm, socially. I think that's really important" (P3). Many youth suggested that stigma needed to be removed before any meaningful change could be made: "Probably like the stigma. That also ties into being educated and more open minded about that. Because if you aren't willing to go the extra mile to go there, transportation will be useless" (P5).

Being more open. Almost all youth also suggested that talking about mental health needed to be more natural and open. They called on the importance of peers being open to

discussing mental health and greater diversity in who is providing support and services: "I think that needs to be more people speaking out about their experiences to give people a sense of comfort, and, um, maybe… more diverse kinds of people we can talk to" (P3). One youth also thought it was a responsibility of healthcare services and professionals to openly say they provide mental health supports and services. Although they recognized that it would not be ideal for some community members seeking help due to privacy concerns, it may help break down the barriers to seeking help: "Probably making it less of a stigmatized thing and having more places that openly say that they are a mental health area" (P6). Another youth suggested that being more educated on mental health, may also be a solution for decreasing stigma: "I feel like the more open we are about it, like the more educated, the more I feel it will be easier" (P5).

Summary

Although all youth who participated in this study shared at least one barrier they faced when accessing a mental health support or service, they possessed an optimism that access could be improved in their school and greater community. Alongside this optimism, they shared a number of suggestions that may improve access, including increased investment in SBS and creating a school community, diversifying the locations of services and identities of service providers, and addressing stigma. Many of these suggestions would not only improve their own access, but would support their peers who they perceived as having similar barriers to access.

Chapter 6: Discussion

The youth involved in this study reported a number of key barriers and facilitators of access to mental health supports and services in their rural community. Youth also reported a number of suggestions that may improve access. A number of the study findings aligned with existing literature (i.e. role of transportation and stigma); however, there were also a few key findings that may not have been previously reported by youth in schools, including the role of parents as supports and the desire for more SBS. This chapter will discuss the key findings in relation to the study questions and their implications for health promotion on a local, provincial and, potentially, national level.

Challenges to Accessing Supports and Services

The purpose of this study was to determine how youth living in one small rural NS community perceived and experienced access to mental health supports and services. The study findings suggest that access is quite poor. Despite the fact that all youth had accessed at least one support or service in their lifetime, many youth commented that their only reason for accessing the support or service was because they perceived no other choice. Some youth also reported that they had stopped accessing supports or services at different points in time because of their dissatisfaction with the support or service. A few youth perceived poor access to certain supports or services, so they did not even try to access the support or service.

One of the secondary research questions asked about key barriers and facilitators of access in the rural community. A number of the barriers identified by the youth were similar to what is known from the existing body of literature, including stigma and factors related to service location, such as transportation. Stigma related to mental health, including internalized stigma and that experienced from peers and in the wider community, is a known barrier to

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forming supportive relationships and accessing supports and services (Corrigan, 2004; Moses, 2010). The literature regarding mental health and stigma draws many similarities to the literature on addiction. Addictions and mental health are often associated because many individuals living with poor mental health also use and misuse substances and stigma between the two concerns can be similar (Motto-Ochoa et al., 2017). In this study, youth identified instances that they perceived as being stigma. Stigma is a broad term that may not always be the best descriptor of what these youth were experiencing. For example, some of their experiences may not have been "actual" stigma, but may have been related to the embarrassment of others. Regardless, their experiences were marked as being "stigma" in this study because it was the term they had used to describe what they perceived was happening in their lives. Despite the difficulty of distinguishing between actual and perceived instances of stigma, the distinction between the two did not matter for this study, as all youth acknowledged stigma as a barrier. Barriers related to service location included a lack of transportation, and factors related to healthcare restructuring in rural, such as retaining and recruiting diversely identifying physicians and attracting mental health specialists to rural areas is widely documented (Herman 1997; Forchuk et al., 2015; Lewis & Khouri, 2004; Willging, Waitzkin & Nicado, 2008). Issues with family doctor shortages have also been widely recognized in NS, as government officials attempt to incentivize more physicians to practice in the province (Province of NS, 2018).

Access and Health Promotion. Access is a key part of health promotion since it plays a critical role in how individuals and communities promote their wellbeing and prevent illness. The Levesque et al. (2013) framework was used to understand factors of perceived access. Overall, this model is useful for thinking differently about access and is a good starting point for discussion on factors of access and how they may relate to health promotion. However,

adaptations of this model may need to be made to fully understand the experiences of youth and individuals in rural communities who are accessing speciality care or supports. Although the model is meant to illustrate access for the general population, it does not address some of the key issues for youth. For example, the model highlights key abilities that a service user should develop to facilitate access. However, these abilities are singular in nature and do not highlight the role that families and communities may play in facilitating access for not only youth, but service users across the life span. This issue is illustrated by the fact that youth were rarely concerned with the "ability to pay" since they had the support of their parents or could access free services through the school.

Secondly, the model seems to have been developed for primary health care services rather than speciality health care services or supports. For those living with a mental health concern, community and private mental health services are usually accessed through a referral from a primary health care provider. This model does not necessarily portray the additional access needs for these speciality services (i.e. repeating the need to seek and reach out to a specialist after reaching out to a primary health care provider). It also does not illustrate the experience that someone may have when accessing an ED or crisis service when experiencing a mental health crisis. The findings from this study and from the existing body of literature also suggest that personal supports (i.e. family) and volunteer support groups in the community are often used in place of formal services in rural communities due to centralization of services (Milligan & Power, 2010). This model may not accurately reflect how individuals access these supports.

It Takes a Village

Based on the information shared by the youth in this study, it is clear that youth in this community are relying on both their families and the school to educate them about mental health, as well as to facilitate access to the services needed to address mental health issues. This finding is not surprising considering that youth spend almost half of their waking hours within the school, with many participating in school-based extracurricular activities that occur before and after school hours, including weekends. Their remaining time is most likely spent within their family home.

Role of family. Very little is known about how youth perceive their family as a support for their mental health. Most of the existing literature focuses on how parents view themselves as supports. Some literature suggests that youth with mental health issues are more likely to come from a dysfunctional family, unlikely to use parents as supports and are unlikely to have parents who notice their mental health concerns (Ciarrochi, Deane, Wilson & Rickwood, 2010; Lecloux, Maramaldi, Thomas & Wharff, 2016; Mojitabal & Olfson, 2010). Findings from this study suggest that youth perceive their parents as being great supports, in general. Many of these parents had their own lived experiences which may influence the support they were able to provide (van Loon, van der Ven, van Doesum, Hosman & Witteman, 2015). There are a number of other reasons why youth in this study may perceive their parents has being good supports. First, the sample size was quite small and gendered (i.e. all participants were female) and does not fully represent the community. It is likely that other youth in the community would have varying experiences of parental support. Secondly, the young women who did participate in the study were highly engaged with the school, which suggests that despite their mental health issues, they may have greater parent support than other youth.

Further, little is known about potential stigma experienced by youth within their family. It is not clear whether parents stigmatize their own children and whether that stigma comes from external pressures or families themselves (Moses 2010; Phelan, Bromet & Link, 1998; Richardson, Cobham, McDermott & Murray, 2013). It is also unknown whether these experiences should be categorized as stigma or whether they may be better explained as shame or embarrassment. One of the only studies to look at perceived interfamily stigma was conducted in the United States by Moses (2010) and found that the majority of youth who were interviewed experienced stigma from a family member. Few youth mentioned stigma from their parents in this study. This difference in perceived stigma may potentially be related to the community and rural living. If youth are concerned about privacy in their communities and schools, disclosing a mental health concern to a parent in the safety of their own home may be viewed as their only option.

Role of the school. Although youth identified several key barriers, they overwhelmingly wanted to see more investment (i.e. human and financial) in mental health in their school - not only for the delivery of SBS, but for the incorporation of educational initiatives. The findings of this study suggested that some of the youth preferred to use SBS, whereas others relied on teachers for support. Although the exact reason why there were differences in preferences of in-school support were not made clear, some of the youth suggested that previous poor experiences when trying to access SBS earlier in their time at the school discouraged them from trying to access SBS later on. Because they felt uncomfortable accessing SBS, many relied on teachers as an alternate source of support. There is a large body of literature on SBS; however, little of it addresses SBS targeted specifically to mental health. The few articles addressing SBS in NS mostly focus on physical activity, healthy eating and sexual health (Gahagan et al., 2012;

Langille, Andreou, Beazley & Delaney, 1998; McIsaac, Read, Veugelers & Kirk, 2017). Only one study, conducted in rural Ontario, collected experiences of youth using SBS for their mental health and highlighted similar key barriers to SBS access as found in this study, including lack of knowledge and uncertainty around teachers' capacities to support (Bowers, Mannion, Papadopoulos & Gauvreau, 2013). Another study out of Alberta focused on parents' perceptions of SBS and determined that parents of elementary school students in Alberta prefer the school as a primary source for mental health services (McLennan, Reckord & Clarke, 2008). Another that suggests that families may find SBS less stigmatizing than community services (Van Acker & Mayer, 2009). However, there is little literature that suggests youths' desire, or lack of desire, to use SBS for mental health supports and services.

Why it matters. The reliance on parents and the school system emphasizes the notion that it takes a village to raise a child. Each group plays an important in role in the psychosocial development and wellbeing of youth. Despite the paucity of mental health services available in their community, all students were able to access at least one mental health support and one mental health service in their lifetime. Most often this was due to the role of families, schools and other communities who offered support and tried to facilitate access to other services. In cases where the government has not provided adequate resources, the literature suggests that communities will often fill the gap by providing support (Milligan & Power, 2010). Although this is helpful for the individuals, it can place unneeded stress on communities and result in burn out of volunteers, families, teachers and other community members. Although the study did not set out to develop a theory, the findings speak to a possible development of a theory around the resourcefulness, determination and resiliency of individuals and rural communities. Resiliency is the "the capacity people have to adapt swiftly and successfully to stressful/traumatic events

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while not reverting to the original state" and is thought to be protective of mental health

(Shrivastava & Desousa, 2016, p. 38). Research on youth resilience in rural NS suggests that

community and family support have an important role in helping youth develop resiliency

(Didkowsky, 2016). Associating resiliency with community support can "reflect a shift in

perspective from community deficits to the potential of communities" (Ungar, 2011, p.1742).

The findings from this study indicates the importance of relationships within a rural community

and may provide new insights on youth mental health promotion in rural Canada.

Implications for Mental Health Promotion

   What is mental health promotion? The WHO (2004) defines health promotion as the

"new public health" and suggests that health promotion can be thought of as the "action and

advocacy to address the full range of potentially modifiable determinants of health" (p.16). With

this definition in mind, mental health promotion can be thought of as a series of actions and

advocating that addresses a range of determinants of mental health. Evidence suggests that

mental health promotion has the potential to "prevent mental disorder and enhance the well-

being and quality of life for people and communities" (Kobau et al., 2011, p.1). Traditionally,

mental health programs and policies have focused on the individual level and on tertiary levels of

prevention, or the management of existing illness (Davis, 2013). However, there has been a push

to begin on focussing mental health promotion, or primary prevention, such as universal

population health strategies, and secondary prevention, such as selective strategies that target

individuals at risk, in order to prevent mental health from languishing and reduce the focus on

treatment (Davis, 2013). This focus on population health can help address mental health beyond

the individual level and target family, school and community factors.

School mental health promotion. Youth were clear that they were unhappy with the services currently being provided in their school, but with increased resources (i.e. human, financial) they would use SBS for their mental health. The body of literature on mental health promotion in Canadian schools is small, and almost non-existent for rural schools; however, there has been a growing body of international literature that supports mental health promotion within the school (Weist et al., 2017). Existing literature suggests that there are several benefits to addressing mental health within the school system, including increased access and support for students who otherwise may not be able to access services in their community (Crockett, 2012; Price & Lear, 2008; Rones & Hoagwood, 2000). However, there are also universal challenges associated with SBS including limited education budgets, concerns about staff training and overworked teachers and administration (Crockett, 2012; McIsaac et al., 2017). It should be noted that the majority of implementations challenges related to SBS for mental health presented in the literature come from school administration and their concerns about educational budgets and overworking teachers, whereas few challenges to implementation have been identified by other stakeholders (McIsaac et al., 2017; Moon, Williford & Mendenhall, 2017). This suggests that all stakeholders, including school administration and staff need to be fully engaged in the planning and implementation process of any SBS.

Short (2016) has adapted Rowling and Weist's (2004) Comprehensive School Mental Health tiered model (Figure 5) in order to better understand school mental health promotion in Canada. This model suggests that mental health promotion can be approached from a "whole-school" perspective in order to promote health for the entire community, but that this work must be undertaken in collaboration with community partners. The Short (2016) adaptation shows how school health promotion can be integrated with community mental health, in order to share

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responsibility for youth mental health promotion (Figure 5). This model highlights the multiple

tiers of prevention and generally suggests that mental health promotion should take place in

school, with most clinical interventions taking place in the community.
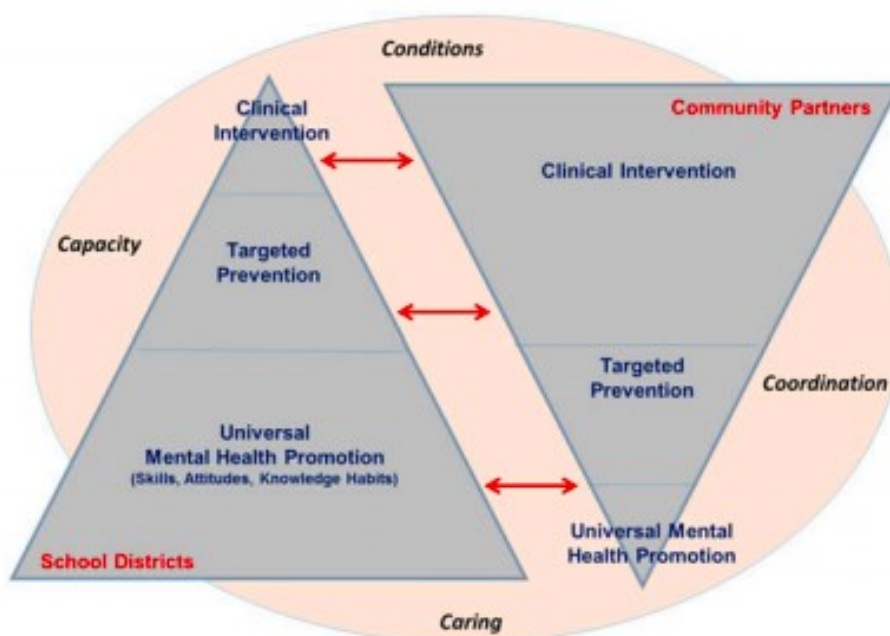
Figure 5 Modified tiered school mental health promotion model (Short, 2016)

However, I believe that this adapted model leaves out many key stakeholders, including

students, families, teachers and invested community members. A recent scan of mental health

SBS in Canada shows that 75 percent of mental health SBS respond to a community need and

they are more effective when there is buy-in from parents, the school board and wider

community (Mannion, Short & Ferguson, 2013). It is important that youth and their support

systems are given the opportunity to inform the services that are being created for them. This

engagement may include inviting all stakeholders to the development process instead of

incorporating their feedback later on. The Short (2016) model also leaves out a key piece of

program planning which has been identified as a large issue for all SBS in Canada –

documentation and evaluation. Alarmingly, less than half of mental health SBS are evidence-based (Mannion et al., 2013). Part of this issue is that current SBS are not well documented, partially because schools have a certain degree of autonomy to respond to community needs outside of provincially mandated programs. Any mental health promotion undertaken by schools should involve evaluation and documentation, which may require the facilitation of a health promoter, in order to inform best practices. Finally, the findings from this study suggest that youth would prefer more clinical interventions to take place in the school rather than the community. This may mean that clinical interventions are still undertaken by community partners, such as the local health authority, but the location of these services are in schools (i.e. integrated mental health services).

Recommendations for mental health promotion. My recommendations are based on the self-identified needs of young women who participated in this study. However, many of the recommendations may be transferable to other schools and communities in rural Nova Scotia, Canada and beyond. Although some aspects of the recommendations are community specific, the majority may be transferable as other knowledge users see fit.

Focus on overall wellbeing. Rowling and Weist (2004) suggest that any school-based mental health strategy should also address emotional and social wellbeing in order to reduce stigma associated with mental health and make mental health promotion relevant for the entire school community. Most youth in this study often mentioned the importance of feeling like they belonged in the school and spoke about their appreciation for school-based activities, like clubs, committees and teams. They suggested that more opportunities that incorporated leisure activities, like talking with friends, playing sports or being around animals may help to build a school community and could promote overall well-being among students. Opportunities to

develop socially and emotionally are important for students of all ages. Within Atlantic Canada, the Socially and Emotionally Aware Kids (SEAK) project is piloting and replicating social and emotional learning (SEL) curriculum in elementary schools. Preliminary research shows there are a number of academic and health benefits for students, teachers and the greater school community when SEL is used (AREKT, 2017; Hughes & Jacques, 2017). SEL could also benefit older students since they are at a key psychosocial development stage, although SEL may look differently for this age group. However, SEL is not incorporated into high school curriculum. Opportunities for SEL should be incorporated into curriculum at all grade levels, as well as extracurricular activities, where appropriate. The promotion of overall wellbeing may also prevent students from experiencing crises, either through management of emotions or prevention of mental health issues, which will prevent overloading health care providers.

There are also ways in which community partners can be involved in promoting overall wellbeing. For example, the implementation of policies and practices that promote population health may benefit youth mental health (Crockett, 2012). Although not unique to this community, youth in this study spoke about transportation challenges. Without public transportation, many youth had challenges accessing mental health services. However, they also spoke about the challenges lack of transportation created in accessing other health promoting activities, such as going to the gym or seeing their friends. In this case, policies that support active or shared transportation, such as the incorporation of a public transit system or the installation of sidewalks in the community, would not only support the overall wellbeing of the community, but would also have direct benefits for youth.

Focusing on wellbeing may also be helpful for targeted prevention of mental health issues for at-risk youth. Additional literature from NS suggests that many individuals are being

siloed into receiving medical or clinical care for their mental health needs; however, addressing the social roots of their mental health may be more beneficial (Leader, 2016). Most individuals will not need medication or psychotherapy to feel mentally well. Some individuals may have equally flourishing mental health if they are able to participate in recreational activities (Leader, 2016; Fenton, White, Gallant et al., 2017). Moving away from a medicalized model of mental health by focusing on the personal needs of the individual may help offset the high workloads of physicians and psychiatrists by reducing unnecessary referrals and care seeking. These activities could take place in either the school or community.

Mental health literacy. Students in this study have identified that positive classroom environments already exist, but more needs to be done around mental health literacy and support, especially for teachers and peers. Key suggestions include the incorporation of mental health in existing school curriculum, either as part of a heath course, or, ideally, integrated into all subjects. Ideally, this curriculum would be integrated at all grade levels based on age-appropriate material (i.e. social emotional learning in elementary school). It is important that all grades have some component of mental health literacy in their curriculum given that mental health issues often start before high school, which was the case for many of the students participating in this study. A recent randomized control trial in Ottawa tested whether mental health curriculum in 30 high schools affected levels of stigma among students. Stigma was found to significantly decrease for the students who took a health course with a mental health component compared to those students who did not talk about mental health as a part of their health course (Millin et al., 2016). The NS school curriculum is regulated by the provincial Department of Education, so policy makers would need to be targeted for this change to be made. Teachers are given very little flexibility to respond to the needs of their students through the current curriculum, as each

minute of the student's class time is outline by the province. There have been indications that mental health curriculum will be implemented in NS high schools in the near future (Palmeter, 2017).

Secondly, youth in this study spoke frequently about their uncertainty towards the preparedness of their supports, particularly teachers and friends. They suggested that more education about support needed to be provided for students and adults in the school. The efficacy of community-based and school-based mental health competency programs has come under heavy speculation over the last number of years due to a focused systematic review by Kutcher, Wei and Behzadi (2016) which suggested that there was no evidence that SafeTALK, a popular suicide alertness program, was effective. However, there is a growing body of evidence that programs like Mental Health First Aid may improve mental health literacy and confidence to support others among students and teachers (Jorm, Kitchener, & Sawyer, 2010; Yap & Jorm, 2011). Introducing a similar program in the school to develop support skills may be beneficial; however, evaluations need to be undertaken to better understand the outcomes of these programs. Further, if a peer support program was to be implemented in the school system, the appropriate checks and balances would need to be implemented to ensure proper training of peers, appropriate supervision and adherence to school confidentiality policies.

School-based services. According to the tiered model, clinical interventions, based on need, should be primary the responsibility of community partners (i.e. community based organizations, local branch of health authority) (Short, 2016). However, students in this study commented that they would feel more comfortable accessing a range of services within the school. This conflict provides the opportunity for community partners who would normally provide services (i.e. local health authority, NGOs) to enter the school and provide integrated

mental health services. There is existing infrastructure in many NS high schools that could facilitate increased SBS. In 2006, Health Promoting Schools (HPS) policies were implemented to improve the health of NS students. The provincial focus of HPS has been on physical activity; however, some schools have decided to adopt mental health promotion strategies (McIsaac et al, 2017). Administrators relayed that it was difficult to implement mental health promotion strategies on their own, so the SchoolsPlus initiative was implemented. SchoolsPlus is a promising program since it is being implemented at all grade levels. This is important since several youth in this study talked about how their mental health issue onset before high school, but there were no services available in school. It comes at a crucial point in NS history as the education system continues to be reformed under the current premier. After a strike and work-to-rule over the past two years, teachers in NS have made it clear that their students need better supports and services in schools, so that teachers, who are often faced within managing their students' complex health needs, can focus on teaching (Doucette, 2016). It is important that the implementation of SchoolsPlus responds to the needs of students, and families, without placing a heavier workload on the teacher.

There are two key objectives that need to be met in order for this integrated mental health model to work: collaboration and consistency. Currently, the hours of operation for the Teen Health Centre are inconsistent, which results in student either going to Student Services when a visit to Teen Health is more appropriate, only going in a crisis, or not going to any service. More consistent health centre hours and collaboration between the SBS in the school may facilitate better access for all students and provide the support that students without students feeling like they need to be in crisis before they seek support. The school must also work collaboratively with external services and healthcare providers. Collaborative care is the direction that the

provincial health authority is headed in and has been shown to best promote mental health in schools (Primary Health Care, NSHA, 2017; Lyon et al., 2016). The inclusion of integrated care within schools may also help connect the student to community services once they graduate. However, ideally, the school would be used as a community hub for community members to access services after school hours. Further, although mental health services should be available in the school, they should also be integrated and promoted as being a part of primary health care, in order to normalize mental health and begin to reduce stigma within the school. If a SBS is labelled as being only for mental health, there may be issues with privacy. Intersectoral collaboration should also be a priority, as it allows for the social determinants of mental health to be better addressed. For instance, existing SchoolsPlus schools include services from the Department of Health and Wellness, Justice and Community Services, which helps facilitate good mental health through both preventative and reactive measures, for youth and their family. By including youths' families and addressing mental health as more than a health concern, this intersectoral collaboration has shown promise in enhancing youth mental health. There is space for further intersectoral collaboration at the community level, which may improve access to existing services. For example, local bus and taxi companies may partner with the school to improve transportation to mental health supports and services.

The study school is modern and has the physical resources (i.e. space); however, there have been issues with staffing for SBS (i.e. nurses). Government officials and policy makers must work collaboratively with schools and communities to provide the necessary resources, including additional support staff and training, for the solution to be effective. This solution will only work if properly trained staff are employed and if the burden is taken off teachers to provide support and services for mental health. The province has recently promised 190 additional

support staff hires (i.e. educational assistants) to help address student health and inclusion (The Canadian Press, 2018). However, hiring practices should ensure that this staff has experience with, or be a part of marginalized populations, in order to increase diversity of service providers.

Person-centered systems. The recommendations that I have provided are not ideas that I have thought of by myself. All of the recommendations were based on the suggestions of youth in the study because they know their needs the best. Many of the barriers to access that they commented on were the cause of system-centered services. Any mental health promotion strategy about youth must involve input from youth. Other literature has highlighted the importance of youth-led mental health promotion in schools (Bulanda, Bruhm, Byro-Johnson & Zentmyer, 2014). Youth-led mental health promotion is a promising practice for any school. Parents, guardians, families and teachers should also be consulted, and their input should be taken into consideration. These individuals provide invaluable support for youth and are also directly impacted by the policies and practices of mental health services.

Limitations

There were a number of limitations to this study, mostly related to the study sample. The study sample was small in size (n=7) and mostly homogenous save for some ethnic diversity. The participants all identified as females, were very involved in the school and community, and all had accessed a service or support. One of the key challenges to rural research is that rural populations are often believed to be homogenous, when in reality they can be quite diverse. Unfortunately, I was unable to recruit any male students to this study and I did not ask about key sociodemographic factors (i.e. income), so this population is not an accurate depiction of the student body. I was disappointed that I could not recruit any male identifying students to participate in the study. I had tried to use a number of recruiting methods to reach a diversity of

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students; however, I received no interest. This is not surprising given that the literature suggests young males are underrepresented in mental health research due to difficulty with recruitment and the tendency for males to not want to talk about their mental health (Ellis et al., 2014). Because the sample was completely female, it is possible that their perceptions, experiences and suggestions for improvement may differ from young males. Incorporating different recruitment techniques, such as through social media or through the male RA, could have helped recruit more males. Social media is a proven effective way of recruiting young individuals, particularly males, to social media. Use of the RA and their ability to speak "guy to guy" may have also been beneficial (Ellis et al., 2014). However, because of potential conflicts of interest and ethical limitations these options were not suitable for this study. Changes in study design, such a mixed methods study where all students in the school are administered a questionnaire and a select few are followed up for interviews, may have also yielded a greater diversity of students.

The youth who participated in the study had also all accessed a service or support. It is likely that if youth who had not accessed a service or support were to participate, that their views may be different. Demographic information on SES was also not collected during this study, so it may be likely that the youth who participated were from similar economic background. Perhaps parents could afford to take time off of work to drive them to appointments or had social capital to facilitate access to services. Although this information is not known, it is important to note that the situations of these youth, particularly the support they received from their parents, may not be the same for all families in all communities.

The second large limitation is that recruitment and data collection took place within the school setting. Although this setting may have been beneficial for recruiting youth, reducing transportation issues for youth, and providing a confidential and controlled research

environment, it also meant that youth with mental health issues who were not students, who were homeschooled, or who were rarely in school because of their mental health would not have been recruited. The participants who were recruited mostly spoke about experiences in the school and also suggested that they wanted more services in the school. However, it is very likely that different opinions and experiences would have been captured if youth who were not as engaged with the education system were recruited. Within the school setting, youth who participated in the study appeared to be highly engaged with the school and were quite courageous in coming forward to share their experiences. It is likely that many other youth qualified to participate in this study, but did not volunteer for a number of reasons. Some of these reasons may have been linked to the level of trust they had in sharing their experiences with a stranger, as well as their engagement with the school. Had a different group of youth participated, the findings would likely be quite different.

Finally, there were some time constraints due to my degree program which affected recruitment. If more time was allotted for this study, it is likely that a number of changes could be made to recruitment strategy (i.e. better incorporation of student RAs or recruiting outside of the school). Doing so, may have had allowed for the greater collection of experiences and perceptions of access from a more diverse group of youth, specifically young men.

Future Research

There are a number of areas for future research based on the findings of this study. Future research may further examine the role of parents and teachers as supports in rural communities, particularly from the youth perspective, as well as the parents' and teachers' perspectives. It may also be interesting to unpack the idea of "crisis" and why young people are waiting until they're in crisis to access services and supports. Additionally, evaluations of mental health SBS at a

community, provincial and national level are needed. All possible efforts should be made to recruit a diverse group of youth, in order to represent the diversity of rural communities.

Knowledge Translation

The findings from this study have the potential to have a meaningful impact at an academic and community level. At the academic level, the findings from this study have been presented at several relevant conferences and seminar series, including the *Canadian Association of Health Services and Policy Research (CAHSPR) Conference* and Dalhousie University's *Primary Health Care Research Day*. In addition, this thesis will be published, and a peer reviewed article will be generated and submitted to a relevant journal. There are also a number of plans to disseminate the findings in the community. A community report will be developed with the RAs and shared within the school and with key stakeholders in the community (i.e. families, students, policy makers). In addition, the student RAs have decided to advocate and implement small changes within the school for the start of the 2018-2019 school year based on the findings of this study. These changes will include incorporating a small information box about SBS on each student's timetable, organizing additional wellness events in addition to what currently happens in the school (i.e. hiking trips, wellness retreats, school community building), and working with Students' Council and staff advisors to organize Mental Health First Aid training for interested students. These activities are a starting point and may adapt to the needs of the school in the future.

Conclusion

Although access to mental health supports and services in the community was generally poor, youth were able to access supports and services largely due to their determination and resilience, and the support of their parents and teachers. Although this study only addressed the

perceptions and experiences of youth in one small rural NS community, the resiliency of the community is not unique and highlights the realities of many rural Canadian communities. After highlighting a number of barriers and facilitators to access (i.e. transportation, stigma, community support), youth were adamant that mental health supports and services should be delivered through the school. Collaborative mental health promotion efforts must be undertaken by schools and communities, particularly in rural Canada, in order to harness their full capacities and create healthy communities for youth and their families. Above all else, youth and their supportive networks, including families and schools, must be actively engaged with the development, implementation and evaluation of school and community-based youth mental health promotion initiatives.

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APPENDIX A: Research Assistant Hiring Strategy

Script for morning announcements and classroom presentations:

Are you interested in health research? Want to gain more research skills? Have a passion for mental health? There is an opening for 1-2 student research assistants for an upcoming research study on youth mental health in Pictou County. Benefits include some limited research experience, networking, and an honorarium. For more information, please visit Student Services or contact Holly at Holly.Mathias@dal.ca.

Student Research Assistant Position Description

Position: Student Research Assistant

Number of Positions: 1-2 (depending on interest and candidate suitability)

Purpose: The student research assistant will support the lead researcher in a study on how youth living with a mental or emotional health concern in rural Pictou County perceive and experience access to supports and services. This research study seeks to better understand the challenges and supports of help-seeking for youth with mental health concerns in the community.

Location: Based at ███████, but work can be done at home

Supervisor: Holly Mathias, MA Health Promotion candidate, lead researcher

Key Responsibilities:
- Assist with developing interview guide
- Help prepare presentation materials for student community (i.e. create infographics, student report)
- Maintain communication with lead researcher
- Attend all meetings (1 in the Fall, 1-2 in the Spring)

Length of Position: September 2017-August 2018

Time Commitment: Approximately 15 hours, as assigned by lead researcher

Qualifications:
- Current ███████ student
- Experience with and interest in mental and emotional health
- Interest in health research
- Strong writing and communication, and organization skills
- Ability to work independently and as part of a team
- Mature attitude, respect of privacy and confidentiality
- Desire to learn!

Remuneration: $150 honorarium

How to Apply: In one page or less, please explain why you are interested in this position and what skills you could bring to this position.
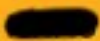
Submit your application to Student Services by **[DATE].**

Questions? Please contact Holly at Holly.Mathias@dal.ca

APPENDIX B: Participant Recruitment Strategy

Script for morning announcements and school newsletter:

A research study on access to mental health supports and services for youth in rural Pictou County is looking for students to share their experiences with accessing mental health supports or services. You must:

- Be between the ages of 16 and 18 years old

- Be a current ▮▮▮▮ student in grades 10-12

- Have experienced within the last year, or be currently experiencing, poor mental or emotional health (e.g. depression, anxiety, eating disorders)

- Have lived in Pictou County for at least 1 year

All participants will participate in a face to face interview and will receive their choice of a $20 gift card to Cineplex, Sportchek or Indigo/Chapters. For more information, please contact the lead researcher, Holly, at Holly.Mathias@dal.ca.

SHARE YOUR STORY!

The research study "Understanding How Youth in Rural Nova Scotia Perceive and Experience Access to Mental and Emotional Health Services and Supports" is looking for students to share their experiences accessing mental health supports during a face-to-face interview with a Dalhousie University Masters student.

PARTICIPANTS MUST:

- be a current ▬▬▬▬ student in grades 10-12

- be 16-18 years old at time of interview

- be experiencing (or have experienced in the past year) a mental or emotional health concern (e.g. anxiety, depression, eating disorder)

- have lived in Pictou County for at least a year

ALL PARTICIPANTS WILL RECEIVE A $20 GIFT CARD OF THEIR CHOICE TO CINEPLEX, INDIGO OR SPORTCHEK!

INTERESTED IN PARTICIPATING? HAVE QUESTIONS?

Contact Holly at Holly.Mathias@dal.ca

DALHOUSIE UNIVERSITY

CONSENT FORM

Project title: Understanding How Youth in Rural Nova Scotia Perceive and Experience Access to Mental and Emotional Health Services and Supports

Lead researcher: Holly Mathias, Dalhousie University
School of Health and Human Performance
Stairs House, Dalhousie University
6230 South Street, Halifax, NS
B3H 4R2
Holly.Mathias@dal.ca

Other researchers
Dr. Lois Jackson, Dalhousie University
School of Health and Human Performance
Stairs House, Dalhousie University
6230 South Street, Halifax, NS
B3H 4R2

Introduction
You are invited to take part in a research study that is being conducted by Holly Mathias, a graduate student at Dalhousie University as part of the Master of Arts Health Promotion degree. You can choose whether or not to take part in this research. It is entirely your choice. There will be no impact on your studies if you decide not to participate in the research. The information below will tell you what is involved in the research, what you will be asked to do and about any benefits, risks or inconveniences or discomfort that you might experiences. You should discuss any questions you have about this study with Holly. Please ask as many questions as you like. If you have questions later, please contact Holly, the lead researcher.

Purpose and Outline of the Research Study
The purpose of this study is to understand how high school students in rural Nova Scotia perceive and experience access to mental health services and supports. Services and supports may include any formal mental health programs and services that you access, or would like to access, to improve your mental health (e.g. Aberdeen Hospital, community mental health services); or other people or resources that support your mental health (e.g. friends, teachers, internet).

To gather information for this study, face-to-face interviews will be held. Approximately 10

students (in 10 individual interviews) from ████████████████████████████████████ will participate.

Who Can Take Part in the Research Study
You may participate in the study if all of the following criteria apply to you:
- You are between the ages of 16 and 18 years old
- You are a current ████ student in grades 10-12
- You are experiencing, or have experienced in the past year, mental health or emotional health concerns (e.g. depression, anxiety, eating disorders)
- You have lived in Pictou County for at least 1 year

What You Will Be Asked to Do
If you decide to participate, you will be interviewed face to face with an interviewer. The lead researcher will ask you about your experiences with mental health services in Pictou County, or other people or places you go for support when you are feeling mentally or emotionally unwell. You will have the opportunity to share and discuss your thoughts and experiences around mental health services and supports in Pictou County.

Each interview will last approximately 50 minutes and will take place at ████. The interviews will be held on school property in a private room during lunch hour.

Possible Benefits, Risks and Discomforts
Benefits:
Participating in this study may not directly benefit you; however, many people find it helpful to share their experiences in a supportive and safe space. You will also be contributing to research that might help us learn more about how rural youth experience mental health and how they access services and supports. It is possible that the findings from this study may inform policy or programs aimed at youth mental health in Pictou County and Nova Scotia.

Risks:
Participating in a research study comes with some potential risks. Participating in this study may cause psychological and emotional harm in the form of distress, discomfort, mental fatigue, and the "triggering" of past experience. There is also a risk of social harm, such as the stigma associated with mental illness and participating in a study on mental health.
In order to minimize the risks, you will have the option to skip questions that you do not want to answer and you can take a break at any time. You may choose how much information you would like to share with the researcher. You may choose to withdraw at any point of the study. The interview room will be in a private area of the school and will be locked with windows blacked out. All identifying information shared during the interview will be removed during the data analysis phase.

Compensation / Reimbursement
If you choose to participate in the study, you will be provided a "thank you" in the form of a $20 gift card of their choice to either Cineplex, Sportchek or Indigo.

How your information will be protected:

Privacy:

The researcher will do everything in their capacity to ensure student privacy. You may choose to have the room locked during the interview. Information shared during the study will be anonymized and will exclude any personally identifying factors in data analysis and sharing the results. Your answers will not be able to be tracked back to you.

Confidentiality:

There are some limits to confidentiality. The lead researcher has the duty to report, in the unlikely event, that there is suspected child abuse or neglect, or if you have indicated that you plan to harm yourself or someone else. If such a situation occurs, the lead researcher will stop the interview. The researcher will contact their supervisor and one of the school guidance counselors. You will be asked to visit with one of the guidance counselors immediately.

Data retention:

All study materials will be securely stored. Informed consent forms will be stored in a locked briefcase during transport between Pictou County and Halifax. Once in Halifax, they will be transferred as soon as possible to the supervisor's office (Dr. Lois Jackson) where they will be locked in a filing cabinet until the end of the 5 year storage period. Identifying information will be stored separately from the collected data. Audio recordings and transcripts will be in digital form. These will be stored on encrypted and password protected hard drive. All study data will be securely destroyed by smashing the hard drive and shredding paper documents after 5 years. Only the lead researcher and supervisor will have access to this data. Findings from the data will be presented and discussed in the lead researcher's thesis, as well as in presentations and journal articles. Any quotations that are used in these publications will not be personally identified. You will not be named in our reports or presentations.

If You Decide to Stop Participating

You are free to leave the study at any time. If you decide to stop participating at any point in the study, you can decide if you want to withdraw any of the study information you have contributed up to that point, or if you want to allow us to still use that information. You will have up until 2 weeks after your participation to inform the researcher if you want your data to be removed. It will be analyzed after that point.

How to Obtain Results

Study results will be made available to participants in the form of a community report. You can obtain these results by including your contact information at the end of the signature page.

Questions

We are happy to talk to you about any questions you may have about the study. Please contact Holly Mathias (Holly.Mathias@dal.ca) at any time with questions, comments or concerns about the research study. We will also tell if you any new information comes up that could affect your decision to participate.

If you have any ethical concerns about your participation in this study, you may also contact Research Ethics, Dalhousie University at (902) 494-1462, or email: ethics@dal.ca (and reference REB file #2017-4202)

Signature Page (Interviews)

Project title: Understanding How Rural Nova Scotia Youth Perceive and Experience Mental and Emotional Health Services and Supports

Lead researcher: Holly Mathias, Dalhousie University
School of Health and Human Performance
Stairs House, Dalhousie University
6230 South Street, Halifax, NS
B3H 4R2
Holly.Mathias@dal.ca

I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I understand that I have been asked to take part in an interview that will occur at ████████████████████████, and that this interview may be recorded. I agree to take part in this study. My participation is voluntary and I understand that I am free to withdraw from the study at any time, until 2 weeks after my interview is completed.

I agree to have my interview audio recorded. ☐Yes ☐No

I agree that direct quotes from my interview may be used. ☐Yes ☐No

_____ _____ _____
Name Signature Date

_____ _____ _____
Researcher's Name Signature Date

APPENDIX D: Interview Guide

1. **What is it like living in a small community?**
2. **What does mental and emotional health mean to you?**
3. **What do mental/emotional health supports and services look like for you?**
4. **Have you ever accessed a mental health service or support?**
   a. **If yes**, can you tell me about your experience? How did you decide where to go? Why? What was your experience like? Did you experience any barriers to access? What made it easy to access?
   b. **If no,** why not? What are some barriers to accessing a service or support? What makes it easy to access a service or support?
5. **How does living in a small community influence access to services?**
   a. Transport? Stigma? Privacy? Identity?
   b. Do you think your experiences would be different if you lived in another community?
6. **What do you think about the current services and supports for youth in Pictou County?**
   a. Do you think there are enough services available for youth? Why or why not?
   b. Do you think many youth know where to seek help?
7. **What services or supports would you use in your community?**
   a. What would this look like? Who could use it?
8. **Why were you interested in participating in this study?**
9. **Is there anything else that you would like to add?**

*Non-verbal prompts may include nodding, smiling, or showing empathy. Additional verbal prompts may include "mhm," "yes," "oh" etc.

DALHOUSIE UNIVERSITY

HONORARIUM TRACKING FORM

Project title: Understanding How Youth in Rural Nova Scotia Perceive and Experience Access to Mental and Emotional Health Services and Supports

Lead researcher:
Holly Mathias, Dalhousie University, Halifax NS   Holly.Mathias@dal.ca

Other researchers
Dr. Lois Jackson, Dalhousie University, Halifax NS

Participant # _____

Date Given Honorarium _____

Person Giving Honorarium _____(Print)

Person Giving Honorarium _____ (Signature)

Finding Support

There are many services and supports available if you are struggling with your mental or emotional health.

This pamphlet includes a list of FREE services and supports available to you within the Chignecto Central Regional School Board Zone.

Mental Health Resources

NORTHERN NOVA SCOTIA

Front Page

Mental Health Services in Your Community

PLEASE CONTACT THE SERVICE FOR MORE INFORMATION

Pictou County

School Guidance Counsellor:
  Where: Student Services, ~~Name~~
  When: School Hours
  How: Make an appointment at
    Student Services.

Community Mental Health Services:
  Where: 835 East River Rd, New
    Glasgow
  When: 8:30 am -4:30 pm (Mon-Fri)
  How: Call 902-755-1288 to make
    an appointment

Aberdeen Hospital Emergency Room:
  Where: 835 East River Rd, New
    Glasgow
  When: 24/7
  How: Ask a trusted friend or
    adult to take you, or call a taxi,
    or in an emergency, call 911

Online/Phone

NS Mental Health Crisis Line:
  Where: Anywhere
  When: 24/7
  How: Call toll-free 1-88-429-8167

Kids Helpline:
  Where: Anywhere
  When: 24/7
  How: Call toll-free 1-800-668-6868

In-Person

There are many individuals in your
community who may be a good
support for you: teachers, guidance
counsellors, parents, friends, your
minister or clergyman, coach or other
trusted community member.

Truro Area

Mental Health Crisis Services Truro
  Where: Colchester East Hants
    Health Centre, 600
    Abenaki Rd
  When: 9:30am-4:00pm (Mon-Fri)
  How: Call 1-800-460-2110 ext
    42606 or visit emergency
    crisis service centre

Canadian Mental Health Association
  Where: 574 Prince St. Truro
  When: 9am-5pm (Mon-Thurs)
  How: Contact 902-895-4211,
    cmha.ceh11@gmail.com
    or drop by

Back Page

APPENDIX G: Dalhousie University REB Approval Letter

DALHOUSIE UNIVERSITY
Research Services

Health Sciences Research Ethics Board
Letter of Approval

July 13, 2017

Holly Mercedes-Mathias
Health\Health & Human Performance

Dear Holly,

REB #: 2017-4202
Project Title: Understanding How Youth in Rural Nova Scotia Perceive and Experience Access to Mental and Emotional Health Services and Supports

Effective Date: July 06, 2017
Expiry Date: July 13, 2018

The Health Sciences Research Ethics Board has reviewed your application for research involving humans and found the proposed research to be in accordance with the Tri-Council Policy Statement on *Ethical Conduct for Research Involving Humans*. This approval will be in effect for 12 months as indicated above. This approval is subject to the conditions listed below which constitute your on-going responsibilities with respect to the ethical conduct of this research.

Sincerely,

Dr. Tannis Jurgens, Chair

APPENDIX H: Letter of Support from School Principal

███

September 18, 2017

To whom it may concern:

Please accept this letter as confirmation of ████████████████████████ participation in Holly Mathias' graduate research project entitled: *Understanding How Youth in Rural Nova Scotia Perceive and Experience Access to Mental Health Services and Supports*. I am aware that Holly will be recruiting both research assistants and participants for her study through ██████ have read Holly's ethics approval request and feel comfortable that any of our students, participating in either capacity, will be have their safety and confidentiality protected.

Sincerely,

████████████████████

Acting Principal

███████████████████████

APPENDIX I: School Board Approval Letter

Chignecto-Central Regional School Board

60 Lorne Street, Truro
Nova Scotia B2N 3K3
ph: (902)897-8900
fax: (902)897-8989

ccrsb.ca

September 21, 2017

VIA EMAIL:
Holly.Mathias@Dal.Ca
Ms. Holly Mercedes-Mathias
School of Health and Human Performance
Dalhousie University
PO Box 15000, 6230 South Street
Halifax, NS B3H 4R2

Dear Ms. Mercedes-Mathias:

Re: Request to Conduct Research

I am writing in response to your request for approval to move forward with the proposed study, *Understanding How Youth in Rural Nova Scotia Perceive and Experience Access to Mental and Emotional Health Services and Supports.*

I am pleased to advise you that your research project has been approved to proceed at ▮▮▮▮▮▮▮▮ ▮▮▮▮▮▮▮▮. Please consult with the Acting Principals, ▮▮▮▮▮▮▮ to begin the research.

I wish you success with your work.

Yours truly,

▮▮▮▮▮▮▮▮▮

Chris Boulter, Supervisor
Systems Development

cc. Stephanie Isenor-Ryan, Director, Programs and Student Services
     Ron Turnbull, Celtic Family of Schools Supervisor
     ▮▮▮▮▮▮▮▮ Acting Principal, ▮▮▮▮▮▮▮▮▮▮▮▮
     Lois Jackson, Professor, School of Health and Human Performance, Dalhousie University

SIR/clb

APPENDIX J: Passive Consent

The following memo has been developed with the school and will be distributed electronically to notify parents and guardians about the study:

Dear parents and guardians,

A Dalhousie Master's student is recruiting student participants from ▮▮▮ for the study *Understanding How Youth in Rural Nova Scotia Perceive and Experience Access to Mental Health Services and Supports*. Participation is completely confidential and voluntary for students. They must contact the researcher if they would like to participate. In order to participate, students must:

- Be between the ages of 16 and 18 years old

- Be a current ▮▮▮ student in grades 10-12

- Have experienced within the last year, or be currently experiencing, poor mental or

  emotional health (e.g. depression, anxiety, eating disorders)

- Have lived in Pictou County for at least 1 year

If you do *not* want your teenager participating, please email the lead researcher, Holly, at Holly.Mathias@dal.ca by **[one week from notification].**