The Lived Experience of Youth Mental Health Care on Cape Breton Island

by

Maeridith Katherine Guy

Submitted in partial fulfilment of the requirements
for the degree of Master of Science in Nursing

at

Dalhousie University
Halifax, Nova Scotia
July, 2021

Dalhousie University is located in Mi'kma'ki
the ancestral and unceded territory of the Mi'kmaq. We are all Treaty People.

Dedication

For my parents, Michael and Theresa Guy, who's unwavering support, unconditional love, and guidance has assisted me in accomplishing my personal and academic goals.

And for the youth participants of this study who were brave enough to share their own story. Thank you for being the voices of the unheard. Your courage and extraordinary resilience did not go unnoticed. Without you, this would not have been possible.

TABLE OF CONTENTS

Abstract

In Nova Scotia, youth often face challenges when seeking care for mental health problems due to a lack of specialty mental health services. Youth in rural and underserves areas of the province face greater challenges than urban youth accessing timely mental health services due to additional factors such as extended wait times and stigmatization. This qualitative phenomenological study focused on youth in the Cape Breton Regional Municipality, an underserved area of Nova Scotia, and posed the overarching question: 'What are the lived experiences of youth who self-identify as having a self-identified, self- defined mental health problem for at least six months?' Interpretive phenomenology was employed to analyse transcripts from 10 youth. Six overarching, common themes emerged from the data: *Trauma; Familial Support; Positive Relations; Negative Internalized Feelings; Service Gaps; and Personal Growth.* Many youth faced challenges throughout their lifetimes contributing to their mental health problems, but their extraordinary resilience prevails.

Acknowledgements

First and foremost, I would like to begin by acknowledging that Dalhousie University sits on the Traditional Territory of the Mi'kmaq and this research took place on ancestral and unceded territory of the Mi'kmaq people on U'nama'ki. We are all Treaty People.

In celebration of the completion of my Master's degree, I would like to thank those in my life who offered support and encouragement throughout this process. First, I would like to thank my thesis supervisor, Dr. Jean Hughes for her constant encouragement, guidance, and support, and for sharing her wealth of knowledge and expertise with me during my Master's program and the writing of my thesis. I would also like to thank my committee members Dr. Megan Aston and Laura Carnegy, for sharing with me with their own expertise and support thought out this process. A large thank you goes to the Maritime Spor Support Unit who provided funding for this research. You all have been invaluable to my experience and this research and for that I am so thankful.

I would also like to thank all of my friends and family who have provided support and encouragement throughout this journey. In particular I would like to thank my partner, Ian, who has shown me endless patience, immeasurable love, and unwavering support and encouragement throughout my time in graduate school. This would not have been possible without you. I would like to thank my cousin and dearest friend Charlotte MacDonald for spending endless hours proofreading my graduate papers and this thesis. I am grateful for you, your support and your witty sense of humour that made editing papers enjoyable. I would also like to thank my classmate, co-worker and friend Nora Conboy. I am so grateful this graduate program brought us together and we were able to

share our journey at Dalhousie, it would not have been the same without you. I would also like to thank my Uncle, Dan MacDonald for providing me with office space in Downtown Sydney to ensure my participants had a private, safe and welcoming environment to speak in. Finally, I want to thank my parents, for which this thesis is dedicated. Thank you both for everything you have done and continue to do for me throughout my life and for always encouraging me to "shoot for the stars." I love you both more than you will ever know.

Chapter I: Introduction

Youth mental health care has become a challenge in Nova Scotia, particularly in rural areas, where long wait times and few community resources are causing a mental health service crisis. Nova Scotians report a prevalence of mental health disorders at 41.7% compared to 33.1% for the rest of Canada (Nova Scotia Health, 2017). Furthermore, it is estimated that 12% of children and adolescents ages 4-17 years have a diagnosable mental illness in Nova Scotia (Nova Scotia Health, 2017). A number of communities in Nova Scotia, such as the Cape Breton Regional Municipality, have faced wait times of up to 313 days for mental health services within the community in the past number of years, the longest wait times in the province (Government of Nova Scotia, 2021). With community based mental health services being limited, emergency rooms (ER) in hospitals across Canada have become a center for mental health care services (Hamm et al., 2010). Furthermore, when youth have immediate problems, often their first contact with the healthcare system is in the ER, not their family doctor (Cloutier et al., 2017). According to the Canadian Institute of Health Information, there has been a 61% increase in child and youth visits to emergency rooms in Canada in the past decade (CIHI, 2020). Wait times for youth seeking mental health care in the ER at Cape Breton Regional Hospital (CBRH) often exceeds 24 hours. In addition, the CBRH does not have an inpatient adolescent mental health unit, forcing youth and their families to travel upward of 4 hours to the IWK hospital, Maritime Canada's center for child and adolescent healthcare, for inpatient mental health services, when needed, in Halifax, Nova Scotia. The burden of mental health problems for youth makes it imperative that

appropriate interventions are chosen and integrated into care (Das et al., 2016). Moreover, these services should be accessible to youth in their community, where they can be surrounded by their support systems. It has been argued that the advancement of youth mental health care services should be the top priority of health services in this country (Malla et al., 2018). In addition, research suggests that there are gaps in the current healthcare system regarding provision of mental health care to youth populations (Foreman- Hoffman, et al., 2017). Currently, no studies exist that focus on youths' subjective experiences when accessing mental health care in underserved areas. Few studies have touched on youths' experiences with community-based mental health services, specifically in underserved communities. The purpose of this research was to explore the lived experiences of youth with a self-identified, self-defined, prolonged, mental health problem and identify the supports and services they have, or have not, accessed on Cape Breton Island. The aim of the research was to: a) Gain a deeper understanding of the lived experiences of youth, ages 16-21 living on Cape Breton Island who have a self-identified, self-defined, prolonged (at least six months) mental health problem; (b) Identify which mental health supports and services youth are using - or not using – and why; (c) Explore the experiences resulting from their decision to use, or not use, supports and/or services; and (d) Explore how Cape Breton youth perceive mental health services and supports are meeting the needs of youth and how these services and supports can improve?

This research aims to build knowledge regarding youths' perspectives of mental health care in underserved areas of Canada, inform future practice and service allocation,

and add recommendations for youth mental health care, from youth, in underserved areas of our province and country.

Cape Breton Island (Unama'ki)

Connected to the mainland of Nova Scotia by the Canso Causeway, Cape Breton Island is home to one fifth of Nova Scotia's population (Muise, 2015). Named Canada's best kept secret by National Geographic, Cape Breton Island boasts more than 10,000 km^2 of beautiful, natural and rugged terrain from the southern end of the island to the highest peak in the Atlantic region, in the northern highlands (Muise, 2015). The island is divided into four regions, Cape Breton, Richmond, Inverness, and Victoria. Sydney, an industrial port city, is the only city on the island. Travel from rural and northern parts of the island into the city center can exceed 2 hours over mountainous terrain, and often harsh weather, especially in winter months (Appendix A). Cape Breton's weather is highly unpredictable, many say you can see up to 4 seasons in one day.

The earliest settlers of Cape Breton Island were the Mi'kmaq, who lived on the island before 1497 when John Cabot, an Italian explorer landed on the shores of the island. This "discovery" led to mass genocide and colonization and in turn, intergenerational trauma, that still affects and will continue to affect Indigenous Canadians for generations to come. The French settled in Cape Breton naming the island "Ile Royale" and began the construction of the fortress of Louisburg (Muise, 2015). The fortress became one of the most instrumental military centres of New France, defending the Gulf of St. Lawrence. Cape Breton was eventually captured by the British and became a part of Nova Scotia in 1763 (Cabot shores, 2010). In 1775, Michael Mor MacDonald, one of the first Scottish settlers to come to Cape Breton, permanently settled in Judique (Cabot Shores, 2010).

The immigration of Scottish settlers increased in Cape Breton and in other areas of Nova Scotia due to the Sottish Highland Clearances. Still to this day, many elderlies in rural areas of Cape Breton Island speak Gaelic, the mother tongue of the Scottish settlers (Cabot Shores, 2010).

Today, Cape Breton, also known as Unama'ki, as named by the Indigenous people of Cape Breton, is the home of approximately 134,000 people (Province of Nova Scotia, 2021). Cape Breton boasts its Celtic heritage through music, dance, and cultural and educational institutions such as Cape Breton University and the Beaton Institute, the Gaelic Collage, the Miners Memorial Museum, the Fortress of Louisburg, The Alexander Graham-Bell Museum, the Cape Breton Highlands National Park and the Cabot Trail. Many of these sites are large tourist attractions, tourism being one of Cape Breton's largest industries (Government of Canada, 2019). Although hardships have faced many families in Cape Breton, Cape Bretoners are resilient, hardworking, and supportive of their people, making everyone feel as though they are at home on one of the most beautiful islands in the world.

It is important to note that I, the researcher, was raised in Sydney, Cape Breton. My own experiences being raised, and living, in Cape Breton in conjunction with my own understanding and geographical familiarity of the island, along with the culture that exists on the island, may have given me more insight into youths' lived experiences that will be discussed throughout this paper. This insight was imperative to the research process, and perhaps some intricacies may not have been captured had I not been a Cape Bretoner myself.

Blue Collar Work and Mental Health

Cape Breton saw an influx of immigrants after the development of coal mining and the construction of the Sydney Steel plant in 1889. Thousands of jobs were available which brought immigrants from Russia, Sweden, Italy, Norway, Lebanon, Poland, Ukraine, Lithuania, and Belgium who settled in mining towns such as Glace Bay, New Waterford and Sydney Mines (Nova Scotia Archives, 2019). Industrial Cape Breton (Sydney) grew from 10000 to over 75000 by the year 1920. Those who settled in Sydney settled near the Sydney steel plant, specifically in Whitney Pier, where, to present day, there is a melting pot of cultures and communities stemming back to this influx of immigrants (Nova Scotia Archives, 2019). From 1890 to 1920, Industrial Cape Breton was the largest cosmopolitan area in the Maritimes, their descendants' living in Cape Breton to this day (Nova Scotia Archives, 2019). Unfortunately, there was an industrial decline and in turn, economic decline and mass out migration following the closure of the Sydney Steel Plant and the local Coal Mines in years leading up to year 2000 (Mackinnon, 2021). The economic decline unfortunately led to a multitude of problems effecting individuals living in Cape Breton, including high unemployment rates, addiction, crime and family violence (MacPhee and Kennedy, 2009). Cape Breton, although home to many industrial towns and a port city, had an unemployment rate of 15.9% in 2020, the highest unemployment rate in the province (Nova Scotia Department of Justice, 2020).

With the development of the Sydney Steel Plant and the boom of the coal mining and fishing industry these trades were at one time the driving force of the economy in Cape Breton. Like so many rural communities around the world, their small towns were home to blue collar workers and their families. Although the blue-collar industry does not

support the local economy at present day, the culture of the blue collared labour force certainly exists on the island. Cape Bretoners are known as hard working individuals who take care of their own, who are not afraid of "an honest day's work." This mentality has been passed down for generations and will be for generations to come. Like other rural communities in the world, this working-class mentality may have an effect Cape Bretons attitudes towards mental health and mental illness even with the strides society has taken to decrease stigmatization surrounding mental health problems.

Research suggests that mental illness is often still stigmatized in rural settings (McLean, 2012). This stigmatization in rural areas can cause those who have mental health problems to avoid seeking mental health care in turn bolsters a self-reliant attitude within rural communities (McLean, 2012). A 2019 qualitative American study comparing blue collar and white-collar workers found that blue collared workers were more likely to be treated for depression when compared to white collared workers. Furthermore, both male and female blue collared workers used services to address the depressive symptoms less frequently than white collared workers within the study (Elser, et al., 2019). Additionally, research suggests that blue collared workers have increased risk for depression and anxiety when compared to white collared counterparts (Joensuu, et al., 2010).

A qualitative 2012 Australian study focusing on rural resident miners found that workers felt that 5-10 years ago, attitudes regarding mental health were much different than they are at present. Workers felt that they may have been *"*looked down on as a sook or looking for the easy way out" (Mclean, 2012, p.129). When compared to the era of the blue collared work in Cape Breton beginning in the 1890s, one can assume that these

attitudes were very much the same if not stronger in the coal mine and steel plant in Cape Breton due to mental health awareness only becoming prominent within society within the last number of years. A similar mentality has shaped the culture on the island, fostering similar attitudes toward mental health that has been passed down from the generation belonging to the post war era. These attitudes may still affect Cape Bretoners, in turn, affecting youth currently growing up on the island as parents who are raising youth in the ages applicable to this study may have similar feelings toward mental illness that has been found to be common in rural communities. These attitudes may have negative effects on youth who have mental health problems as familial support is often imperative to youths' positive outcomes (Honey, et al., 2014)

Literature Review

The following section will discuss the youth population and challenges that this age group faces at this time in the life cycle; including definitions of mental illness, mental health problems and common mental illnesses in this population. Furthermore, this section will discuss literature regarding availability and accessibility of speciality youth mental health care in Canada and in Nova Scotia, the Nova Scotia health care crisis and how this has affected Cape Breton's health care system, including the mental health system. Finally, this review will discuss emergent mental health care services and barriers to care in this area including stigma, and a review of research regarding youths' experiences with community-based services. The literature review is prefaced with 6 definitions that will serve as a foundation for this study including mental health, mental illness/disorder, mental health problem, and access/accessibility.

Key Definitions

There are several definitions that should be discussed to lay a foundation for this research, including mental health, mental illness or disorder (often used interchangeably), mental health problem, accessibility, availability, affordability, and acceptability.

Mental Health: defined as "a state of well-being in which every individual realizes his or her own potential, can cope with normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community" (World health Organization, 2014).

Mental Illness or Disorder: "medical conditions that affect a person's thinking, feeling, mood, ability to relate to others, and daily functioning. Mental illness can be seen as the result of a chain of events that include flawed biological, psychological, social, and cultural process" *(Varcarolis, 2013)*.

Mental health problem: For the purpose of this research, mental health problem will be used as a broad term to describe a self-identified, self-defined, prolonged (persisting for at least 6 months) mental health problem that *has or has not* been diagnosed for which youth may, or may not, have accessed services or supports. This study did not require participants to have a diagnosed mental illness to participate. Participants were recruited on the bases of self-identifying as having a "self-defined, prolonged mental health problem."

Youth: The United Nations defines "Youth" as persons between the ages of 15-24. Youth mental health is the primary focus of this study. The researcher is cognizant that mental health problems that occur in adolescent development commonly persist past age 19. For the purpose of this study, individuals ages 16-21 were the focus and the broad term "youth" will be used throughout this paper to identify this age group (United Nations, n.d).

Access/Accessibility: "the empowerment of an individual to use health care and benefit from services, given their circumstances and experiences in relation to the health care system" (The Provincial Center of Excellence for Child and Youth Mental Health at CHEO, 2010, p.11).

"Access is considered to have 3 dimensions: 1. *Availability*- includes physical and time dependent access, as well as elements of quality and quantity available. 2. *Affordability*- relates to the individual's ability to pay in the full costs of care, including travel and lost earnings; (3) *Acceptability*- defined as the fit between provider and patient attitudes towards, and expectations of, each other" (The Provincial Center of Excellence for Child and Youth Mental Health at CHEO, 2010, p.11).

The Youth Population

The youth phase of the human development is one of the most rapid and influential periods of the life span which can have paramount influence on the rest of an individual's life (American Psychological Association, 2018). Throughout this critical time in the lifecycle, although timing varies between individuals, youth face many changes, not just physically but also in the areas of cognitive development, allowing for an increased ability to make logical judgments, changes in hormone levels, sleep patterns and emotional responses. Additionally, as youth become more autonomous, challenges may arise in relationships with friends and family. Youth may face changes in their daily responsibilities, feel pressure to conform to society's norms, and become stressed about planning for their future (WHO, 2018). With the multitude of changes and stressful life events that this population faces, there can be a large impact on self-confidence, self-esteem, and perceived self-efficacy, in turn having a vast impact on mental health (Fitton et al., 2013). Due to the sensitive research subject and the need for the youth participants

to have the ability to self-identify a prolonged mental health problem, 16 years of age has been identified as the minimum age to participate in this research study. Furthermore, although 19 years of age is the oldest age for an individual to receive mental health care as an "adolescent patient" in the province of Nova Scotia, the researcher is cognizant that the mental health problems that often emerge prior to 19 years, often precede into early adulthood making 21 years of age the maximum age to participate in this research study.

Youth Mental Illness

Mental health in the youth population has become a global concern. In Canada 1.2 million children and youth are affected by mental illness (Mental Health Commission of Canada, 2019). Furthermore, 50% of mental illnesses in the youth population that persist into adulthood have an onset before 18 years of age (Das et al., 2016). It has been estimated that in Canada 20% of children and youth living with a mental illness are not getting the medical attention they require (Mental Health Commission of Canada, 2019). As noted above, 12% of Nova Scotians ages 4-17 have a diagnosable mental illness (Nova Scotia Health, 2017).

Many mental health problems present before 18 years of age and follow individuals into early adulthood. Mental health concerns in youth populations have a direct effect on future health care as those who suffer from mental illness have a shorter life expectancy than those without a mental health concern, as well as increased risk of other physical health problems later in life (Malla et al., 2018) Additionally, mental illness is associated with smoking, substance misuse, obesity, and increased risk of contracting sexually transmitted diseases, in turn, leading to further comorbid risk factors, such as cardiovascular disease, dementia, and diabetes, later in life (Malla et al., 2018). Common mental illnesses that affect youth are anxiety, depression, psychosis, and

self-harm (WHO, 2019). Anxiety and depression are the most common mental health disorders to be experienced in this population (Nilsen, et al., 2012).

Anxiety

Not to be confused with fear, anxiety is defined by Varcarolis (2013) as "a feeling of apprehension, uneasiness, uncertainty, or dread resulting from a real or perceived threat whose actual course is unknown or unrecognized" (p.166). The disorder affects one's personality by breaking down self-esteem, and self-worth (Varcarolis, 2013). Anxiety exists on a continuum from mild, which is experienced in everyday life, to panic which causes "disturbed behavior" (Varcarolis 2013 p. 168). The term anxiety encompasses many specific disorders such as panic disorders, phobias, social anxiety disorders, generalized anxiety disorders, obsessive compulsive disorder, body dysphoric disorder and hoarding. These disorders can be applied to both youth and adults. Separation anxiety is specific to children and youth which causes an individual to experience extreme panic when they are separated from their primary attachment figure. This sense of panic may also occur when the child, or adolescent, anticipates the separation (Varcaolis 2013). According to Ramsawh (2012), one in every three individuals in the age group 13-18 years will meet criteria for an anxiety disorder. This diagnosis is associated with problems in school such as "school absenteeism, school refusal and poor academic performance" (p. 2). Furthermore, the earlier the onset of the anxiety disorder the more chronic the disorder will be and anxiety may be manifested in more somatic complaints such as stomach aches, headaches, or nausea and vomiting (Ramsawh et al., 2012; Varcarolis, 2013, p.510). Worldwide, anxiety is the eighth-leading cause of disability in the youth population (WHO, 2018).

Depression

Onset of Major Depressive Disorder (MDD) occurs around 14.5 years of age and will occur in 18% of individuals in this age group (Varcarolis, 2015). This number could be significantly higher as underdiagnosis of youth depressive syndromes is common. However, it is not uncommon that MDD, when diagnosed in a youth, is associated with substance misuse and/or antisocial behaviors, which can make diagnosis difficult (Varcarolis, 2015). Varcarolis, 2012, defines Major Depressive Disorder as: "a severely depressed mood, usually recurrent, causing clinically significant distress or impairment in social, occupational, or other important areas of a person's life. The depressed mood can be distinguished from the person's usual functioning and might occur suddenly or gradually" (2012, p.152). Depressive symptoms occurring before age 15 are associated with a more chronic disorder. Like anxiety, depression can manifest itself in youth as physical symptoms, although the most common symptom of depression in youth is irritability (Carona, et al., 2013). A 2016 study found that there is an association between gender and depressive disorders (Brody, et al., 2016). Females are almost 50% more likely to be diagnosed with a depressive syndrome than males (Brody, et al., 2016). Familial factors such as substance misuse, instability and heritability are significant risk factors for today's youth (Carona et al, 2013). Diagnosis of additional psychiatric disorders are common at the time of a depression diagnosis. Depression is most commonly diagnosed as being a comorbidity with anxiety or a phobia, substance abuse or attention deficit/hyperactivity disorder. According to Carona, 66.7 % of youth have at least one comorbidity while 10 to 15% have two or more diagnosed comorbidities (2013). Mixed anxiety-depression as stated by Varcarolis can have extreme effects of patients (2013). Antidepressant medications may have a decreased effect on patients with

depression who have a comorbidity of anxiety. Additionally, anxiety as a comorbidity can also cause greater social impairment, increase in physical illness as well as an increased risk for suicide. According to the World Health Organization, depression is the ninth leading cause of disability in this population (2018).

Psychosis

Psychosis is a symptom, not a diagnosis, and describes many conditions that affect one's mind such as auditory or visual hallucinations, causing inability to distinguish reality from what is not (Varacalois, 2015). According to CAMH, 3 in 100 people will experience an episode of psychosis in their life time (2019). The onset of psychosis is often identified and diagnosed by early adulthood. Many mental illnesses present with psychosis as a main symptom such as schizophrenia, bipolar disorder, schizoaffective disorder, depression with psychotic features, and organic psychosis, often caused by head injury. In addition, the use of alcohol and drugs such as cannabis, LSD, cocaine and ecstasy can occasionally cause drug induced psychosis (CAMH, 2019).

Common experiences with psychosis are delusions, when someone believes ideas that are in fact not true, and hallucinations, having sensory perceptions such as seeing things that are not real in reality (Varacalois, 2019). Additionally, one may experience disorganized speech, behaviours and thoughts. These are considered positive symptoms of psychosis, which distort normal functioning (CAMH, 2019). Negative symptoms of psychosis induce limited ability to complete daily tasks, difficulty expressing oneself verbally and emotionally, and reduced socialization and motivation (CAMH 2019).

Self-Harm

Following accidents and assaults, suicide is the third leading cause of death for this age group (Das et al., 2016). Suicide is defined as "the act of intentionally ending

one's own life and opting for nonexistence" (Varcarolis, 2015, p.466). Suicide is often referred to as a "Suicide Spectrum" (Anderson, et al., 2005). At one end of this spectrum is self-harm and at another is suicide. As youth move along this spectrum of self-harm to suicide, there is a rise in their intentions to end their own life (Anderson et al., 2005). Non-fatal attempts of suicide can also cause immense pain and suffering. Additionally, this can also cause increased risk for a re-attempt to end one's life (Grupp-Phelan, 2012). Risk factors that are associated with suicide in the youth population are drug and alcohol use as well as aggressive behaviours (Varcarolis, 2015). Furthermore, youth with a diagnosis of MDD are seven times more likely to end their life than their peers (Das et al., 2016). Some other behaviors that are associated with youth suicide include, unplanned pregnancy, running away from home on a regular basis, unstable family life, loss of a loved one, and withdrawing from school or social activities (Varcarolis, 2013). Rural living youth are two times more likely to die by suicide when compared to urban dwelling youth (Hardin, et al., 2020). Furthermore, a familial factor relating to suicide exists. Suicide tends to "cluster" in some families making family history a strong risk factor when it comes to youth suicide (Varcarolis, 2015). Gender also plays a role in youth suicide. Females are 2 times as likely to *attempt* suicide compared to males. Males, when compared to their female peers, are three to five times more likely to *complete* suicide. Studies suggest that this is because males tend to use more violent means when attempting suicide while females tend to use methods that are able to be treated or reversed, such as overdose (LeVasseur, et al., 2013).

In recent years, the media has shed a light on the effects of bullying and its relation to suicide. According to an American study conducted in 2013, youth who

reported being involved in bullying were more likely to consider attempting or committing suicide when compared to those who reported they were not involved in bullying (LeVasseur et al., 2013). The same study noted that lesbian, gay and bisexual (LGB) youth are at very high risk of completing suicide. This study estimated that as many as 1/3 of all youth suicides in the United States have involved a youth from the LGB community. Furthermore, 1 in 3 LGB youth have considered taking their own life while 1 in 12 heterosexual youth have considered the same action (LeVasseur et al., 2013).

The advancement of technology has had a vast impact on the way the youth population communicates and interacts with the world in which they live (Shah, et al., 2019). A recent study found that 91% of youth use social media platforms such as Facebook, Instagram, and Snapchat to keep in contact with peers, and 94% of these youth use social medial on a daily basis (Shah et al., 2019). Although technology has many positive effects such as its use for educational purposes, technology has been found to negatively affect mental health. Greater use of technology has been found to be associated with decreased body satisfaction; however, it is unclear whether social media use in general has negative effects on body image and self-esteem. Studies have found that for some youth, social media has led to superficial means of increasing self-esteem while for others, like those who achieve high levels of happiness, have been found to rarely engage in negative comparisons with others on social media platforms (Shah et al., 2019). The use of technology and social media, however, does put youth at risk for cyberbullying which has become a significant issue in schools. A study in the United States found that reports of attempted suicide were highest in youth who were being

cyber bullied and bullied in school. This study also concluded that suicide attempts were higher in youth who were being bullied in any way compared to their peers who were not victims of in school or cyber bullying (Schneider et al., 2012). Nurses and doctors agree that suicidal behavior is "another voice" for youth, yet the message they are trying to send is very complex (Anderson et al., 2005). It takes excellent practitioners to figure out what youth with suicidal behaviors are "not saying" (Anderson et al., 2005, p. 323).

It is clear that mental health disorders have an immense effect on a youth's health and wellbeing. It is imperative that timely and responsive interventions are taken by health care professionals to reduce the burden that mental health disorders have on youth, especially for those who have limited access to timely health care services like those in many parts of Nova Scotia, such as Cape Breton Island.

Accessibility and Availability of Speciality Youth Mental Health Services

According to (Malla et al., 2018) the response to youth mental health service in Canada "has been inadequate and inappropriate." Canadian youth are experiencing high prevalence of mental health concerns, "extreme delays" when trying to access the appropriate care even when access to services is imperative for the youth's safety (Malla et al., 2018). Furthermore, there is still a high use of emergency-based service for mental health care and an overall lack of involvement of the youth and their families specifically when it is time to transition to the adult mental health care system after the age of 19, an ongoing issue not only in Nova Scotia but all over the country (Malla et al., 2018).

A 2016 study of the perspectives of rural working primary care physicians regarding child/youth mental health in Canada found two most important themes: resources and psychiatrist accesses (Zayed, et al., 2016). Resources referred to insufficient availability of speciality mental health professionals, insufficient knowledge regarding

mental health, and insufficient access to inpatient beds. Psychiatrist access referred to long waitlist, lack of availability of psychiatrists, and refusal of referrals (Zayed et al., 2016). In the Atlantic region of the country, the most reported issues were lack of resources, psychiatrist access, referrals to professionals, process issues (referring to an easier referral process and lack of funding for mental health when compared to other areas of health), professional development (more youth mental health education) and workload. The physicians reported their frustrations about lack of access to adolescent mental health psychiatrists, leading to the need to rely on adult psychiatrists for youth's care (Zayed et al., 2016). Across Canada, physicians identified lack of access to assessment and treatment, long wait times, lack of child psychiatrists, the need for more inpatient beds, tele health, and more access to psychology and therapy resources. It is noted in this study that these themes are consistent with the current literature regarding child and adolescent mental health access (Zayed et al., 2016).

Parents have a large role to play with regard to accessibility of services of youth. General Practitioners (GP's) are more likely to refer a child to specialty mental health services if a parent is vocal about their concerns and requests referral (Crouch, et al., 2019). A study from the United Kingdom found that parents do face barriers to care for their child's anxiety concerns. Parents reported "chasing, fighting or pushing" when describing gaining access to mental health care services for their child. Most parents felt that their persistence was needed to access supports, unfortunately, not all children have a supportive adult to do this for them (Crouch et al., 2019). Parents in this study also reported a delay of seeking out services on their part as they were unsure if their child really needed

help. Most parents reported that their GP played an instrumental role in accessing services (Crouch et al., 2019).

In Canada, primary care providers are playing a large role in the area of child and youth mental health care. Primary care is the easiest and most affordable to access by families and youth who seek mental health care, leading primary care providers to be in a unique position to fill the gaps within our health care system regarding specialized mental health care (Gotovac, et al., 2018). There is also a lack of stigma related to seeing a primary health care professional rather than a specialized mental health care provider (Gotovac et al., 2018). Indeed, physicians report a lack of education surrounding mental health reporting a lack of confidence, skills and training to provide the care that is required to youth who seek mental health care; however, would attend training programs to address these gaps in their education (Gotovac et al., 2018).

Nova Scotia Health Care Crisis

Situated on the east coast of Canada, Nova Scotia is home to more than 900,000 Canadians. As for many of the maritime provinces, Nova Scotia has an aging population and low birth rates. By 2030, more than 1 in 4 Nova Scotians will be over the age of 65 years (Nova Scotia Department of Seniors 2017). In conjunction with an aging population and high rates of chronic illness, in recent years, Nova Scotia's health care system has been facing a multitude of challenges regarding availability and accessibility of services as well as a shortage of service providers. Nova Scotia has a shortage of family physicians as well as long term care beds, a multitude of emergency room closures and long wait times for essential services (NSGEU, 2018). Currently, 65, 526 Nova Scotians do not have a family doctor (Nova Scotia Health, 2021). In 2019, within the province there were 90 family doctors' and 97 specialists' vacancies (CBC, 2019).

Hospitals have become overcrowded and health care professionals are in short supply. With a lack of long-term care beds, hospital beds are being used by patients who are waitlisted, leading to emergency rooms being backed up, as no beds are available elsewhere in the hospitals. This has led to extremely long ER wait times and a backup of patients with paramedics in emergency room hallways (CBC, 2019). On March 12 of 2019, 15 patients were registered per hour and 53 ambulances came through the emergency room doors at the Halifax Infirmary in just 24 hours and patients waited up to 12 hours for care (The Star, 2019). In addition to backed up emergency rooms, paramedics report that the emergency room wait times have been affecting ambulance availability due to offload delays (Global News, 2019). At times only one ambulance has been available in the Halifax Regional Municipality (Global News, 2019). It is not uncommon for no ambulance to be available with calls pending, in some areas of the province, becoming a public safety issue. A safety survey conducted by the Nova Scotia Government and General Employees Union, found that 62% of Nova Scotian nurses have felt that their work load has "increased significantly" in the last 5 years. In addition, 89% of nurses reported that their unit often works with staffing shortages, 47% reporting this occurs 1-5 times a week and 38% reporting more than 5 times a week. Nurses were also asked if they thought that patients were being put at risk due to staffing shortages and 93% of nurses reported "yes" (NSGEU, 2019).

Mental health services are also severely affected by the health care crisis in Nova Scotia. According to the Nova Scotia Health, the prevalence rate of mental health disorders in Nova Scotia is 41.7% compared to 33.1% country wide. Nova Scotia Health also notes that this gap is wider for those in disadvantaged situations (2017). The health

authority acknowledges that Nova Scotians experiencing mental illness do experience harms. These harms can be attributed to lack of access to services, lack of availability of services, lack of awareness, issues surrounding affordability of services and fear (Nova Scotia Health, 2017). In the past number of years wait times for adult mental health services reached 363 days for adult mental health services in some areas of the province such as Cape Breton. The longest wait times for adult mental health services were 309 days for non-urgent in 2019 (Government of Nova Scotia, 2021). Current adult wait times are 84 days for non-urgent and 7 days for urgent care (Government of Nova Scotia, 2021). At the IWK current wait times for mental health care are 7 days for urgent care while non urgent care wait times are no more than 37 days (Government of Nova Scotia, 2021). The wait times represent the number of calendar days it takes from time of referral to the time a patient is seen (or expected to be seen) by a mental health clinic (Government of Nova Scotia, 2021). Patients are triaged based on their current condition from 1-3. Triage 1 is emergent care in which patients would be seen through an emergency department or crisis services and given immediate care. Triage 2 is urgent care where patients should be seen within 7 days. Finally, triage 3 is non- urgent care where the target wait time is within 28 days (Government of Nova Scotia, 2021).

Nova Scotia Children/Youth Mental Health Services.

Emergency and Inpatient Mental Health Services

The IWK health centre provides high caliber care to children, youth, women, and families not only in Halifax, but in Atlantic Canada and nationally. IWKs mental health and addictions program is one of three programs provided at the health centre. The centre uses patient and family centred practice to care for children and youth up to 19 years of age. As families are paramount to a child or youths mental health treatment, the program

includes families as a partner in treatment. Youth who are close to their 19th birthday, the treatment team works with patient and family to begin a transition to adult programing and services including assisting youth with increasing awareness surrounding self-care and advocacy (IWK, 2021).

The mental health and addictions program at the IWK provide services to youth in clinics, schools, residential settings as well as inpatients settings, which are offered to the children and youth who are acutely ill. Training is also offered to community members to enhance skills of community based mental health workers as well as works collaboratively with family practitioners. Youth are able to access the services through the IWK by going to the IWK emergency department if the youth believe they are at risk of danger to themselves or others, by referral from community agencies, as well as self-referrals from youth or their family (IWK, 2021).

Outside of the Halifax Regional Municipality, children/adolescents can be seen on an emergent basis at community hospitals across the province. Most community and regional hospitals in the province do not have a child/adolescent inpatient mental health unit resulting in youth either waiting for services within the community and/or if warranted, being sent to the IWK for inpatient care (CBC, 2017).

Community-Based Services

In addition to hospital-based services, there are multiple community-based services available to Nova Scotian youth and their families. These services include but are not limited to the Mobile Health Crisis Team, Schools Plus, School Mental Health, Community Mental Health clinics (Halifax, Dartmouth, Sackville), Laing house and Strongest Families (Nova Scotia Health, 2018).

The Mental Health Mobile Crisis Team is a provincial service that provides all Nova Scotians who are experiencing mental health crisis or distress, including children and youth, with crisis intervention (Nova Scotia Health, 2018). Youth are able to contact the mobile crisis team by phone, in times of crisis to be seen within the community. When an individual contacts the crisis team they will be triaged via phone and will assess the individual in person within the area they are calling (Nova Scotia Health, 2018). This service will help individuals to access additional resources while providing short term management. This team also offers a crisis line that is available 24 hours a day 7 days a week to those who are facing mental health crisis such as suicidal thoughts, depression, substance misuse, anxiety, or difficulty coping with trauma or distress. This service is also able to support families and community agencies though education and outreach (Nova Scotia Health, 2018).

Child and Adolescent community mental health clinics provides services, assessments, diagnosis and treatment to children and youth who are under the age of 19 years who have mental health problems, who face substance misuse challenges or gambling problems (Nova Scotia Health, 2018). The treatment team works with families to support children and youth up to 19 years of age through therapy (individual and group), education, psychiatric consults and group sessions. For Nova Scotian families to access this service, a referral must be made by a family doctor or other health care professional or a community agency. In addition, parents are able to call central intake to access the service. These services are available in Truro, New Glasgow, Elmsdale, and Amherst (Nova Scotia Health, 2018). The central referral process includes a first "choice" appointment allowing youth and their family, with assistance of clinician to

make a choice regarding next steps. If chosen, a second appointment, a "partnership appointment" will be scheduled for the youth and their family to discuss treatment options that are best for the youth, their family and their goals (IWK, 2021).

Nova Scotia Early Psychosis Program provides at risk and newly diagnosed youth with early intervention, support and follow-up services. The program serves 12-35-year old's who are experiencing symptoms of psychosis (Nova Scotia Health, 2018). This program is connected with high schools within the Halifax area which allows for early intervention and for the youth be followed within the school system. The treatment team consists of psychiatrists, psychologists, nurses, recreational and occupational therapists who works closely with the patient and their families to assist in finding proper treatment and reaching goals (Because Your Mind Matters, 2021). Within Halifax Regional Municipality (HRM) families and youth can access this service through referral though a family doctor, a mental health professional/agency, by teachers, families or by self-referral. Outside of HRM, a referral from a health care professional is needed (Nova Scotia Health, 2018).

The Community Support Program is targeted at school aged children and adolescents who are part of the Child and Adolescent Mental Health Program. More intensive than office-based treatment, this program takes place within pre-school, schools, homes and community while further supporting clinical based treatment plans (Nova Scotia Health, 2018). The program offers parents and guardians with the tools they need to support their child or youth through education, skill development and behaviour management strategies. Nova Scotians are only able to access this program if they have been referred by their current mental health and addictions health care professional or physiatrist (Nova

Scotia Health, 2018). This program is provided to youth and their families throughout the mainland of Nova scotia in areas such as, Bridgewater, Barrington, Digby, and Yarmouth.

The Healthy Minds Navigator is a service that is provided by *Healthy Minds Cooperative* which is a service that provides services to individuals and their families who live with mental health issues (Healthy Minds Cooperative, nd.) This cooperative additionally provides input regarding development and evaluation of the current mental health services in Nova Scotia. The program has identified that navigating the mental health system can be a challenge for individuals and their families leading to the development of the healthy minds navigator. The Healthy Minds Navigator assists people living with mental illness to connect with the services and resources they require within their community such as support groups, referral services, web-based resources, programs and workshops (Healthy Minds Cooperative, n.d)

Strongest Families Institute is a non- profit organization that provides mental health services to youth and their families through evidence-based coaching (Strongest Families, 2018). Customized coaching is done via phone or internet in the families own home at a time that is convenient for them. The program provides supports to individuals 3-17 years of age on the topics of Attention Deficit Hyperactivity Disorder (ADHD), oppositional defiance disorder, anxiety disorders and depending on funding, nighttime bedwetting (Strongest Families, 2018). Nova Scotians are not able to self-refer to this program; however, local mental health agencies are able to refer to Strongest Families (Strongest Families, 2018). An additional distance support available to Nova Scotian youth is *Kids Help Phone* which is a national service available 24 hours of the day 7 days a week. This

program provides counselling, education, referrals and text-based support to youth. Youth are able to access these services via phone, text, the Kids Help Phone website or mobile app (Kids Help Phone, 2019).

The Laing House is a peer support center that serves youth ages 16-29 who have been diagnosed with a mental health disorder in the category of mood disorders, psychosis, or anxiety disorder (Laing House, 2019). The program runs as a drop-in where youth/adults are able to meet other youth/adults who have a similar lived experience. The program offers art, music, camping trips, meals, education sessions, and employment services and family support (Laing House, 2019). The program is now accessible to Nova Scotians outside of the Halifax and Yarmouth area via satellite (Laing House, 2019).

School-based Services

School mental health professionals provide mental health services in conjunction with the SchoolsPlus team, teen health centres, social workers and guidance counselors in schools. These professionals provide individual and group therapy for students and provide education, support and health promotion activities to school's staff regarding mental health (Nova Scotia Health, 2018).

The SchoolsPlus Program is a support program that serves students and their families through schools in the province. The program uses a collaborative care model for delivery of health, justice, mental health, and social work services and resources beyond the school day (Department of Education, 2019). SchoolsPlus uses facilitators and outreach workers to connect students and families to community resources and supports within the system. School mental health professionals are also part of some schools that participate in the SchoolsPlus programing. Youth can be referred to this program by school principals and families also are able to self-refer by contacting SchoolsPlus

(Department of Education, 2019). Unfortunately, not all schools are part of the SchoolsPlus program in the province, although this is the goal.

Although there are available services in the province, individuals still face extensive wait times for treatment unless facing a mental health emergency (CBC, 2018). The wait times for community mental health care is having detrimental effects on Nova Scotians. In 2019, there were 137 suicides, this number is up from 75 in 2000 (Nova Scotia Government, 2021). Youth suicide rates have since increased in the face of the global pandemic, Covid-19 and will be discussed further in coming sections of this text. Furthermore, the lack of services in more rural or underserved areas of the province are causing longer wait times, and less specialized services due to a shortage of physicians and emergency room closers.

Mental Health Care Provision in Rural and Underserved Settings

Mental health care provision in rural communities, such as those in Nova Scotia, is more of a challenge when compared to urban areas. This challenge is due to lack of services and mental health specialists (Reed & Fitzgerald, 2005). The importance of rural mental health services is not lacking in the literature. A 2018 study based in North Carolina found that youth residing in rural locations of the United States were almost twice as likely to die from suicide than youth living in urban areas (Thompson et al., 2018). As noted previously, rural areas often have shortages in mental healthcare providers. Additionally, a 2017 study found that rural youth face additional service barriers such as issues surrounding insurance, poverty, and few community resources (Robinson et al., 2017). The literature suggests that health care professionals working in rural settings report "poor knowledge and skills, lack of assistance, and the need for ongoing support and education to provide effective care" (Reed & Fitzgerald, 2005 p. 2).

A 2015 study of rural Australian youth mental health care showed that rural populations want to seek help when it comes to mental health but often have trouble identifying services for themselves (Wilson &Usher, 2015). This study also suggested that it is of utmost importance that youth in rural settings feel they are in a safe and comfortable environment which, in turn, will "enable ongoing mental health care and early intervention" (Wilson & Usher, 2015 p. 2643). Parents tended to not want to travel to obtain child mental health services for their child unless they were absolutely certain that they are in need of emergent care (Wilson & Usher, 2015). In an attempt to fill the gap in mental health services in rural communities, Telemental health services have been implemented in many rural communities allowing for access to mental health specialists on-line in rural areas and even settings such as correctional facilities, schools and homes (Gloff, et al., 2015). This service offers itself as an accessible, evidence-based resource to close the gap in mental health services in underserved communities.

A 2020 quantitative study from Memorial University focused on received barriers to accessing mental health services for rural and small city Cape Breton youth (Church, 2020). This study gathered, from surveys through two regional school boards and nine schools in Cape Breton. From small areas, 62 youth participated in the study while in rural areas, 83 youth participated. The study found a lack of awareness regarding available resources and a lack of education in relation to mental health (Church, 2020). Youth also noted a lack of mental health professionals as a barrier to mental health services. Further, youth felt fear of stigmatization as this could lead to social exclusion, and shaming by family or friends (Church, 2020). This study also found that rural and small area youth did not differ in relation to perception of community barriers, however

system level barriers were more of a concern for small area youth. In Addition, rural youth more prominently felt that accessing mental health services would lead others in their community to thinking they are "crazy." (Church, 2020, p. 13).

Cape Breton Island Health Care Crisis

The Nova Scotia health care crisis has not only affected the mainland but has had drastic effects on Cape Breton. The Cape Breton Regional Hospital has one of the highest rates of mortality in Canada, which demonstrates how negatively the crisis is affecting the area (Cape Breton Post, 2018). Nova Scotia Health has had challenges recruiting and retaining physicians to work on the island. Cape Breton Regional Hospital, the island's largest medical facility, lost 14 doctors in 2019 (CBC, 2019). In addition, Cape Breton once had 16 psychiatrics yet there are only 4 psychiatrists currently working at the CBRH, none of which specialize in child and adolescent psychiatry. Physicians at the Cape Breton Regional Hospital are calling recruitment "inadequate and ineffective" (The Telegram, 2018). Emergency departments at Glace Bay Hospital, New Waterford Consolidated Hospital and the North Side General Hospital face temporary or extended closures regularly leaving the Cape Breton Regional Hospital the only functioning emergency department in the CBRM. This is causing overcrowding in the local emergency department in Sydney, and extensive wait times (CTV, 2019). In the 2018 fiscal year, the Glace Bay Hospital had the highest number of hours of closure in the province with 1,835 hours at this one emergency department alone (National Post, 2018). In Neil's Harbour, a northern region of Cape Breton Island, the Buchannan Memorial Hospital emergency room faces temporary closures due to no physician coverage (Cape Breton Post, 2019). The closest Emergency room is 2 hours away in Beddeck. Further, if this emergency room is also closed there is another thirty-minute drive to Sydney's

Regional Hospital. If there was an emergent situation there could be severe consequences due to ER closures in remote regions of the island (Cape Breton Post, 2019). The crisis is putting much strain on health care professionals, and families in Cape Breton. Families have gone as far as contemplating leaving the island if there is no improvement in the health care system (CTV, 2019). Parents have been transporting their own children to the IWK when the ER at the Cape Breton Regional Hospital is at maximum capacity and their child needs immediate medical attention. No available ambulances are leaving some parents no choice but to drive their children to the IWK, 4 hours away (CTV, 2019).

The Nova Scotia Government has given Cape Breton 100 million dollars to expand the Emergency room at the Cape Breton Regional Hospital, the Intensive Care Unit, the islands Cancer Center and the Glace Bay hospital emergency room (Cape Breton Post, 2019). The new construction comes in an attempt to make more space in the emergency department and will take approximately 3 years. In addition, the province will be closing two hospitals in Cape Breton, the New Waterford Consolidated Hospital and the North Side General Hospital, which has gotten mixed reviews by doctors and residents of the area (CBC, 2019). The hospitals will become collaborative community health centers employing, physicians, nurses, nurse practitioners, dietitians, and psychologists (CBC, 2019).

As noted above, Cape Breton has some of the highest wait times for mental health services in the province, and the island is lacking a child and adolescent psychiatrist. Nova Scotia Health has acknowledged services accessibility as a system challenge specifically for those who are part of a marginalized group and for children and adolescents (2017). Cape Breton has the highest wait times in the province for urgent and

non-urgent care (Government of Nova Scotia, 2021). One physician at the Cape Breton Regional Hospital called the state of psychiatry in Cape Breton "dire" (The Telegram, 2019). Currently, in Cape Breton, there is no child and adolescent physiatrist; however, there are child and adolescent psychiatrists traveling to Cape Breton every 6 weeks to see youth who have been referred to psychiatry by Child and Adolescent Mental Health and Addictions (Margaret Marsman, personal communication, 2019). Nova Scotia Health has employed tele-mental health to provide psychiatric care to the island from Halifax. Margaret Fraser, a physician in Cape Breton, does not believe that tele-mental health services are a great substitute for a face-to-face assessment of a client. She believes, it can be easy for a patient to hide their current state of health over video conferencing (The Telegraph, 2019). The province has, however, committed to expanding the Teen Mental Health Outreach Program started ten years ago by CaperBase, a program that will be discussed further in coming sections of this review. The program will expand to 41 schools in the north and western parts of Cape Breton. The 11 new workers will be working in schools to connect with students, who are allowed to self-refer to the program. Referrals can also be made by school staff, health care professionals and community agencies (CBC, 2019). Child and adolescent mental health and addition services clinicians are "basically run off their feet" as they face staffing shortages, along with barriers to providing efficient care to youth and their families due to services being siloed. This lack of communication between service providers, slows down the provision of care for youth (Margaret Marsman, personal communication, 2019).

Child and Youth Mental Health Services and Supports on Cape Breton Island

Services

Child and Adolescent Mental Health Services provide services to youth and families up to 19 years of age. Treatment through the child and adolescent services in Cape Breton include outpatient individual or group therapy and in-home services by their multidisciplinary team which includes social workers, case workers and phycologists. For Cape Breton families to access this program a referral is needed by a family doctor or self-referral. In keeping with the rest of the province, Cape Breton also has a school mental health program and SchoolsPlus programming, in almost every school on the island, as discussed above (Nova Scotia Health, 2018).

The Ally Centre of Cape Breton is a non-profit organization that focuses on prevention of the spread of blood borne pathogens through unsafe needle use. The Ally Center operates a primary health clinic that targets vulnerable populations such as those who are affected by HIV/AIDS, Hepatitis C, mental illness, members of the LGBTQ+ community, sex trade workers, and those affected by domestic violence, including youth. This clinic aims to provide those who may feel stigmatized a safe place to receive care (Ally Center of Cape Breton, 2019).

CaperBase is an interdisciplinary outreach service in Cape Breton that focuses on building positive supports opportunities and community by collaborating with schools, families and youth up to 24 years of age. Access 808, a service offered by CaperBase, offers group programs, life skill development workshops, laundry facilities, counselling, computer access, emergency clothes/food, shower facilities, and referrals to the community. Caper Base offers multiple programs for youth and families called Free2BU. These are 8-week programs with focus on promoting healthy life style, fitness, healthy families, and reducing drug use. In addition, Caper Base offers the UP! Series which

provides youth and families with four 6-8-week programs that focus on middle school years, cooking, recreation programs within the community, or individual, or group recreation therapy. All programs within Caper Base are free of charge and no referrals are needed to access their programs (Caper Base, n.d).

Supports

The Whitney Peer Youth Club (WPYC) in Whiney Pier, Cape Breton is a sector of the Boys and Girls Club of Canada that focuses on the wellbeing of youth in the area ages five to 18. The program focuses on youth who otherwise would have little access to programing. The WPYC does work at the individual and community level. The programs focus on educational, volunteer, recreation and self-improvement programming. The club offers mental health programming such as Flex Your Head, leadership programs, after school programs as well as weekend activities (BGCCB, 2019).

Relays, is a crime prevention initiative that works with the Cape Breton Regional Police force. This project works with 70 at risk youth from ages 12-17 per year. The goals of the project include increasing respect of peers and community, coping skills, and confidence levels, reducing violence and substance misuse and aims to improve life skills, empathy for others and school achievement (Relays CBRM, 2021).

Undercurrent, is a youth center with locations in both Sydney and Glace Bay that focus on allowing Cape Breton youth to have opportunity to grow in their community free from addiction, homelessness, and poverty. Their centers in Cape Breton provides all youth, no matter background or familial income level, with a safe space, programming and mentorship. Undercurrent provides programming such as the junior. High RISE program, which teaches youth valuable life lessons through hands on activities such as meal preparation, and learning from others through public speakers. Undercurrent also

offers a multitude of recreation programing such as hockey, skateboarding and scooter programs for boys and girls (Undercurrent Youth Centre, 2021).

Emergency Mental Health Services

Youth who require urgent mental health services in Cape Breton area are able to go to their nearest emergency department or call the provincial mental health crisis line. Unfortunately, the Cape Breton Regional hospital does not have inpatient mental health services for children or adolescents. If these services are required, youth are to be transferred to the IWK hospital in Halifax, up to a 6-hour drive from northern, rural areas of Cape Breton.

In recent years researchers have shed light on the issues that exist in emergency rooms when managing youth in crisis. Studies such as Broadbent (2002) and Dion (2010), suggest that more education needs to be provided to nurses working in emergency rooms which, in turn, will increase confidence levels when implementing mental health screening. More training is believed to result in more positive attitudes, less stigma, and an overall more positive experience when working with youth mental health issues. Research regarding nurses' experiences with youth mental health matters such as anxiety, depression and suicide is limited, especially with regard to studies from rural hospitals. In addition, studies regarding youths' experiences with mental health care in emergency room settings are also limited, even more so in rural contexts.

Experiences of Youth When Accessing Mental Health Care in Emergency Rooms

People who experience mental health disorders present to emergency rooms five times more often than people without a diagnosable mental illness (Vandyk, et al., 2017). Additionally, increased psychiatric visits to the emergency room are linked with increased costs to the hospital (Vandyk et al., 2017). Literature in a 2017 systematic

review found only nine studies regarding experiences of patients who have mental illness and present to emergency departments (Carstensen, et al., 2017). Results from this study included patients feeling that they were being judged negatively by the emergency room staff and that their symptoms were ignored and seen as "non- urgent." In seven studies, part of the systematic review, patients "emphasized the importance of caring and attentive staff, who were characterized as communicating with both respect and dignity, as well as taking time and being supportive" (Carstensen et al., 2017, p.318). It is important to note that none of these studies in this systematic review focused on the youth population. A 2016 study (Summerhurst, et al., 2016) found that youth experience difficulties when trying to find supports and services within the mental health system. This study also suggested that sixteen- to eighteen-year-olds had more difficulty identifying services compared to older young adults in this study (Summerhurst, et al., 2016). Again, this study did not specifically examine the experience of youth accessing mental health services in the emergency department as there is no current literature pertaining to this subject.

Experiences of Emergency Room Nurses and Mental Health Care

Limited literature exists on the topic of nurses' subjective experiences regarding the provision of mental health care in the emergency room, especially in rural or underserved settings and with youth populations. A phenomenological study of nurses' experiences from Queen's University found that nurses believe ineffective care is related to themes such as: lack of education, time, stigma, environmental constraints, ethical issues and need for role clarification (Tyerman, 2014). In a 2013 qualitative study of emergency room nurses' experiences found powerlessness as the largest theme regarding provision of mental health service to patients in the emergency department (Plant &

White, 2013). Additionally, a 2011 study found similar themes, stating that patients who access mental health care need longer assessments, which disrupts the norms of the emergency room. This study also found that nurses believed that the emergency department is not the right environment to care for people with mental health concerns (Marynowaski- Traczyk & Broadbent, 2011). Nurses participating in this study believed that patients who continually presented to the emergency department for mental health concerns were a burden. One nurse in this study commented "They keep coming back, the same patients all the time, I feel exactly the same thing that most people feel, like not again!'' (Marynowaski- Traczyk & Broadbent, 2011 p. 176). No studies were found regarding youth perspectives or regarding rural/underserved area experiences.

Stigmatization of Mental Health Problems

In recent years, societal strides have been made in regard to stigmatization of mental health problems and there has been a large focus on the importance of mental health for individuals globally, especially in the face of the Covid-19 pandemic. However, according to CAMH, mental health stigma still prevents 40% of individuals with depression or anxiety from seeking treatment (2021). Further, 60% of individuals with a mental health problem will not seek help due to the fear of being labeled (Mental Health Commission of Canada, 2021). Mental health stigma derives from a lack of education surrounding mental health disorders and illness as well as the significant need for those suffering to seek assistance from the health care system (Lindow et al., 2020). Often those with mental illness are seen as "crazy" and individuals bear the burden of society assuming their illness is "their own fault" (Audu, et al., 2011, p. 56). Further, the western world often believes that those with mental illness are often violent and untrustworthy leading to high contact with law enforcement and crime rates

(Audu, et al., 2011). These negative connotations affect how one perceives oneself within daily life. According to Yap and colleagues, societal, peer, and self-stigma often prevent youth from seeking help for mental health related problems (2013). Additionally, stigmatization has been found to affect academic achievement, and increased social isolation in youth (Livingston and Boyd, 2010).

Initiatives from international and national organizations such as the WHO and the Mental Health commission of Canada (MHCC) focus on mental health stigma reduction. MHCC initiatives focus on reducing stigma within families and in workplaces by improving mental health literacy through online courses such as mental health first aid programs, the Workkind Mind course from managers and employees, and the Understanding Stigma online course for healthcare providers (MHCC, 2021). Finally, the WHO has assisted 110 countries extend mental health care and launched the *WHO Special Initiative for Mental Health (2019-2023): Universal Health of Mental Health* to assist 12 priority countries with supplying affordable and quality mental health care (WHO, 2021).

Stigmatization from the Health Care System

Nurses in the emergency rooms are considered "the first point of contact" for youth who arrive in hospital in a mental health crisis (Anderson et al., 2005 p. 319). One study goes as far as saying that the emergency room is possibly the "only point of contact" linking youth to the health care system (Cronholm et al., 2010). In particular, research suggest that the attitudes of health care professionals towards those who seek care due to suicidal behaviours will impact the effectiveness of treatment provided (Anderson et al, 2005). This statement makes it imperative that nurses working in emergency rooms are educated and competent when working with youth with mental

health concerns. According to Clarke (2007) stigma toward mental health patients exists and has many effects on patients. Stigmatizing behaviors and attitudes in the emergency rooms can affect the care that patients receive. When patients are treated poorly, they leave the emergency room with a poor perception of the healthcare system which in turn may affect the use of the system again. "A caring, respectful, nonjudgmental approach provides reassurance and invites more cooperative behavior from the person seeking help" (p.129). Lack of education surrounding mental health crises in emergency room practitioners can significantly affect care received by patients (Hamm et al., 2010). Stigmatization of mental health does not only affect those seeking crisis care in the emergency department but throughout health care systems. According to the Mental Health Commission of Canada, Canadians with mental health problems have reported feeling "devalued, dismissed and dehumanized " by healthcare professionals they have been in contact with when seeking out services within the healthcare system (2018). According to the World Health Organization, individuals with severe mental illness die, as much as two decades, earlier than those without mental illness, due to a preventable physical condition (2021). These negative feelings and perception of the health system in turn will affect treatment outcomes not only of mental health but physical health as a result of avoidance of the health care system.

Mental Health Screening in Emergency Rooms

As noted above, the emergency room may be the only point of care that a youth has with the health care system which makes the emergency room an important place to implement mental health screening. Screening in this setting allows practitioners to identify mental illness and proper interventions (Baren et al., 2008). "…from the statistics, often times, at least suicidal teenagers, have some contact with a health care

profession soon before or attempting or committing suicide, so it's obviously an important intervention in a relatively high-risk group" (Cronholm et al., 2010, p.112). Screening for mental illness is not a task that can be completed quickly, even in areas with less time constraint than emergency rooms. Due to these time constraints in the emergency room, mental health screening of youth can be avoided or overlooked. Other barriers to screening for mental health disorders in the emergency department may include, limited trained psychiatric professionals, issues surrounding coverage for crisis intervention, funding, and a lack of resources for providers to offer patients, and stigma surrounding mental illness. Even in the face of these barriers, according to Baren (2008), studies show that screening for mental illness in youth, specifically for depression and suicide can be done successfully in the emergency room setting (p.402).

Regardless of how an emergency room chooses to screen patients for mental health disorders, health care providers, including nurses, must be comfortable with implementing screening. Lack of confidence regarding mental health patients is a common trend in the literature (Broadbent 2002). The Cronholms study reported this trend noting that some nurses are not comfortable with screening youth for mental health disorders (2010). Comfort levels in this study were linked to experience, training levels and perceived self-efficacy (Cronholm et al., 2010). One study participant stated "...I'm not so comfortable with it, like I said, I'm a little scared; I wouldn't even know how to approach a patient to talk to them about those things" (p.113). Other participants noted that they felt uncomfortable when they realized that a mental health concern, such as depression, may need to be diagnosed but feel more confident if they knew of the proper resources for the patient. Even though some participants in this study felt uncomfortable

with addressing mental health screening, nurses felt that they should be the ones to administer the screening tool as they have "greater patient contact" and "good rapport with patients" (Cronholm et al., 2010). Studies such as Broadbent (2002) have shown that there was an increase in comfort levels with mental health screening and patient care from nurses when a specific screening tool was formatted for the emergency room. Nurses in this study were found to "down triage" mental health patients due to poor understanding (Broadbent et al., 2002). With the implementation of the screening tool used at triage, the nurses reported having better understanding of mental illness, more confidence during mental health assessments and better attitudes toward patients with mental health disorders (Cronholm et al., 2010).

Youths Experiences with Community Based Mental Health Services

There is limited literature surrounding youths' subjective experiences with community based and outpatient mental health services (Persson, et al., 2016). It is important to note that these studies are not focused on underserved areas, but in large city centers. A 2016 study conducted in Sweden used two phases, focus groups with youth ages 10-18 years and surveys with the same age group (Persson, et al., 2016). The study revealed 3 overarching themes from the two phases of data collection: *accessibility, being heard and seen, and usefulness of sessions*. Youth expressed the importance of staff making the youth feel comfortable, and importance of the pacing of the sessions, ensuring that youth do not feel rushed through appointments (Persson, et al., 2016). In addition, ease of travel to clinics largely affected whether youth were able to get to appointments, as public transport, or parental involvement, was not always an option (Persson, et al., 2016).

A study from the United Kingdom in 2006 found 13 themes after conducting a study using focus groups with 9-14 years of age regarding outpatient mental health care experiences (Day, et al., 2006). Major themes included knowing about the appointment beforehand, allowing the children to be able to prepare themselves before appointment times, therapist lead questions can cause some discomfort, the youth preferred activity-based appointments as these were less anxiety triggering and felt they were able to express themselves more accurately (Day, et al., 2006). This study also found that timing of appointments was important as some children did not want to miss school to go to therapy sessions (Day, et al., 2006).

A 2012 interpretive phenomenological study based in Australia, focused on youth using mental health services to seek help for depressive symptoms (McCann & Lubman, 2012). The participants in this study stressed the importance of having a supportive school environment and school counselors who help refer students to services. It is important to note that some participants were reluctant to use school counsellors as a resource as they worried that the counsellor may tell their peers that they were going to counselling (McCann & Lubman, 2012). This study also found that youth valued the accessibility of services, and believed it was important that services were on public transport routes. Finally, the youth participants reported that wait times were a barrier to their care as some youth had to wait more than a month to be seen by a health care professional (McCann & Lubman, 2012).

Youth Mental Health and Covid-19 Pandemic

Although the data collection for this study was completed approximately two months prior to Covid -19 affecting Nova Scotia, it is of much importance to consider what implication the pandemic has had to youth mental health in not only in the province,

but all of Canada, and how the pandemic effects future service provision and allocation. Canada's top children's hospitals have called a “Code Pink” to declare a mental health emergency in the pediatric population (Children’s First Canada, 2021). Canadian hospitals are reporting that admissions for suicide attempts have increased by 100% while substance use disorders by 200% when compared to pre- pandemic. Advocates blame the lack of access to recreational activities, school closures and social isolation for this mental health emergency in children and youth (Children First Canada, 2021). These closures have caused youth to be confined to their family unit, and for some youth this means within a dysfunctional environment, leading to deprivation from structured support. Youth are now relying on finding peer support through social media platforms (Rousseau and Miconi, 2020). It is also important to note that with the exacerbation of mental health problems due to Covid -19, the virus also leaves some youth grieving loved ones they may have lost during the pandemic (Rousseau and Miconi, 2020). It is imperative that child and youth mental health is of the highest priority in years to come, post pandemic, to provide timely trauma informed, and adequate supports and services to youth as they begin to heal from nearly two years of immense change and high stress that has led to this youth mental health emergency.

Currently, limited literature exists regarding youths subjective lived experiences with mental health disorders and regarding their access to services both emergency/inpatient and within the community. Gaps in the literature also exist surrounding youths’ perspectives in relation to mental health services and supports youth find helpful. Due to these gaps, this study has identified what services or supports youth are currently using, or not using, in Cape Breton and why. Further, this study has

addressed if youth feel mental health services are meeting the needs of youth in Cape Breton. Such information has allowed for deeper understanding of youths lived experience when living with mental health problems and a gain in insight regarding youths' perspectives of the mental health services and supports in their community. This research aimed to assist in filling the gaps in the current literature regarding youth mental health care in one underserved area of the province of Nova Scotia.

Chapter II: Methods

Purpose

It is clear that there is limited literature regarding youths' lived experience with mental health care in areas that are underserved and in regard to hospital-based and community-based services. The purpose of this research was to gain a deeper understanding of the lived experience of youth, ages 16-21, who live in Cape Breton Regional Municipality (CBRM) with a self-identified, self-defined, prolonged, mental health problem and what they do about these concerns (i.e., accessing, or not accessing, services or supports) while on Cape Breton Island. This research aimed to aid in filling the gaps in literature regarding youth mental health care services and supports in an underserved area of Nova Scotia, while also identifying services that are, in the participants opinion, imperative to youth's mental health care that may or may not exist in the geographical area of study.

This qualitative research used hermeneutic phenomenology as methodology. Phenomenology focuses on individuals and their interactions with others and their environment, consistent with nursing's philosophy, making this method a particularly good choice for this research study (Lopez and Willis, 2004). Interviews were conducted with youth, ages 16-21, who self-identified as having a prolonged mental health problem for at least six months to understand their lived experiences and identify what services and supports they had used, or not used and why, as well as their resulting experiences. Mental health problems prolonging for at least six months was chosen as a benchmark for participation in this study, as this length of time, or more, allowed for the youth participants to decide if they wanted to seek mental health support/ services or not. For

the purpose of this research, supports and services could have been formal or informal. *Formal services* included organized mental health services such as, speaking with a health care professional (such as mental health nurses, phycologists, psychiatrists); emergency room services, telehealth services, helplines (such as Kids Help Phone or Strongest Families); community-based services (such as child and adolescent mental health services); and school-based services (such as school health nurses, social workers, and guidance counsellors). *Informal services or supports* included, but were not limited to, activities that were not solely focused on, but could positively contribute to, a youth's mental health, such as after school programs, youth peer programs, recreational activities, arts, or music programs, and speaking with friends or trusted adults, etc.

The following section will discuss the research questions and objectives of the study, hermeneutic phenomenology, the study design, sampling, recruitment, data collection, and ethical considerations in detail.

Research Questions

The research questions for this study included: (a) What are the lived experiences of youth who self-identify as having a self-identified, self- defined mental health problem for at least six months? (b) What mental health supports, or services (formal or informal) have youth used (if any), for what reason, and their resulting lived experiences? (c) If supports or services were not used, why not, and their resulting lived experiences? (d) From the perspective of participants, in what ways are mental health services and supports meeting, or not meeting, the needs of youth with mental health problems on Cape Breton Island? In what ways do these services and supports need to improve?

Objectives

The objectives of this study were to: (a) Gain a deeper understanding of the lived experiences of youth, ages 16-21 living on Cape Breton Island who have a self-identified, self-defined, prolonged (at least six months) mental health problem; (b) Identify which mental health supports and services youth are using - or not using – and why; (c) Explore the experiences resulting from their decision to use, or not use, supports and/or services; and (d) Explore how Cape Breton youth perceive mental health services and supports are meeting the needs of youth and how these services and supports can improve?

Hermeneutic Phenomenology

As outlined in the literature, there are not only gaps in the current healthcare system, particularly in underserved and rural areas regarding mental health care for youth, but there is also limited literature regarding subjective experiences of those seeking these services. Interpretive phenomenology was used to examine the lived experiences of youth who seek mental health care. Hermeneutic phenomenology, also known as interpretive phenomenology, does not solely focus on description, but also on the true meaning of an individual's experiences (Lopez and Willis, 2004). "Phenomenology seeks to understand human experience from an individual's perspective" (Tembo, 2016). Van Manen describes phenomenology as "the study of the lifeworld- the world as we immediately experience it pre-reflectively rather than as we conceptualize, categorize, or reflect on it" (van Manen, 1990 p. 9). Phenomenology brings forth the true meaning of one's subjective experiences with a specific phenomenon making this methodology a perfect fit for the study of youths lived experiences. Dating back to the 18th century, phenomenology has been influenced by scholars such as

Husserl and his star pupil Martin Heidegger, French philosopher Merleau Ponty, and in recent times, Canadian phenomenologist, Max van Manen (Dowling, 2007).

Husserl, a German scholar, known as the father of phenomenology, believed that the "aim of phenomenology is the rigorous and unbiased study of things *as they appear* in order to arrive at an essential understanding of human consciousness and experience." (Dowling, 2007, p.132). Husserl proposed using phenomenological reduction or bracketing. He believed that phenomenologists must "ignore one's own beliefs, assumptions, and biases" (Inglis, 2010 p. 26). Husserl's student, Martin Heidegger, expanded on Husserl's work but focused on hermeneutics, the meaning of being human and exploring lived experiences (Inglis, 2010). Max van Manen, a Canadian scholar, believes that a true understanding of hermeneutic phenomenology comes from "actively doing it" (van Manen, 1990, p. 8). Van Manen stresses the importance of consciousness. Anything within one's consciousness is of interest to phenomenology, "whether the object is real or imagined, empirically measurable or subjectively felt" (van Manen, 1990, p. 9). Hermeneutic research aims to bring forth the "fullness of living" and to examine what it really means to be who we are (van Manen, 1990, p.12).

This study was informed by Heideggerian phenomenology and guided by van Manen's approach to hermeneutic phenomenological research. "To do hermeneutic phenomenology is to attempt to accomplish the impossible: to construct a full interpretive description of some aspect of the lifeworld, and yet to remain aware that lived life is always more complex than any explication of meaning can reveal" (van Manen, 1990, p. 18). Lifeworld existentials refer to themes that permeate the lives of all human beings, regardless of factors such as gender, culture, socioeconomic status, although not in a

common way (van Manen, 1990). The existentials are spatiality (lived space), corporeality (lived body), temporality (lived time), and relationality (lived human relation) (van Manen, 1990). These lifeworlds can be described independently but cannot be fully separated as they are all connected, forming one's lived world (van Manen, 1990, p. 105).

Lifeworld Existentials

Spatiality

Spatiality refers to lived space. Spatiality does not, however, refer to the physical space that one finds themselves in but, instead, refers to how that space makes us feel. Spatiality is defined by van Manen as "felt space" (1990). For example, a person walking the streets of an unfamiliar city may feel a sense of fear, loneliness, or perhaps for some, excitement (van Manen, 1990). In a sense, humans embody the space in which we find ourselves. The theme of lived space allows us to question ways that humans experience day to day life and allows us to understand the meaning of one's day to day affairs (van Manen, 1990).

In the context of youth who seek mental health care, the space in which they seek care becomes the felt space for patients. This setting (i.e., Emergency rooms, acute inpatient psychiatric units, outpatient mental health clinics or doctors' offices) may be unfamiliar, frightening and overwhelming. With the idea of embodiment of spaces we are in, youth may become anxious and frightened in these unfamiliar settings. How one feels in these spaces will directly impact one's overall experiences in the setting.

Corporeality

Corporality seeks to explain that "we are always bodily in the world" (van Manen, 1990 p.103). When meeting another being, it is their body that we connect with first. Our

bodies reveal things to another person, yet at the same time we unconsciously conceal aspects of the self. Environments are seen differently depending on the body who perceives it. For example, the environment of the emergency room, is perceived differently by a youth seeking care than by a nurse working in the emergency room who experiences the environment every day.

Temporality

Temporality refers to lived time. Lived time is time that seems to fly by when one engages in enjoyable activities and comes to a halt when experiencing boredom (van Manen, 1990). Temporal landscape constitutes one's subjective past, present and future. It is one's temporally way of "being in the world" as a youth looking towards the future or as an older soul recollecting past memories (van Manen, 1990, p.104). The past, present and future shape one's temporal landscape and who one is as a human being. Past memories affect one's future experiences as well as how one presents oneself in society, the language they speak and the mannerisms they have adopted from others in their life which, in turn, affect their present. The future is upheld though hopes and dreams and expectations that are held for one's self.

A youth's past experience will affect future feelings and experiences. If one has a negative experience when seeking mental health care at, for example, a community-based service, one may be unlikely to want to engage in care in that setting in the future. Alternatively, if a positive experience has come from a visit to the community-based service, one may feel comfortable using those services again in the future. I believe it is important to note that this holds true for service providers. For example, for nurses, the past experiences of managing those with mental health disorders directly affects how they will manage and engage with patients with mental health problems in the future. The care

provider and the patient's experiences here are connected in the sense that a nurse who had a good experience with mental health patients in the past may be more comfortable with screening and providing the patient with a positive experience which, in turn, will affect their future decision making.

Relationality

Relationality is defined by lived other (van Manen, 1990). Relationality is lived relations that we keep with others in a common space. Meeting another is done in a physical way through touch (handshakes) or by forming impressions, even before meeting. We form impressions of others though thoughts about them before physically meeting. These ideas and impressions are found as true, or false, once one connects with another in a common space (van Manen, 1990).

The way care providers perceive youth seeking mental health care will directly impact the care provided. Their preconceived ideas about this group may facilitate or impede holistic, competent care. Youth suffering from mental health problems may, or may not, seek mental health support or services voluntarily. This could affect one's perceptions of the care provided and make it difficult for continuity of care.

Research Design

Sampling

In an effort to understand the lived experiences of youth who self- identify as having a mental health problem for at least six months and what they do, or do not do, about these concerns, this study used purposive sampling methods to retrieve information from ten youth, ages 16-21. Purposive sampling refers to a process by which the researcher selects participants who are able to inform understanding of a specific phenomenon (Creswell & Poth, 2018). In phenomenological studies purposive sampling is essential as all participants must have experienced the same phenomenon (i.e., a mental

health problem). Snowball sampling was also used in this study. Snowball sampling provides participants with information - about the study and ways to contact the researcher - to share with potential participants through word-of-mouth (Creswell & Poth, 2018). This type of sampling has shown to be especially effective for topics such as mental health (Parrish, et al., 2017). Studies have shown that youth in particular are more likely to participate in a study if they have heard about the study from a friend through word-of-mouth. Furthermore, participants must have been able to articulate the phenomenon experienced (Creswell & Poth, 2018). In keeping with the standard of phenomenological study, ten participants was the goal sample size and this was achieved (Creswell & Poth, 2018). Ideally, in qualitative research, studies exemplify diverse perspectives and do not generalize. For this reason, this sample size was flexible (Creswell & Poth, 2018). Of the ten youth who were interviewed for this study, nine identified as female and one youth identified as male. Further, at least one youth was interviewed within each age between 16 and 21 years. For the purpose of this study, youth had to self-identify as having a self-defined mental health problem for at least six months. The youth participants must have been between the ages of 16-21 and be living in Cape Breton, specifically CBRM. It was not a requirement of youth to have previously sought formal mental health services in the past to participate in this study. If youth had sought formal mental health services, the researcher aimed to gain a deeper understanding of the youth's experiences with having a mental health problem and their experiences with the supports or services they have accessed. If youth had identified as having a mental health problem but had not previously sought mental health care supports or services, the researcher aimed to gain a deeper understanding of their

experience with a mental health problem along with why the youth had been reluctant to seek care, or unable to access care.

Recruitment

Recruitment strategies used by this study included flyers posted in public areas, as discussed below, as well as on social media. Community based recreational and peer mentorship services (such as Whitney Peer Youth Club, Caper Base, specifically Access 808 Clubhouse) were approached as community-based resources to aid with recruitment for this study (i.e., flyers posted in the clubhouses and sharing flyers on their social media platforms). In addition, flyers were posted at Cape Breton Regional Library in Sydney, and at Cape Breton University in the cafeteria, library, and common areas of the campus. Flyers were advertised on social media platforms, Facebook and Instagram, using a public page for the research study on both platforms. Social media advertisements have been shown to be successful recruitment strategies for studies involving youth in particular. Youth have reported that if the advertisement is visually appealing and describes a brief overview of the study, they are more likely to want to participate (Parish, et al., 2017). Flyers were written in plain language specifically designed for this age group to easily understand. The researcher's contact information – unique from her personal contact information - was given for youth to set up a mutually agreeable time and place for a private interview. Youth were able to contact the principal investigator by phone, text, or email. See Appendix B for sample of the recruitment flyer and social media advertisement. Recruitment of ten youth for this study was completed within one week. Because of the sensitivity of the research topic, youth participants were provided with a pocket-sized list of possible supports and services for mental health assistance such as Kids Help Phone, and the Nova Scotia Mental Health Crisis Line (Appendix E)

(Parrish, et al., 2017). Furthermore, participants were given an honorarium ($30.00 cash) to pay for their contribution of time and information to the study (McCormick et al., 1999). Due to the older age group of youth in this study, and sensitivity of the research topic, monetary compensation was used as honorarium for participants' time, effort, and contribution to the study. Participants in this age group may have their own jobs for which they are being paid an hourly wage; therefore, this study was also treated as a job in which participants received monetary compensation. For participants who may have needed assistance with transportation, taxi chits were to be used to pay for their transport to, and from, the interview location; however, no participants requested this service.

It was beyond the scope of this research to conduct and analyze interviews with service providers; however, a consent form was developed to allow the researcher to collect data through interview with community-based youth mental health supports/services in CBRM to answer questions about services that the organizations provide to youth. This information was used to provide clarity to the researcher regarding programming and to gain perspective of mental health services in CBRM from a service provider. Please see Appendix H for consent form and Appendix I for verbal consent form. An honorarium was not used for the service provider interview. The researcher reached out to two different service providers in CBRM. Unfortunately, when providers were approached, the province had just lifted Covid-19 restrictions leading to a very busy time, especially for community-based youth programing. One service provider was able to accommodate a 1-hour interview with the researcher. The interview was conducted with the director of the Whitney Pier Youth Club via phone. Prior to this interview a letter of interest was sent to the service provider requesting a 1-hour conversation

(Appendix G). Please see Appendix J for service provider interview guide. Information from the interview will be further discussed in the discussion chapter of this paper.

Data collection

Interviews

In qualitative research, interviews are "attempts to understand the world from the subject's point of view, to unfold the meaning of their experiences, to uncover their lived world" (Creswell, 2018 p. 164). Furthermore, van Manen describes hermeneutical phenomenological interviews as tools used to develop a deeper understanding of the meaning of a phenomenon (1990). To understand the experiences of youth who have a self-identified and self-defined mental health concern for at least 6 months and have, or have not, used mental health services or supports, semi-structured interviews were conducted with 10 youth in CBRM. Two interviews were held at CBU one in a private boardroom and the other in the Verschuren Centre; one interview was held in a private room at the McConnell Library; and the other seven were held at a private office space in downtown Sydney. All interview spaces were agreed upon by both researcher and participants prior to meeting time. All interviews were held in person and recorded. Care was taken to provide the participants with a private, comfortable, safe environment (Creswell & Poth, 2018).

Regarding informed consent, youth were asked to sign informed consent prior to beginning the interview process. In the province of Nova Scotia, there is no lower age of consent regarding health care decisions and health care treatment; therefore, parents were not required to give consent for youth under the age of 19 to participate in this study (Capital Health, 2014; Globe and Mail, 2018). No lower age of consent allows capable youth to have autonomy, which can open up services and supports to which they may not

have access, especially in situations where youth lack parental support. Further, health care consent in Nova Scotia is based on *capacity* rather than *age*. It has been found that age, is not an accurate measure of a person's maturity. Dr. Gordon Wallace, managing director of Safe Medical Care at the Canadian Medical Protective Association, says that in a situation between a youth and a doctor, he always asks patients to explain back what was discussed during their conversation in their own words (Capital health, 2014; Globe and Mail, 2018). With this in mind, the researcher in this study, explained the research study to the youth participant, including risks and benefits and the option to stop the interview process at any time without consequence. The researcher then asked the youth to reiterate what was discussed in their own words to ensure that the youth understood the previous conversation. Please see Appendix D for the youth consent form.

Semi-structured interviews with open-ended questions is a method of data collection that is often used in healthcare research (Gill, Stewart, Treasure, & Chadwick, 2008). This type of interview method includes probing questions to guide the conversation. Because this type of interview is more flexible than a structured interview, it allows for an elaboration of participants' thoughts and possibly leading the researcher to new information that may not have been thought of as pertinent (Gill, et al., 2008). Interviewing in phenomenology serves as a means to explore and gather narrative material which allows for the understanding of a phenomenon as well as to initiate a conversation about the meaning of an experience (van Manen, 2016). Please see Appendix C for youth interview guide. The interview process began with informed consent, reviewing the purpose of the study, and notified participants that they had the option to stop the interview processes at any time, for any reason. No participants asked

to end the interview process; however, some did request a few moments to collect their emotions, which was given along with support from researcher. Participants were given the opportunity to ask any questions they might have had about the study and the study's procedures. As mentioned, a signed consent form from youth was obtained before the start of the interview. Regarding member checking, research participants were asked, during the informed consent process, if they agreed to being re-contacted following data analysis to discuss whether they believed the findings were representative of what they shared in the interview. This was voluntary, and participants were in no way pressured to take part in the member checking process. If a participant did want to take part in the member checking process, the researcher asked them how they would like to be contacted (e.g., by email, phone, or text). Participants were also asked to leave an email if they wanted to receive a summary of results of the study. Nine participants agreed to take part in member checking and requested a summary of study results.

Interviews began with questions that participants were able to answer easily, thus building rapport with the participant before asking questions about a more sensitive topic such as mental health (Gill et al., 2008). This method of building rapport "generates rich data that subsequently develops the interview further" (Gill et al., 2008, p. 292). Probing questions were used to explore participants' responses – for example when participants were having trouble articulating experiences, or if more detail was needed for the researcher to understand. In addition, as Van Manen (2016) suggests, silence was also used as a useful tactic to prompt the participant, allowing for time to collect their memories and proceed with a more detailed description. Likewise, if participants began

speaking in general terms, the researcher asked for a specific example, to guide the interview back to the essence of the experience being researched (van Manen, 2016).

Interviews were recorded with an audio recorder and transcribed verbatim by the researcher. Transcripts were stored securely electronically (in encrypted files) and physically (in locked cabinet) at Dalhousie University. Pseudonyms (participant numbers), were used instead of participant names to add protection. Master lists of participants and their contact information were stored separately from information containing pseudonyms to protect the anonymity of participants.

Reflexivity

In recent years, qualitative research has become increasingly more reflexive. Reflexivity is defined as "the fact of someone being able to examine his or her own feelings, reactions and motives and how these influences what he or she does or thinks in a situation" (Cambridge Dictionary, 2019). Reflexive writers are said to be ethically and politically aware which makes them a part of their own inquiry (Creswell & Poth, 2014). Reflectivity allows for transparency of research, which is important in qualitative research, particularly in phenomenology, as conclusions are drawn from the researcher's interpretation of the data (Darawsheh, 2014). Throughout this study, the researcher reflected - prior to, during, and post - data collection as well as during data analysis. The researcher reflected upon her own values, beliefs, biases and preconceived stereotypes as well as upon experiences as a healthcare worker regarding the topic of inquiry; recognizing that her personal experience as a registered nurse working in mental health may affect personal ideas about the subject. The researcher also reflected on her own social position in society (race, gender, socioeconomic status). The reflective process ensured that the researcher's own beliefs, position in society, and experience as a

registered nurse did not affect the interview process or data analysis. Reflections were recorded in a journal throughout the research process, including after each interview and throughout data analysis (Darawsheh, 2014).

Data Analysis

Data analysis was conducted using van Manen's approach to hermeneutic phenomenological thematic analysis. Van Manen refers to thematic analysis as phenomenological reflection, "to try and grasp the essential meaning of something" (van Manen, 1990, p.77). Moreover, van Manen states that the "meaning or essence of a phenomenon is never simple or one dimensional. Meaning is multidimensional and multi layered" (van Manen, 1990, p.78). During analysis, researchers attempt to determine the phenomenological themes of the experiences. In the experiential accounts' researchers try to form "something meaningful or something thematic" from the accounts (van Manen, 1990, p. 86). To uncover these themes in this study, the researcher used van Manen's three approaches to forming thematic statements and the consideration of reflective existential lifeworlds. First the holistic, or sententious, approach was used which looks at the transcribed interview as a whole and asks what phrase captures the real meaning of the whole text. Next the highlighting approach was used. This approach has the researcher read the text multiple times and highlights the most important phrases which reveal meaning about the phenomenon being explored. This allows for the researcher to become familiar with the data. Finally, a line-by-line approach was used which examines every sentence and asks, "what does this sentence, or sentence cluster, reveal about the phenomenon or experience being described" which formed codes (van Manen, 1990 p. 93).

Once the data were coded using van Manen's approach to thematic analysis, concept maps were used to organize single codes into larger essential themes. A document was used to organize themes and subthemes as common or uncommon between participants. Once common themes were identified, by a theme being common between most, if not all, participants the researcher determined that the themes were essential in relation to youths' lived experiences with self-identified, self-defined mental health problems lasting at least 6 months and their experiences with seeking- or not seeking- mental health supports and services. These essential themes were verified by the researcher asking herself questions such as "Is the phenomenon still the same if we imaginatively change or delete this theme from this phenomenon? Does the phenomenon without this theme lose its fundamental meaning?" (van Manen, 1990, 107). This process is what van Manen calls "free imaginative variation" which allows the researcher to verify if a theme is essential to the phenomenon under study (van Manen, 1990, p.107). Finally, the researcher's supervisor was asked to independently code all interviews which allowed examination of the reliability of the researcher's coding. Using these guides for thematic analysis, the results were able to bring forth the true meaning of the lived experiences of youth on Cape Breton Island with self-identified, self-defined mental health problems of at least 6 months.

Data Storage

Data collected during this research study included encrypted audio recordings of interviews with youth and the transcribed copies of the interviews, as well as field notes taken by the researcher during the research process. Paper copies of data were stored at Dalhousie University, in a locked office, in a locked filing cabinet. Computer files were stored on a password protected computer and all files regarding research also were

password protected. These files also were backed up on a USB drive, which also was stored in a locked filing cabinet. Creswell (2018) notes the importance of using high quality recording devices and protecting the real names of study participants with pseudonyms, which was carried out in this study. Data will be stored securely for five years and then destroyed (Creswell & Poth, 2018).

Trustworthiness

The trustworthiness of this hermeneutical phenomenological research study will be discussed using the following criteria: credibility, dependability, confirmability, authenticity, and transferability (Creswell & Poth, 2014). In this study, *credibility*, referring to the truth of the data set, was established by continuously making sure the researcher understood the experience that the participant was describing throughout the interview process. Additionally, to increase credibility, the researcher attempted to carry out "member checking" with consenting participants to allowing the researcher to discuss the findings of the research with the participants to ensure the proper meaning has been applied to the data (Cope, 2014). *Dependability* of this study was established by keeping a record of all the methods used in the process of this conducting the study methodology. In doing so, this allowed for the study's processes to be replicated by other research studies in the future and would be deemed dependable if these future studies yielded similar results (Cope, 2014). *Confirmability* of this research was established by continued self-reflection carried out by the researcher to identify her own biases, or stereotypes, that could be unknowingly present. Additionally, this was achieved by descriptions of how the researcher interpreted the data and came to form conclusions. According to Cope (2014), confirmability can be achieved in qualitative research by using "rich quotes from the participants that depict each emerging theme" (p. 89). *Authenticity* of this study was

established by using direct quotes from youth participants so that "readers grasp the essence of the experience" (Cope, 2014). Finally, this research met the criteria of *transferability* as the findings of this research possibly could reflect experiences of other youth from different rural or underserved areas – provincially and nationally.

Ethical Considerations

The principal investigator of this study had no conflict of interest to report in relation to this research. Prior to conducting data collection for this research study, ethical approval from Dalhousie University was obtained as this study involves human participants. Permission was granted from all community supports and services to allow for recruitment posters to be posted in their establishment. Youth were made aware that they were able to bring a support person to the interview if this increased feelings of comfort and safety for participants. Before interviewing youth, informed consent was reviewed and signed by each participant (Creswell & Poth, 2018). Participants were in no way coerced into signing informed consent. All participants were notified that the study was voluntary and that they were able to withdraw their participation at any time during the interview and would not be required to answer all interview questions (Creswell & Poth, 2018). Participants also were informed about the purpose of the study and assured that all answers to interview questions were anonymous (Creswell & Poth, 2018). All youth participants were informed that there were no foreseeable physical risks in relation to participation in this study; however, they may be at risk for psychological distress due to the sensitivity of the research subject. Because of this, the primary investigator provided participants with a list of local or accessible (via text/phone) provincial/national supports for youth mental health care. The researcher acknowledged the potential for youth to become psychologically distressed during the interview process; therefore, a

plan was created by the researcher and committee members for ways to take action. If the youth had become emotionally distressed but the researcher was not fearful that the youth might hurt self or others, the researcher would ask the youth if there was a friend or family member whom they could call to come and be with the youth. A participant who was visibly upset was never to be left alone by the researcher. If a research participant did become emotionally distressed the researcher would have done everything in her ability to reassure and calm the participant. However, if the participant was threatening to harm self or others, or if the researcher was concerned about the participant's well-being, the researcher would have called 911. If the youth had become upset during the interview, and did not have a proper way to get home, the researcher would have used taxi chits to pay for the participant's transportation.

It is important to note that none of these measures needed to be used during the interview process; however, time was taken to allow some participants to regain composure after becoming emotional during the interview. As the researcher was from Cape Breton, she was aware of the culture of Cape Breton which was considered during the interview process with the aim of being culturally competent when interviewing. Participants were reimbursed for their time and travel by $30.00 cash payment. Participants were informed that they were able to withdraw from the study at any time until the end of the interview - after which data analysis proceeded. None of the youth participants requested to withdraw from the study, or recontacted the researcher post interview with a withdraw request. Rapport was built to encourage trustworthiness between interviewer and interviewee. Leading questions and deception were not used in this study and data were analyzed and reported truthfully (Creswell & Poth, 2018). The

primary investigator was continually in consultation with thesis supervisor and thesis committee members throughout the data collection, analysis and thesis writing process for guidance and support.

This chapter has outlined this study's purpose, research questions, and objectives. Additionally, phenomenology was explored and a review of how this methodology was employed for this study was provided. The research design, including data collection and analysis was described in detail as well as ethical considerations applicable to this study. The following chapter will report the findings from interviews with 10 Cape Breton youth who have a self-identified, self-defined mental health problem of at least 6 months. The procedure carried out to conduct the 10 interviews will be reviewed and the six themes extracted from the data will be explored and compared to existing literature.

Chapter III: Findings

This chapter reports the findings of 10 semi structured interviews with 10 youth on Cape Breton Island. Youth ranged in age from 16-21 years and had a self-identified, self-defined, prolonged mental health problem. It is important to note that seven of the ten participants in this study did have a formal diagnosis from a healthcare professional. Data were collected between January and February 2020. All efforts were taken to keep youth information anonymous. All self-identifying information has been removed from quotes reported in this text. The data have been used to answer the following four research questions for this study:

1. What are the lived experiences of youth who self-identify as having a self-identified, self- defined mental health problem for at least six months?
2. What mental health supports, or services (formal or informal) have youth used (if any), for what reason, and their resulting lived experiences?
3. If supports or services were not used, why not, and their resulting lived experiences? 4. From the perspective of participants, in what ways are mental health services and supports meeting, or not meeting, the needs of youth with mental health problems on Cape Breton Island? In what ways do these services and supports need to improve?

Procedure

Interviews with the ten youth were held in multiple locations, including: Cape Breton University (CBU), the McConnell Library (public) in Sydney, and a private office in the core of downtown Sydney. All interview locations were agreed upon by participant

and the researcher prior to the meeting. Youth called, sent a text message or a direct message via Instagram or Facebook to the researcher when they arrived. The researcher then met the youth at the front door of the interview location and together they went to a private interview room. One participant met the researcher in a common area of CBU as requested by the participant. The researcher sent a text message to the participant regarding a visual description of the PI along with her specific location. There were no issues noted regarding meeting locations or participants being unable to identify the researcher at the meeting location. Interviews were recorded by a high-quality digital recorder and then transcribed verbatim by the researcher. All personally identifiable information during the interview process was removed.

As previously discussed, the researcher conducted all 10 interviews with youth. Upon arrival to the interview location, the researcher ensured that the participants were feeling comfortable and safe with the location of the interview. The consent form was reviewed with the youth. The youth were asked to read the plain language consent form on their own before the researcher reviewed the document with the youth. The researcher asked youth to reiterate key points of the informed consent document to ensure they were in full understanding of the document. The youth were asked if they had any questions or if any points needed to be clarified. The researcher reiterated to youth that if they felt any discomfort or did not want to continue with the interview, they could pause the interview, or end the interview, at any point. If youth had no further questions, they were asked to sign the informed consent document (Appendix D). Youth also were asked if they would like to participate in the member checking process (optional) and if they would like a copy of the results of the study (optional). Once the informed consent process was

complete, the researcher explained that the interview would begin with basic questions to get to know the participant, and then proceed into questions about their mental health problem. Interviews, on average, lasted 45-60 minutes and were conducted using a semi-structured interview guide (Appendix C). The guide included 13 interview questions. One question only applied to those who had recently moved to Cape Breton; however, this question was not used during the interview process as all participants had been living in Cape Breton for more than three years. This guide was developed by the researcher with assistance from the studies supervisor using van Manen's lifeworlds as a framework (van Manen, 2016). Each question included multiple probes that could be used to encourage youth to elaborate on their responses to the main questions. Time was spent with youth following the interview process to review a take home document of local and provincial services/supports that youth could use if needed in the future. As mentioned, an honorarium of $30.00 was given to youth to participate in the interview. The honorarium was given post interview along with the resource document.

Following the transcription and anonymizing of the transcripts, the researcher used Van Manen's approach to hermeneutic phenomenological thematic analysis (2016). As noted previously in this text, the researcher read the text as a whole, followed by reading in clusters, highlighting important phrases, and finally line by line, forming "codes". Concept Maps were used to organize the codes into essential themes. Themes were then sorted into a document which included overarching themes and subthemes, which the researcher thought were essential to the lived experiences of the youth. Final themes were chosen based on commonality among participants. Final themes and subthemes were found to be common amongst the majority, if not all participants, which

gives meaning to the lived experience of youth with self-identified, self-defined mental health problems on Cape Breton Island.

To ensure that the interpretation of the transcripts was dependable, the researcher and the researcher's supervisor independently analysed the data and compared codes. Each coded transcript was reviewed by the studies supervisor. In addition, the thesis committee was given 2 uncoded transcripts to code independently. A thesis committee meeting was then held during which the researcher presented the coding of the transcripts and sought feedback from the committee. The committee agreed with the analysis of the two chosen transcripts; therefore, approval to continue with data analysis with the support of the supervisor was given.

Six themes were extracted from the 10 youth interviews. These themes have been identified as essential to the phenomenon of youth with mental health problems on Cape Breton Island including:

1. Trauma
2. Familial Relationships
    a. Familial support
    b. Lack of familial support
3. Positive Relations
    a. Social support
    b. Service support
    c. Peer Support
4. Negative Internalized Feelings
    a. Guilt

b. Fear of Stigmatization

c. Lack of Self-confidence

5. Service Gaps

    a. Lack of youth specific supports

    b. Lack of trust in the health care system

    c. Need for education (youth and parents)

6. Personal Growth:

        a. Resilience

        b. Reciprocity

This chapter will use van Manen's Lifeworlds (relationality, spatiality, corporeality, and temporality) as a framework to discuss the findings from interviews with the 10 youth who partook in this research. The lifeworlds were used as a framework for interview questions, then lifeworlds were applied to emergent themes during the data coding process. Each of the six themes and subsequent subthemes that emerged from the data will be discussed in relation to youth's experience with mental health care on Cape Breton Island, and existing literature. The pronoun *"they"* has been used throughout when discussing youth participants in attempt to ensure anonymity of participants.

Trauma

Trauma was the emergent theme that was most commonly described by youth participants. Nine out of the ten youth interviewed had experienced a form of trauma in their short lifetime. Some youth described a parental divorce, parental death, childhood illness, and witnessing a large accident, while others described their experiences within the foster care system, childhood abuse, and substance misuse.

Traumatic events experienced by the youth participants had immense effects on their mental health, ability to cope and, in turn, heal. In relation to van Manen's lifeworld existentials, the theme Trauma can be discussed in relation to all four lifeworlds. First and foremost, trauma affects every facet of a person's temporal landscape: their past, present and future. The following three quotes depict trauma and the aspects of the participant's life that these events have affected. One participant recounted the abuse of her parent while living in another province which led to years of foster care until moving to Cape Breton to live with their grandparents:

"Well, I guess it started back a few years ago with my step father. He was abusive and he got his son, I think, to do things to me and my sister. It's emotional" (Participant 9). The participant continued on to say:

> I don't talk about it much because kind of hurts. I think about him [step father] hurting my sister. We moved around. We were in foster care so it kind of hurts and I don't like to talk about. I don't bring it up much and I guess school, it was ok, and I got bullied a lot for stupid stuff… I just keep it all inside. I don't talk about it much (Participant 9).

One participant recalled their experience witnessing a large accident which led to Post Traumatic Stress Disorder:

> Over the summer there was an ATV accident and there was a 16-year-old boy bloody on the side of the road …and I was driving by and I had to stop and there was only one other adult there, and she didn't know what to do. So, I ended up, like holding his like body while he was suffering… so that's like part of the

> PTSD… and then he didn't make it and it was really hard for me to know that I was holding him when his mother wasn't. (Participant 3)

Using the previous quote as an example, this particular participant's past traumatic experience has affected, and will continue to affect, their present and future as this participant shared having PTSD symptoms. Further, trauma affects an individual's ability to build and maintain relationships with others (relationality) throughout the lifespan. The human body's response to trauma includes increasing the body's cortisol, which in turn, increases an individual's heart rate and blood pressure (Georgetown University Centre for Child and Human Development, 2014). In childhood, if this stress response is unremitting, the development of the brain and other organs can be disrupted. These disruptions can lead to cognitive impairment that persists into adulthood (Georgetown University Centre for Child and Human Development, 2014). Indeed, the persistent stress response can cause children to view "almost any situation as a threat - an outlook that distorts their world view" (Georgetown University Centre for Child and Human Development, p.2, 2014). This distortion, in turn, can disrupt social functioning and can cause children to have difficulties building relationships throughout their lifetime (Georgetown University Centre for Child and Human Development, 2014).

Past traumas can cause certain physical spaces, or characteristics in physical spaces, to remind a person of their personal trauma - whether that be a hospital room, their childhood home, or certain scents in a space - to be uncomfortable, frightening, and stressful. This is congruent with van Manen's life world, spatiality. One participant recalled being a witness to an accident at school. The participant stated, "Um well. Do you remember when at (Local school) someone got hit by a bus, I witnessed it, so every

time I drive by busses or cars, I go into full blown panic attack and I just start crying" (Participant 10). This participant noted having panic attacks when being near school busses, triggered by a traumatic event they witnessed. While this participant may not specifically be near the environment where the traumatic event happened, there are characteristics in other physical spaces in which they find themselves that cue an emotional response. Finally, a person's body is affected by trauma, not only *physically* as aforementioned, but *bodily* in how one presents themselves to others and in what they consciously or subconsciously conceal from those around them. Additionally, individuals with traumatic experiences may have a strained relationship with the body (physical or sexual abuse for example) leading to alienation, or disembodiment, from one's body thus affecting how the individual views the world (Briere et al., 2005).

Individual trauma is defined by "results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (Menschner and Maul, 2016, p.2). Further, traumatic events affect a person, their safety, their ability to regulate emotional response, their sense of self, and relationships with others (CAMH, 2020). Examples of traumatic events that often affect an individual are loss of a loved one, abandonment, natural disasters, abuse, violence or illness (Georgetown University Centre for Child and Human Development, 2014). By definition, trauma can be divided into three categories: acute trauma, chronic trauma, and complex trauma. Acute trauma is short lived or a single event in one's life, while chronic trauma in a prolonged event that is recurring. Complex trauma includes traumatic events and the physical and emotional

effects resulting from the event (Georgetown University Centre for Child and Human Development, 2014). It is beyond the scope of this paper to examine and define the specific traumas experienced by the participants of this study; therefore, the broad term *trauma* is used when referencing any trauma experienced by youth. Critically important, as noted by Waldron and colleagues (2019), trauma often does not occur in isolation, but rather occurs more than once in a person's lifetime. Further, most youth who have experienced trauma in the past report experiencing more than one type (Waldron et al., 2019).

Those affected by traumatic events can experience long lasting effects that cause feelings of hopelessness, fear and shame (CAMH, 2020). Trauma can lead to physical health problems such as liver and heart disease, premature death, and mental/emotional disorders (Georgetown University Centre for Child and Human Development, 2014). Early traumatic experiences also have been determined to be a risk factor for development of mood disorders and depression in youth (Waldron, et al., 2019). In a 2007 study, children who had experienced trauma were found to have 2 times the rate of psychiatric illness than children who had not had traumatic experiences (Copeland, et al., 2007). It is clear that childhood trauma can cause manifestations of mental, physical and behavioural disorders if unaddressed. However, if childhood trauma is addressed, a child's brain does have the ability to adapt and manage traumatic events (Georgetown University Centre for Child and Human Development, 2014).

Familial Relationships

The theme Familial Relationships was extracted from the data. All participants discussed their familial relationships, or lack thereof, during the interview process. In terms of who youth believed were included in their "family", most youth discussed their

parents/guardians, siblings, and grandparents. Four youth discussed having unwavering support from their family, while three youth reported parents/guardians needing education and understanding of their mental health problem before receiving parental support. Further, three youth discussed their challenges with a lack of support from family throughout their mental health journey. Youth who had a supportive relationship with their parents/guardians spoke of their families in a positive light; however, those who did not have a supportive relationship often spoke negatively, or longingly, about their parents/guardians. Youth who felt supported by their families used the terms such as "*positive, wasn't alone, understanding, and safe,"* while youth who once lacked support, or still do lack support, used terms such as *"alone, brushed aside, no one cared, and misunderstood"*. Some families, through education and time, learned to support their loved one while other participants continue to have challenges with familial support; a topic that will be discussed further in this chapter. Due to these differences, this theme was divided into two subthemes: (1) familial support, and (2) lack of familial support, to best reflect the data collected from participants.

Familial Support

Four participants discussed receiving much emotional support from their parents/guardians, siblings, or grandparents throughout their journey with their mental health problem(s). However, for three participants, it was identified that this support was not received outright. Indeed, families were very confused and misunderstood the participant's mental health problems. In contrast, one youth recalled having continual parental love and support from the beginning, which made the participant feel cared for, and not alone, in their journey. This participant has had positive relations with their

parents, leading to a strong bond and a safe and accepting environment. The participant recalled the following in relation to their family's reactions:

> Actually, pretty good to be honest. I think it's just nice to know even when you kind of have those really low lows and when you go through something that was kind of as severe as that was …and even before when I had a lot of these kind um …when the anxiety was bad, they kind of built me up. I think over, it was actually pretty good. It made me feel like I had people who cared about me, and they were going to stick with me. I wasn't alone. I think in a lot of ways it was positive (Participant 5).

As noted above, for three youth, their parents/guardians needed to be educated about mental health problems to fully understand it for themselves, and subsequently be able to understand and support their child. One participant noted this change:

> Well, my parents never believed me at first when I said I was feeling really anxious until I started crying and having meltdowns every day and they were like "this is really not you. You're such a bubbly kid." I'm still super bubbly but I struggle with my mental health more. I've never been someone who was depressed or sad, so I think it was hard for them to identify with that. I think it took me crying and having mental breakdowns in front of them in order for them to realize that "she is actually struggling" and I took my parents to the doctor with me when I started medication. So, I think they 100 percent are supportive of me now, but it took a little while for them. Nobody wants their child to suffer with mental illness, but I know that it was easier for me… for them to believe me... than when my little brother was telling them that he was really anxious. I don't

> think his is as bad as mine, but I know he definitely didn't really fully struggle as much… they were like "oh [name] is always like that because he has ADHD". So, I think it was easier for me than for him (Participant 2).

Like the above youth, other participants had siblings who struggled with mental illness, and yet, parents still had trouble understanding the participant's struggle with mental health problems.

The following quotes describe one participant as feeling stigmatized by their parents initially, even though the participant's sibling has schizophrenia. As time went on, this youth also gained familial support.

> Yeah. Actually, from my parents at the start …because for a while they just thought I had behavioral issues and they were like 'everyone has that'… but mine were more extreme than others. They would talk to other parents, and my parents realized that it was more than what other kids were doing. It was like they didn't want to believe it at the start. When I would call my mom from school to get her to pick me up - cuz I was throwing up because I was so anxious - she would say 'oh you're fine if you just go home and rest, you'll be fine tomorrow'. So, specifically with my parents at the start …but then my older brother actually suffers from schizophrenia …so I feel like, I feel like without my parents knowing about that, it would have been a lot worse… But until I went on antidepressants that's when they said 'ok it's serious'. I remember the day I said 'I did some research on it and for 19 years of my life you brushed it off like it's an everyday thing'. I feel like it was my parents who stigmatized me the most (Participant 4).

The participant continued on to say:

> Luckily, I feel like my older brother set the tone for my parents to understand me. If my brother didn't suffer from schizophrenia …maybe they put their walls up and be like 'mental illness is not a thing' because they didn't experience it themselves …so they wouldn't know (participant 4).

One youth reported that their parent self-identified the need to educate themselves to better support and care for their child with mental health problems. The youth described their mother attending counselling to learn more about her child, to help better understand their illness. This youth's parent assisted with identifying professional supports (counselling), activities to use as coping mechanisms, accessing a professional diagnosis and prescription medication.

> I feel like they're a lot better now. Again, like with the medication that I'm on, I feel like it really helped and my mother has also done a lot of reading on the subject …and she went to a counsellor as well to see how she could be better… and they also got me a dog so yeah (Participant 3).

This participant continued on:

> So, I was going through a really like dark patch… I guess, or rough, patch… and I couldn't get out of bed for a while and mom went out and got me a weighted blanket. She was trying to show 'your support, like I knew this would help you, so I did this for you'. Or sometimes she would see that I'm overwhelmed and say '[name] it's one class, you can stay home today' and she'll make me food …or she'll come home with a tea and she'll say 'just relax with the dog, listen to music, play your guitar, just like unwind, get a bath, whatever'. I feel like we really improved when she used to yell at me …for me …for it …well she didn't

> understand. It wasn't like abuse or anything [laughing] it was a teenager and her mom …but I feel like she understands it more, I feel like I have a support system with me constantly when I'm home (Participant 3).

Literature suggests that youth who receive support from their parents have more positive mental health outcomes (Shaw, et al., 2004). Further, a 2007 study found that family engagement, communication, parent healthy role modeling and closeness were positively related to youth social competence, self-esteem, and health promoting behaviour (Yongblande, et al., 2007). A previous study scored families "Expressed Emotions" or "EE" (attitudes and behaviours) towards an ill relative. Families with a high EE score often were found to be more critical or over involved, while families low EE ratings were found to be congruent with positivity and warmth from family members leading to more positive youth outcomes (Le Grange, et al., 2012). In addition, an Australian study (Honey, et al., 2014) reported that parental responses to mental health issues affect youths' feelings, behaviour, and wellbeing (i.e., youth's acceptance of illness, participating in treatment, and engaging in pleasurable activities such as exercise and social relationships), which is consistent with the findings of this study. Once education was provided and understanding gained, youth then felt supported and accepted by their family. Support from participants' families in his study lead to more positive outcomes as parents assisted with navigation of the health care system, leading to identification of appropriate professional supports or services, and medication if needed.

Lack of Familial Support

Three youth discussed a general lack of support from their parents/guardians in relation to their mental health at some point in their mental health journey. This lack of support caused great divides in relationships between parents and child, as well as lasting

temporal effects in other areas of the youth's life, such as building trusting relationships with others.

One youth discussed feeling a lack of support from their family for many years, causing many internal familial issues.

> Um I think a lot of my problems came from, of course, like my childhood …but then being misunderstood growing up from there on out. So.. like… if I had someone that would have understood it, I could have prevented a lot of things… but when I told my family …they didn't understand it, which was… they were like mad and they didn't, I guess. Like they know that now. I told my mom that 'like, you really didn't really react like you should have'… and she understands that now. It's just unfortunate that it had to be that. Like I had to be the one to tell my mother that you could have raised me a little better with a little more love… like you know, but it is what it is (Participant 1).

This participant expressed feeling brushed aside by parents and described the temporal effects this had on them, for example, not feeling able to open up to others:

> Um probably I would say when I was like 17. I started like doing stuff they didn't agree with, or whatever, and then I felt like my parents never really cared. They always just brushed me aside pretty much and whatever I said, they didn't take seriously (Participant 1).

This participant continued on to say:

> I usually don't… like I don't open up to many people. I told my mom like when I was 16 and I was suicidal, and wanted to kill myself, and I was super depressed, and I told my mom, and I was crying …and all she said was 'oh that's just

> hormones'… and that's all she said… and I never talked to my mom ever since (Participant 1).

She further recounted an event form her adolescent years:

> Ah well actually it [mental health problems] completely tore my family apart. I never talk to my family. I left home when I was 15 years old and didn't talk to my family until I came home pregnant, 17 years old. My brothers still to this day they don't like… it's not the same …and when I was actually walking out the door with my bags packed and stuff… my brother looked at me from the top of the stairs and said 'if you walk out that door it's never going to be the same, and I'm never going to look at you the same'. I was just a kid and so I walked out the door… but it really hasn't been the same yet… but I'm like really, really in recovery …and still like that… so I know it's going to be really good someday (Participant 1).

This youth had in childhood, and still has, a strained relationship with all members of their family. Not only should youths' relationships with their families be considered but the impact that these relationships have on youth's other social interactions and relationships outside of the family unit should also be considered. This lack of *relationality* between the participant and their family has caused temporal effects, leading to fear of opening oneself up to others, both in the past and present, due to fear of being brushed aside as the participant's mother once did. As the youth's relationships with those in their household were strained, the home environment was not identified as a positive space to grow. The youth being able to identify that their own recovery, in time, could mend broken relationships, illustrates the lifeworld corporeality, their body and

mind's growth, and the hopefulness inside. Over time this recovery and resilience could lead to positive relationships in the future and their parents' home being a positive and supportive space for this youth.

More generally, the broad theme of Familial Support is connected predominantly with the lifeworlds: relationality, spatiality, and temporality. Youth noted that spaces often felt most welcoming, safe, and comfortable due to the people who were found in the spaces, not just the physical environment itself. One youth discussed these feelings:

> Like more of the people that I'm around rather than the setting… so if I have a group of friends with me, or if I'm with my sister or a family member, I feel like that's what makes something a safe place for me (Participant 3).

Home environments were most comfortable for youth who had positive relations and support from their parents or guardians. Prior to parents/guardians becoming accepting and understanding of youth's mental health problems, some youth felt that their home life was strained, making for a negative space to live in, along with negative relations within their space. This change over time, caused an improvement in youth's views of their relationships with their parents/guardians and the space in which they live, which brings to light the lifeworld temporality. This change is illustrated in the following quotes from a youth participant:

> …Even at my house, I was awkward coming out of my room and socially with my parents. If I said something, or if they said something to set me off, then it would just be like a spiral for the rest of the night. (Participant 4)

This participant recalled the following when asked if they felt more comfortable in their home space more recently:

> Yes, I would say now I am… because before my parents were almost shy to it and didn't want anything to do with my issues and I felt alone. My older brother doesn't live with us …and I feel like if he lived with us, I could ask him what his experience was like… but I mean my parents, god love them, they had to take me to counselling and knew there was an issue. They just didn't think it was a bigger issue than it was. …I feel more at home and they feel more comfortable with it, like they know I'm regulated, and stuff… and they ask if I took my medication today… and ask how I'm feeling… and maybe book an appointment with your doctor to go over everything. They're more comforting now (Participant 4).

Existing literature suggests that a lack of early childhood parental support is associated with a higher risk of developing depressive symptoms in adulthood (Shaw, et al., 2004). In addition, literature has suggested that parents of youth with mental illness often experience "family stigma" (Eaton, et al., 2016). This stigma is transferred from child to parent, leading to self-shame and caregiver stress, due to the association with their child (Eaton, et al., 2016). This could be a contributing factor as to why parents of youth with mental health problems may choose to ignore, or downplay, a youth's mental health concerns. Further, as discussed previously, there may be generational factors, such as negative attitudes toward mental health, that could be affecting how parents on Cape Breton Island view and, in turn, manage their child's mental illness. Research also suggests that children living in rural communities are at higher risk of having a parent who faces their own mental health problems (Robinson et al. 2017).

It is abundantly clear that positive familial relationships and adequate support from family are paramount to youth with mental illness. Positive parental responses to

youth with mental health problems directly affect youth's ability to navigate and access services, leading to learned positive coping mechanisms, and at times access to required medication. Overall, parental/familial responses dictated whether, or not, youth felt supported, safe and accepted within their homes.

Positive Relations

The theme Positive Relations refers to relationships held by the participants outside of the family unit. All participants were able to identify positive relationships within their personal life or within their community. This included, but was not limited to, friends, co-workers, teammates, professors, teachers, and healthcare professionals. This theme was divided into three separate sub themes: Social Support and Service Support, and Peer Support.

Social Support

Seven youth participants felt they had support from their friends, teammates, teachers/professors and co-workers, and felt safe in spaces when these individuals were present. This again brings forth the importance of the individuals within spaces, not just the environment itself that makes youth comfortable. One youth discussed that relationships with their friends actually improved and became stronger when they were able to open up to them about their mental health:

> I think actually overall it's kind of weird to say, but I think it kind of strengthened a lot of bonds that I have with …like I'm really lucky that I have a really stable home life and I have a strong circle of friends and they were really supportive throughout this whole thing. I opened up a lot of what was going on and everything that I was feeling and they really had my back through a lot of it and they really kind of helped me a lot. I felt like I was going through it with them

> and strengthened a lot of those bonds that I had. In a way it kind of helped them see another side of me and me see another side of them (Participant 5).

Another participant expressed feeling as though their friends were able to relate to them, as they had similar experiences. This youth, over time, felt supported by friends and comfortable expressing feelings without being questioned or looked down upon:

> So, like over the years now that people kind of like get it and understand I feel like they're good support systems and some of my friends suffered the same things… so they get it first hand and they know what works for them, so it's really beneficial that way. Um it's just so good knowing when you're with someone close, I can look at them say 'I need to get out of here' and like 'I need air now'. They just get it no questions asked. And like you're not going to be left alone (Participant 3).

While most youth felt supported by their social circles, some youth, such as the youth above, did note that at times they felt their friends only superficially understood their struggle with their mental health, and did not fully understand what they were going through as these friends had not ever experienced mental health issues personally in the past. One youth recalled, "Um my friends, they understand when I take a panic attack but they fully don't understand what goes on in my own head… so it's really hard to explain to them cuz they really don't know at all" (Participant10).

Finally, participants who were in university or collage noted most of their professors to be supportive of decisions to take time away from school, or give extensions on assignments. One youth noted that opening up to a professor was

beneficial, as now their professor knows why the youth may need help focusing on schoolwork:

> Well, the other day we were talking about, well I'm in CCA, so we're learning about the body and stuff and we talked about marijuana… and then I said 'well I have depersonalization from it' and I explained it to her and she was like 'oh gosh' …and that's why it's so hard for me to focus in school …and when she's teaching I can't' really focus. But I'm glad I said it, cuz now she knows (participant 10).

Social relationships and support in adolescence is extremely important due to the large transitions that occur in youths' lives at this time, leading to great vulnerability. An association has been found between social support and psychological problems during this developmental time (Spitz, et al., 2020). Social relationships, in general, have been linked to positive psychological wellbeing; while social isolation, few social relationships and few social supports have previously been associated with greater feelings of loneliness and depressive symptoms (Barnett and Hotlib, 2001; Kawachi and Berkman, 2001; Matthews, 2016). The emergence of adolescence brings about temporal changes in youth's social circles. Children's support systems shift from primarily parental support to a broader range of individuals such as friends, teachers, and relatives as they grow older. However, literature suggests that as youth grow older, the interactions with supportive adult figures decrease (Montemayor and van Komen, 1980; Spitz, et al., 2020). Yet, as children move into adolescence their peers become their centre for social support. A 2020 study found that satisfaction and frequency of support from best friends increases with age, a finding especially true for female participants (Spitz, et al., 2020). Finally, youth

tend to perceive teachers as a less important support than friends or parents during this age; however, feel validated by teacher's support throughout adolescence (Spitz, et al., 2020).

Social relationships in youth not only affect the temporal landscape but all aspects of the lifeworld, such as building relationships with their peers, co-workers, and teammates. Youth are able to build positive and meaningful relationships with those in their community (friends, teachers, teammates etc.), leading to a positive support system and supportive environments in which youth are able to continue to grow and learn. Youth noted some friends who did not fully understand their mental health problem. Although their friends did not fully grasp the extent of their problems, and the youth participant was cognizant of the situation, they still felt supported by them. This finding suggests that participants were able to be supported by those who do not have personal experiences or relatability to the youth, but are able to offer safe and caring relationships and a supportive space for them (spatiality). In addition, social relationships with others have a corporeal aspect, from being able to physically connect to another through touch, such as a handshake, but also being able to reveal, or in some cases, conceal parts of themselves from others. It is imperative that youth have access to positive support systems within their community, and their homes, to decrease risk for social isolation and increase positive psychosocial well-being.

Service Support

Youth participants were able to identify multiple services within the community who were able to assist and support youth throughout their journey with their mental health problem, and for some participants, still continue to do so. Services identified by participants included General Practitioners (GP), Nurse Practitioners (NP), Social

workers, psychiatrists, Child and Adolescent Mental Health Services, Employee Assistance Program, youth community programs, school health centres, and Alcoholics Anonymous (AA).

One participant expressed appreciation for their General Practitioner (family doctor) in the following quote.

> I was 17 turning 18 when I was put on medication and, to this day, she'll [family dr.] ask me how I'm doing and for someone who is so busy, she'll sit down with you and say 'how are you doing', and say 'how do you think the medication is working, do you think you need to go down, up'… like if you say 'I'm feeling overwhelmed' she'll say 'let's go up now and see how that adjusts, and it's just a patch in your life' …and she'll slowly ween you back down and she really works with people, and I feel that that is such a great support… but I think it's kind of ridiculous the amount of people I have seen, and she was the one that was helping me (Participant 3).

Another participant believed that their social worker had a large effect on their self-confidence and was able to reassure, and advise, the participant leading to increased academic achievement. The participant noted the following:

> I found it helped a lot just to like go and talk to him for an hour… and he would like build my confidence almost, and made me feel better about myself and reassure myself… and I did better in school cuz I could talk to someone, and he would give me good advice (Participant 7).

Another youth discussed attending Alcoholics Anonymous, in an attempt to begin a journey to recovery from alcohol misuse:

> The most safest, most comfortable place [Alcoholics Anonymous] and most loving, open minded, in the world. I try to get people that aren't even alcoholics to come. They say I don't have a drinking problem. I say you gotta come feel the love, it feels so good (Participant 1)

This participant continued on to recall:

> ...Then everyone started giving me hugs… and like um when you go around the room everyone is talking and every person was talking right at me and just so much love. I never felt that in my life, and I just loved it from the second I walked in. That would definitely be the most comfortable place for sure (Participant 1).

A 2020 study found that the most commonly used mental health services among youth ages 12-17 years were, in order of commonality, outpatient mental health services, school counselors, general medical services, and inpatient mental health services (Mojtabai and Olfson, 2020). This study found that most youth used only one service; however, those who used general medical services were more likely to receive care from another service (Mojtabai, et al. 2020). These findings were similar to the findings of my study. Youth participants used their GP and NPs for support, medication prescriptions and refills, and referrals to specialized mental health services. These supports were instrumental in many youths' journeys in conjunction with therapy/counselling sessions, at a time facilitated through their GP/NP office. Participants saw a Social Worker (though their GP office), child and adolescent mental health services, or Employee Assistance Program (EAP) at some point in their mental health journey. All youth who were able to access EAP did so through their parent's health benefits from their employer. This led to

counselling sessions in person, in downtown Sydney. It is notable that only one youth noted going to the emergency department to receive mental health care. As discussed in previous literature review, often the first contact for mental health services is the emergency room, and not a family doctor (Cloutier et al., 2017). In my study, youth were more likely to talk to their family doctor, or nurse practitioner, regarding mental health concerns than presenting to the emergency department. Youth may not be inclined to present to the emergency department in Sydney as unfortunately, Cape Bretoners in general are very aware of the long wait times that exist when going to the emergency room at the Cape Breton Regional Hospital. The wait times youth may feel they will face at the emergency department may be a deterrent to seeking emergency mental health care.

One participant believed that their doctor was one of their greatest supports, although the participant had seen multiple other services. It is important to note that the participant appreciated their doctor's time and compassion, being cognizant that their doctor was often busy. One youth, as quoted above, appreciated their doctor being able to sit down and talk, asking about how they are doing, if their medications were working, all showing that they truly cared about the participant's well-being. The doctor's caring approach towards the participant made them feel supported and cared for in a time of need. Another participant, also quoted above, had the courage and strength in their recovery to start their journey towards sobriety. This youth decided to attend Alcoholics Anonymous, which has come to be the largest support in the youth's life. The relationships that this youth had formed with those who also had a history of harmful use of substances brought the feeling of love, relatability, comfort, and safety. The youth's

ability to connect with others who, like them, were presumably seeking support, and acceptance in a society where there is not always a safe space for those with substance misuse issues, brought strong bonded relationships and a safe and loving environment. This is one of many examples of the life world's relationality and spatiality in relation to the theme supportive relationships.

Peer Support

Although most participants did not seek out *formal (*trained workers within an organization) peer support services, they discussed receiving *informal* peer support from their friends who had lived experiences with mental health problems. This led to increased relatability, understanding and acceptance within peer groups.

> I would say it was just like that thing before, and I didn't really say anything… like now a certain amount of my friends know cuz like they have mental health issues too, and like they understand more than other people who don't have the same experience with mental health… but like my friends now, like I can just like tell them whatever. They make me feel comfortable (Participant 6).

This participant continued on to say:

> …there's a handful of my friends, who like, I don't want to say that they don't have real mental health struggles, I don't know about them… so like the ones that do, if they do seek counselling, they're on meds and they were diagnosed, so like I'm more apt to talk to them because they better understand (Participant 6).

One participant received peer support from their dance company. This youth was the youngest dancer in the company and benefited from one hour check ins with company members to share feelings and provide support to other members. This youth, as the

youngest member, felt respected, and felt an aspect of relatability to the other dancers who had similar live experiences.

> Just a group of people that will respect you. Um cuz like the dance studio that I'm at right now… it's 12 of us and it's like a company, and I'm the youngest 17 and the oldest is 29 …so it's like respecting everyone's opinions no matter if they're old and like understanding and not judging I guess (Participant 8).

The participant continued on to say:

> ... most of them actually went through a similar experience and I feel most comfortable talking to them because they're older and know more… so I like talking to them (Participant 8).

In recent years, there has been an increase in trained peer support workers, with lived experiences, working within health care systems with consumers of mental health services. As discussed in a 2017 study, peer support workers have been integrated into health care systems to positively affect mental health outcomes in areas such as hope, communication, and mental health programing (Thomas and Salzer, 2017). These services have been found to be just as effective as professional services. Peer services could possibly be more effective on improving outcomes, hope, and quality of life (Bellamy et al, 2017). Due to their shared experiences, peer support workers serve as excellent role models, and are thus able to support consumers through treatment, assist with accessing services within the community, and share a relatability that has been associated with positive outcomes (Chinman et al. 2008; Gidugu et al, 2015). Further, research has suggested that providers of mental health services, with lived experiences of mental health problems have more "positive therapeutic relationships" with patients

leading to increased empathy and a decrease in stigmatization from the health care provider (Thimas and Salzer, 2017). One participant in the current study had this experience with a psychiatrist who had similar experiences to the participant. This relatability created a safe space, and increased acceptance and hopefulness in recovery for the participant. "It was good [service]. He told me stuff, like he actually had it himself before too. So, it was nice to know that someone else had it and I'm not the only one. He had it for 15 years he said and then he said it went away" (Participant 10).

Peer support for the youth participants brought about feelings of acceptance, hopefulness, and relatability to their peers and, in one case, their care providers. This relatability leads to the feeling of safety in spaces with those who are accepting and supportive of the participant's diagnosis. This could, as noted from the aforementioned literature, increase positive outcomes for treatment, hopefulness and self-determination. Receiving peer support also could increase the participant's level of self-confidence which, as discussed previously, was a large issue for youth in my study. Although youth often received support from peers who had similar lived experiences with mental health problems, only one youth discussed a formal aspect of peer support. Youth should have access to services that provide *formal* peer support especially in rural areas where a lack of services and stigmatization exists.

Supportive relationships are imperative for youth in general, and particularly for youth who struggle with mental health concerns in a time of great vulnerability. From friends to general practitioners, counsellors, or community supports such as AA, youth reach out in a time of need to many different resources with the hope of building a supportive, caring and safe relationship with others.

Negative Internalized Feelings

Youth participants felt internal reactions regarding their lived experiences with mental health problems. Most notably, participants had internalized feelings of guilt, fear of stigmatization from others, and a general lack of self-confidence, as result of their mental health. These examples make up the three subthemes of the overarching theme, Negative Internalized Feelings.

Guilt

Many youths felt guilt about causing strain or worry for others, such as family members or friends. Youth reported not wanting parents to believe that their mental health problems were their fault, or that they did something wrong when raising their child that led the child to internally conceal their true feelings, or thoughts. Youth also noted emotional reactions such as feeling angry with themselves as they felt unable to control their emotions and arguments with family members. One participant reported:

> I felt like it was my fault that I was losing people, and arguing with people even though I couldn't really control how I felt because I was so angry with myself because I couldn't… didn't really understand …why am I suffering? (Participant 3)

Another youth noted feeling "hate" towards themselves. This youth stated:

> "Sometimes I hate myself. I want to be good for my grandparents, but I also want to do what I want to do. And I don't want to disappoint anyone. I don't know" (Participant 9).

Participants felt guilt for having lost time at school due to mental health problems, and for some youth, for leaving post-secondary education due to lack of motivation. This exit from school led to guilt and disappointment in self. One participant recalled:

> *"*When it started, I lost a lot of motivation… like my marks at school went right down and that was happening for a little bit, and then I was tired and just like not myself I guess*"* (Participant 8).

Youth also discussed believing that relationships or certain circumstances in life could have been different if not for their mental health problems, leading to internalized guilt; however, circumstances were beyond their own control.

> Um it made me feel really bad about myself… like I said before, I felt that if I didn't suffer from this stuff that my relationships could have went differently, or like my friendships whatever …or maybe I could avoid a fight with my parents as much as I did, or things like that, but I couldn't… I didn't know at the time that I was suffering from this, because I feel like when I was growing, it was not really common… like I only got diagnosed when I was 19 officially." *(*Participant 4)

Additionally, some youth worried about friends not fully understanding a participant's mental health which, in turn, lead to feeling guilty about not always wanting to spend time with them, which at times lead to loss of friendships. One youth noted a strained relationship with boyfriend and family, leading to guilty thoughts and feeling "like a bad person":

> People just got really confused as to why, like I wasn't showing up, or they thought I didn't want to be friends. They thought I was a really shitty friend and it caused a lot tension between my relationship with my boyfriend. We were only together a year before I started having mental health issues, so I was always scared that he was going to leave me, or I was going to fall out of

> love, or losing him so I always felt like I was a really bad person… so it affected all of our time together… so every conversation was about my mental and it was a constant strain, but like I'm still with the same person… so 3 years later we're doing really good. At first, I think it just made things really hard and my parents really worried *(*Participant 2).

Literature suggests that individuals with mental illness and who believe that their illness is genetically based, may have an "irrational sense of implicit guilt", as their illness is seen as a fundamental trait and could cause the individual to see their illness as part of their identity (Rusch, et al., 2010, p.331). These negative views of the self could cause an individual to "suffer in silence" in effort to protect themselves from others viewing them as "crazy" (Church et al., 2020, p. 2). Further, guilt is related to other issues such as stereotypes, stigma and discrimination which leads to barriers when accessing mental health services (Church, 2010). All lifeworlds (relationality, spatiality, corporeality, temporality) are prominent in the subtheme "guilt" and, as previously discussed, are interconnected, as lifeworlds cannot truly be separated from each other. Youth's relationships with others, as we have seen in previous themes, are at times strained due to youth's mental health concerns. For example, relationships may become strained by a change in time spent with friends, or the youth feeling as though they have become a disappointment within their family unit. The change in relationships over time can cause unsupportive and uncomfortable spaces for youth in which to be present and grow. Guilt, for most youth, was an internal negative feeling which they felt throughout their mental health journey. This subsequently demonstrates the lifeworld, corporeality. Youth hold this guilt internally, often concealing this emotion within their bodies. This

causes family and friends to be unaware of how youth feel, ultimately perpetuating strained relationships. Consequently, it is important that families, friends, and other supportive relationships of those with mental illness or mental health problems, are aware of the internalized negative feelings that individuals may have about their own illness or concerns and the precipitating changes that youth may face in their relationships, and in their daily lives.

Fear of Stigmatization

Stigmatization was a prominent fear of youth participants interviewed as part of this study. They had fears of being stigmatized by others, whether that be by their family, their friends or within the communities in which they live. One youth reported believing that everyone in their small community knew they had a mental health problem:

> Um I just seen how bad it is in Cape Breton… like how um hard it is to have a mental health issue especially where I'm from… it's such a small area that like everyone like knows when something is wrong, like it's not a secret (Participant 7).

Youth also felt that there was a lack of support in their communities due to the lack of awareness by society regarding mental health. One youth identified that schools run campaigns regarding prevention of physical health problems, such as a flu shot campaign during flu season; however, this youth noted that there are never any campaigns that focus on checking in with your mental health. This youth used the term "secret" as well when referring to mental health, noting that mental health is a secret due to a lack of conversations around mental health on the island.

> There's little to no talk about mental health in Cape Breton. Like you see signs all around the school like 'Did you get your flu shot?' But nobody ever has a sign

that says ‘Have you checked in about your mental health lately?’ What’s the point of being physically healthy if you don’t have good mental health? I don’t think it’s talked about enough. I think there’s less of a stigma, but I feel like it feels like a secret. Like everybody has mental health but I don’t understand why people don’t learn to identify with that more (Participant 2).

One youth reported feeling uncomfortable in group therapy, leading to feelings of vulnerability:

I never really liked it. I felt vulnerable and I felt like if people knew me, I didn't like the idea of that. That made me really anxious but it was nice to know that there were other people like me so that made me feel good, but I didn't like the idea of people seeing my face and stuff like that, so it made me feel awkward and vulnerable (Participant 4).

This youth also feared that without being on medication it would lead to an illegitimacy of their illness. The youth noted that the stigmatization they felt affected their personal life, in terms of how they acted around others. This youth noted that over time, they became more comfortable talking to others about their mental health as the conversation about mental illness became more common in everyday life:

I feel like in my confidence, and stuff like that, I feel like up until this year when I would go to school and professors would make you write out that information sheet, I never felt obligated to tell them that. Because I felt that if you weren't on medication for it then it wasn't important… which was a crappy feeling because there are some people who can't afford medication, or too scared to talk to their doctor about it, or scared what they would do, or

> something like that …so I feel like I never really brought it up to a lot of people. I find now that I'm more open about it, only to people I'm really close with. It's ok cuz it's more common now and it's ok to have that so like… I feel like… I just recently told a professor about it the other day and she was like that's ok and if you need someone to talk to... and my parents are like that, and my friends are like that now, but I feel there is definitively stigmatization that affects your personal life and how you act and stuff like that (Participant 4).

Finally, this youth discussed the fear of going to counselling in a building in which there are also addiction services offices. The youth was worried that someone they knew may see them going into the building and assume they were seeking treatment for drug use.

> I was really awkward at first to even go to the office. I didn't like the idea of people seeing me walk from the car to like here… because I said to my mom 'the sign said addiction services' and I said mom 'they're going to think I'm addicted to drugs', but she said 'but you're not though' (Participant 4).

The importance of the language used within spaces in which youth seek care is paramount. Youth did not want to be labeled due to seeking care for mental health problems, and had genuine fears surrounding being labeled or stigmatized by those who may see, or learn, that they are accessing services.

Although society has made significant advances regarding de-stigmatizing mental health disorders and mental illness in the last number of years, youth noted negative experiences from opening up about their mental health to others. These past negative

experiences largely dictated who youth were willing to talk to about their mental health problems at present and who they are willing to talk to in the future. These temporal effects undoubtedly play a role in continuity of care for youth in Cape Breton, which will be expanded on in coming sections of this chapter. In addition, youth often noted that the small size of the communities in which they live affected their comfort levels with seeking services or support as they believed that there is lack of confidentiality within the tight knit communities. One youth, as reported above, discussed feeling uncomfortable at group therapy. This type of therapy in a small town caused feelings of vulnerability and led to the fear of knowing others at the sessions, or others knowing what they looked like, and the fear of others knowing that they needed treatment for a mental health concern. Group therapy for this youth is an excellent example of how spatiality affects youth and their treatment outcomes. This youth determined that group therapy did not feel like a comfortable environment in which to be. However, later they found that one-on-one in person therapy with a trusted therapist was what was best for them. It was what made them feel safe and comfortable in the space, leading to better patient outcomes.

There is little research regarding mental illness and stigmatization in rural communities (Schroeder, et al., 2020). Literature suggests that stigma is a large barrier in rural communities due to a general lack of anonymity and, in turn, the fear of being given a negative label (Rost, et al., 1993). A 1993 study found that high levels of stigma are directly related to lower levels of treatment in rural communities, due to low levels of mental health literacy (Rost et al). However, this study found that rural culture does not automatically attach stigma to mental health when compared to urban areas; however, rural area stigma tends to be a “stronger deterrent to seeking treatment” due to the tight

society network in rural communities (Rost, et al., 1993, p.61). Rural living individuals believe that they will be stigmatized by everyone they know rather than just a few individuals in an urban setting (Rost, et al., 1993). A 2020 study of Cape Breton youth also found that stigma was a prominent barrier for youth (Church et al., 2020). Youth had fear of gossip, social exclusion, fear of shaming their family, and fear of stigma from their friends (Church, 2020). The current study participants had similar fears of individuals in their community knowing about their mental health problem and treatment, as noted in the above quotes. This finding demonstrates how this fear of stigmatization affects youths' relationships with others, with themselves, and also affects how comfortable they feel within spaces in their communities (relationality, spatiality, corporeality). Youth believing that the entire community knows about their mental health problem may cause strained relationships with others, possibly leading to over time, feelings of lack of social support and social isolation (temporality).

Lack of Self-Confidence

Many youths when asked about their perceived self-confidence noted challenges with their confidence levels and self-esteem due to a multitude of contributing factors such as uncomfortable social environments, social media/societal expectations, bullying, and negative past relationships (relationality). One youth noted a decline in academic performance due to their mental health problem, which caused the participant to change the way they saw themselves, leading to internal feelings of failure and self-doubt.

> I had to drop two classes last winter, so I went from a full course load to three classes and even then, I didn't go to any so like I got like 50s which really… it did affect my self-esteem and how I saw myself …and then I thought I was going to

be behind graduating and then I felt like what's the point. I didn't want to take longer to graduate because of this but like yeah, I don't know (Participant 3).

Other participants noted feeling anxious in social environments. One participant felt self-conscious in restaurants, due to fear of comments being made about the size of their meal, as the participant was recovering from an eating disorder.

> When it comes to eating in public, though, like I hate going to restaurants with people that I've just met because I don't like the idea of like eating in front of someone, I don't know …because I'm scared they're going to comment on how little I'm eating, or I don't know, I guess I'm nervous about that, so that still affects me. (Participant 3)

Another youth discussed a feeling of *not being enough*, and experiencing social anxiety that caused low self-esteem and self-doubt:

> Absolutely drained. I'd say it started probably two years ago it was definitely not as severe, but I felt it was this thing where it was almost like …you know I kind of had these feelings of that I wasn't going to be enough… I would perform poorly in social situations so that lead to a lot of self-doubt, and it kind of snowballed and got worse. It was a vicious cycle where the more I thought about it, the more it just started to feed into that belief and eventually it, ah you know, it kind of culminated into what it was say a month ago (Participant 5).

One youth was affected by social media posts, at times when they were unable to participate in social events with their friends due to poor mental health:

> Not good [self-confidence]. Yeah, for a while I just felt really crappy about myself because I would see everyone posting fun pictures because they were

> out on the weekend, and I was in my room… but I know I have the option to go out, but I physically can't make myself go, even if I tried. That's not a nice feeling (Participant 4).

Participants noted social media affecting their self-confidence and negatively comparing self to peers seen on social media, a common problem in today's world. One youth noted they believed that it was not necessarily social media but society's unattainable standards, often reinforced by social media posts, which further caused low self-confidence levels. "I feel that smartphones are not the problems, but I mean they caused a lot of the body image issues that I have, but it's not the phone's fault, it's society" (Participant 3). A 2016 study found that social media use, specifically nighttime social media use, is associated with increased depression and anxiety as well as low self-esteem and self-worth (Woods and Scott, 2016). Similarly, a 2018 study (Kelly, et al., 2018) found an association between social media use and depressive symptoms and an association between social media and body image. Further, individuals who used social media for more than 5 hours a day were more likely to be dissatisfied with body weight.

Youth noted all lifeworlds to have been affected by a general lack of self-confidence. Literature suggests that youth with high self-esteem have more positive mental health outcomes, coping skills and decreased levels of depression (Puskar et al, 2010). Most youth in my study noted a temporal decline in self confidence after the emergence of their mental health problem; however, some youth noted that they have never had a high self confidence level. Social settings (spatiality) for many participants were anxiety provoking. In addition to a lack of self confidence in social settings, participants noted that mental health problems in general caused a lack of self-confidence

internally due to changes in daily activities such as sports or attendance at school, and in turn, their grades. These changes often lead to an internal struggle with self which manifested as frustration, anger, and self-doubt (corporeality). Social media also had a negative effect on some participants' self-confidence, noting that social media often causes feelings of anxiety and negative comparisons to others.

Internalized negative feelings, as depicted by the subthemes above, caused many changes in the participants lifeworld. Over time, how youth were feeling internally about themselves, and their environment, greatly impacted how youth thought about themselves, their relationship with those surrounding them, and how they carried themselves within society.

Service Gaps

Multiple gaps within the health care system were identified by youth participants. Three sub- themes emerged from the data*: Lack of youth specific supports, Lack of trust in the healthcare system, and need for mental health education: youth and guardians.* Youth generally were frustrated with the mental health care system, and overall believed that the system and the limited support and services were not meeting the needs of youth in Cape Breton. Youth often reported being distrustful of the system itself and of health care professionals working within the healthcare system. Youth identified many areas in which they required support for their mental health but generally had a knowledge gap regarding services and support availability, and how to begin to access services. Therefore, they often required support to begin the process. Additionally, some youth believed their parents or guardians also needed increased mental health literacy. The following section describes these experiences and explores existing literature regarding these subthemes.

Lack of Youth Specific Support

As discussed previously in the literature review, there is a general lack of mental health services in Canada for youth and even more so in rural or underserved areas. Therefore, it was not a surprise that youth identified a general lack of support for youth on Cape Breton Island. Youth believe that more preventative measures should be taken on Cape Breton, as at present, youth think crisis intervention is being used in place of mental health promotion and prevention.

> If I think of my previous experiences, it makes you realize there is little to none. We have the highest age population in Nova Scotia. It's like 47.5 or 48 in Cape Breton median age so I feel like a lot of the stuff isn't geared toward younger audiences. From my experience, there is little to none, and you have to have a family doctor and you need to wait 2 years to see a psychiatrist or psychologist. What if you have to wait 2 years to see somebody and you're struggling with your mental health? Do you think in 2 years you will be capable? It doesn't make any sense to survive on your own without getting help (Participant 2).

This participant proceeded to note:

> We just use our crisis like material measure for everything, so you don't get identified even when you're in the beginning stages of struggling with your mental health… but when you are not in crisis yet, but still struggling, we don't have the resources for that. If we had more preventative measures, we would save the healthcare authority money. If you had preventive measures, it would stop you using the crisis resources. I just don't understand why we don't have more of that and in the past four or five months we have four young people kill themselves and that was just the

> past 4 or 5 months. I don't get how people don't see that's a problem. When I know so many people from high school that have died, it's not normal. I just think it's awful. (Participant 2)

As previously mentioned in the above quote from a youth participant, wait times have become a great deterrent for youth to seek formal mental health services. Many youths expressed frustration regarding the long wait times in Cape Breton. As previously mentioned in the literature review, current wait times for non-urgent adolescent mental health services are 197 days and for non-urgent adult services current wait times are 217 days in CBRM (Government of Nova Scotia, 2021). Youth describe these feelings in the following quotes:

> I think just it was the wait times, like being afraid of the wait times, that's why I waited so long after adolescent [services] cuz I knew like you see it everywhere in the news like Cape Breton has the like the highest wait list for mental health services… so like that was definitely holding me back… it would be a huge wait like 400 days just to have an intake appointment. I had no idea there was a social worker in the doctor's office… so that would be, that holds a lot of people back (Participant 6)

Another participant also noted a general frustration regarding wait times:

> …but there's a wait list for everything. I remember I called up for a therapist from [service] and it took almost, I want to say 15 months it must have took. Like it was a long time. I remember I was 15, so I was just about turning 17 when I got an appointment. It was crazy like by that time I don't know it was just such a weird time in my life, cuz like I had the appointment before I left home… and

> then I left home and my whole life flipped upside down and there was nothing I probably needed more at that time was to talk to someone… but it just – back then I remember it was crazy you couldn't talk to anyone (Participant 1).

Youth also noted that without easy access to publicly funded services, many choose to use private services. However, youth identified that without health benefits, private mental health services can be costly, making these services inaccessible to some youth. This is especially true in areas such as Cape Breton where high poverty rates exist. Issues surrounding insurance in rural areas is a common trend in the literature (Hauenstein, et al. 2006; Robinson et al., 2017). Youth also noted that only a certain number of sessions are covered by their parents' health benefits. One youth noted the need for rationing therapy sessions in case a time came later in the year when the youth was in need of treatment again.

> I feel like there's little to no resources in Cape Breton. I think that's why people and youth struggle because you have to wait over 2 years to see a psychiatrist. If you want to apply through the hospital, or if you want to go see a private, that's like $150 per hour and so many people in Cape Breton don't have it because they're under the poverty line (Participant 2).

Another youth revealed that their boyfriend was unable to access mental health services due to the high cost of therapy sessions. This youth also noted a lack of mental health literacy surrounding where, and how, to book appointments with mental health clinicians; a large issue that has been identified by Cape Breton youth throughout my study, and will be discussed further within this theme.

> …a year or two ago I would not know where to start to even try to get help. Like if it was just me on my own, cuz I know like my boyfriend he's… the last month he's been having a few problems with drinking and stuff like that. It's kind of bad and I was trying to get him help and he's like how? And I'm like, I actually don't know how to reach out to a therapist and getting an appointment. So I feel it's not talked about enough and also like it's like way too expensive if you don't have insurance. He's not going cuz he can't spend $100 on an appointment. He works at [restaurant] so (Participant 8).

Along with the challenges of accessing services due to a lack of availability and long wait times, youth identified that transportation to services was another large issue, especially for youth living in more rural areas who need to seek support in Sydney. Travel into Sydney can range from 15 minutes, up to two hours, from rural communities. These times are based on good weather, and due to the harsh winters in Cape Breton, at times travel to Sydney from rural communities is not an option because of poor weather conditions. One youth noted that talking to a guidance counsellor in high school was convenient as no travel was necessary. However, this youth subsequently had trouble accessing services outside of school due to a general lack of knowledge surrounding how to make an appointment with a psychiatrist, and issues with transportation to and from appointments.

> Um yes because I would have to... like in high school it was easier to get access cuz you could just meet them there once a week, or twice a week… but now that I'm living on my own, I don't have a vehicle and I can't like afford to get cabs there …or and like, I don't know how even to make an

> appointment with a psychiatrist it would take a very long time. I just feel like it wouldn't be worth it (Participant 7).

Another youth grew up in a more rural area and also identified transportation to services as an issue in Cape Breton, as well as a lack of knowledge about services in other areas of the island.

> Kids in rural areas they might not have transportation to Sydney to see like adolescent mental health. It should be in more communities, not just Sydney based. Like I grew up in [rural community] so we didn't even know there was a boys and girls club …so anything you did... so any kids that live on the outskirts they don't know about it. They can't access what they don't know about (Participant 6).

Youth also reported that it took trial and error to find the right counsellor, or therapist, once services became available to them (i.e., getting off a waitlist). Some youth participants had seen upwards of 5 counselors before finding a healthcare professional to whom they were comfortable opening up. It is important to note that the following quotes are from youth who had access to private counselling.

> I would say between 12 and 14 [age of counselling]. So, I would go there and I just hated my life from the time I sat in the office. The whole time I was in the office, to the time I was leaving, I would cry when I got in the car. They should have something more that they can do to find a way to connect you with someone for you to get along with. Maybe do a trial session before you get into it. Like [name] was really good with certain aspects but really bad with certain

other aspects and [name] was good with some and bad with other. So, I feel like it did benefit me but some stuff almost made me over think stuff (Participant 4).

This participant also noted:

> I don't know what needs to be put in place but there should be more… I don't know if interviews with counsellors before you actually go to see them… to see like how you feel with them because there's nothing worse than going to talk to someone you don't like. I would cry the whole time, and I would get frustrated cuz they would say something I didn't want to hear and I would get more overwhelmed… so, I feel there needs to be more options. It's very limited around here. Maybe it's because it's such a small place (Participant 4).

Another youth participant discussed seeking publicly funded services. This youth spent time with one particular clinician during an initial session, then unfortunately was informed of another clinical taking over for a maternity leave. This frustrated the youth as this information came as a surprise for the youth and involved having to open up, likely about previously discussed topics, to a new clinician at the next appointment.

> Yeah, child and adolescent were good. I liked them I think they can do a little more. Maybe not like, like the thing that gets me is how they just like get me to open up for an hour and a half and her go on maternity leave …cuz it's hard enough, like I don't have trouble opening up to like a trusted professional, but other people it may be hard for them to open up to one person… for them to say 'ok, I'm not going to see you again for the next year'. So, I think they could be more like aware of that, but otherwise I know it can take like a year and a half to get in… but I was fortunate enough to get in in a reasonable amount of time, so I was lucky to have that chance… but I think they can be way better (Participant 6).

Access to a therapist, with whom a youth is able to have a comfortable and safe therapeutic relationship, is invaluable. It is important to note that youth participants who felt supported and comfortable with their therapist, or counsellor, and who felt safe in their physical space described their therapist interactions in a positive light. For example, one participant reported their experience with private therapy as "really great, really helpful and quick and overall, really positive" (Participant 5).

Finally, many youths identified the need for more mental health services within the school system. Participants reported a lack of services in junior. high schools and long wait times in high school to see a School Health Nurse. One participant reported:

> I feel like having more in schools would be beneficial because we didn't even have a health centre in the junior highs in Cape Breton. There was in high school and the amount of people that would make appointments to try to see a nurse or anyone just to talk was ridiculous. If we had educational psychologists, literally anyone just to have in schools …I think they think that junior high is too young, and they don't need it, but a guidance can't do the same thing. I told a guidance counsellor in junior high that I failed a test and I felt like so overwhelmed and worthless and stuff and she said "you just got to say 'oh well you can be the Oh Well Girl". I was like 'well it was nice talking to you' [laughing] but I feel like if there was someone there that specializes in mental health that we wouldn't have the crisis that we have now (Participant 3).

One youth discussed the local university as having only one counselor for a large student population. This youth thought they could not rely on this service and believed it was

inappropriate for the university to only have one counsellor, especially for the age group of those attending university.

> Yeah, I really didn't enjoy the counsellor here at [university] and it really makes me sad because like one in five Canadians have mental health issues and only 1 in 4 ever get treatment or help. Like I'm at the prime age to be affected by mental illness and having one full time counsellor is so inappropriate and so unreliable (Participant 2).

Youth remarked that many services are not youth specific and tend to focus on adult care and, therefore are not meeting the needs of youth on the island. Many youths identified lengthy wait times as being a deterrent to receiving care, leading to hopelessness and frustration with the healthcare system as youth believed that needs are not being met. Literature suggests that rural living residents are more likely to receive inadequate mental health treatment (Hauenstein, et al. 2006). The lack of availability, and access to, mental health care over time affects youth's lifeworld. A lack of mental health care treatment may affect youth's perception of their physical surroundings where they may feel unsupported and misunderstood, in turn, affecting youths' relationships with others. A lack of mental health care also affects youths' relationship with themselves, as youth reported many changes in their daily lives such as confidence levels and self-stigma. Temporarily, if there is no change in sufficient service availability and access, youth will continue to have poor mental health outcomes due to insufficient treatment in underserved and rural areas, a common theme in the literature (Hauenstein, et al. 2006).

Youth also discussed feeling frustrated with finding the correct therapist or counsellor, noting that this took many youth multiple attempts to find someone with

whom they were comfortable. Literature suggests that patients often discontinue therapy sessions if they are not satisfied with their therapist or their provided treatment (McCarthy and Frieze, 1999). This is a risk, as those who terminate therapy sessions, often give up on seeking out another therapist or form of treatment, leading to an ongoing, untreated mental health problem. Further, Randomized Control Trials have found that 35-40% of patients see no benefit from psychotherapy and 5-10% actually deteriorate (Lambert 2007). It is imperative that individuals find the correct therapist, best practice, and effective treatment methods be used specific to address the individual's mental health concern.

With regards to aforementioned school-based services, there are not only educational but also emotional and social benefits to school based mental health services (Kardin, et al., 2018). School based services have been found to overcome barriers such as confidentiality, fear of parents being notified by insurance companies of prescriptions, and transportation issues (Kardin, et al., 2018). School based services, although well supported in the literature, have shortcomings such as a lack of school based mental health professionals (Reinke

et al., 2011; van Vulpen, et al., 2018). In addition, school-based services are not available to all students, often only offered to students who are receiving "special education services" leading to a lack of access and availability for students who need mental health assessment, referral, or treatment (Weist, et al., p. 45, 2006; van Vulpen, et al., 2018). This could be an issue in CBRM, as school-based programming *does* exist within the school system; however, youth participants in the current study believed that the existing services were lacking. This is possibly because school-based services are being offered to

higher risk students, or these services are not being advertised to all students. The need for additional mental health education and advertising of services will be discussed in the coming subtheme: need for mental health education- youth and guardians.

Lack of Trust in the Health Care System

Youth participants in this study discussed a general lack of trust in the health care system regarding their mental health problems. One participant discussed feeling uncomfortable accessing professional services for their mental health problem. This participant noted wanting to feel "comfort, empathy, love and respect" from their health care professional (HCP) in their time of need:

> Sometimes it's not that cut and dry. Sometimes you don't need to talk to someone who knows it all. Sometimes you just want to talk to someone who you know at the end of the day knows you and cares about you. If you are hungry you could say 'hey I need ten bucks' or 'do you want me to go buy a couple of things'....You know what I mean, there just needs to be comfort, empathy, love and respect. Something that you *want* to go to, not something that's going to be uncomfortable (Participant 1)

Other youth discussed that a fear of negative reactions from their HCP led to an avoidance of seeking treatment. This youth worried about being told that they are a "shitty person" and will downplay their diagnosis. This youth also noted long wait times being a deterrent to seeking care:

> I want to go a counsellor, or psychiatrist, but I know that you have to wait over two years in Cape Breton to get in to see a psychologist or psychiatrist. It's a huge list and sometimes I'm scared when I go they're just going to tell me that my anxious thoughts are really …and that I am a shitty person …but that's just my

anxiety. I think that I would go if the time was not so long of a wait (participant 2)

Youth expressed frustration surrounding HCP "shutting down" youth and feeling as though they were one in a long list of youth who needed to be seen. This participant felt as though interventions were not being individualized which was affecting outcomes:

> I don't want to use the word 'useless' because people have benefited from them… but for me however, I found a lot of the services unprofessional and questionable. I feel like they don't take younger youth as serious, and I get that… I mean if kids aren't sleeping that it will affect them, but their go to is always like 'why don't you go to bed at 9:00?' And I'm like it's not going to stop me from killing myself in the morning. Like when I was bulimic, I told the one that my family doctor referred me to, I think she was a clinical social worker, and she looked right in the eye and said "well do you think that's really going to do anything?" I'm like, are you allowed to shut it down like that? (Participant 3)

This youth continued on to note:

> I feel like a lot of people that I talk to, especially male social workers, they were very like… obviously they were serious, but they were very like reserved and they just like …it honestly seemed like they were looking at it like you were just, I don't know how to put it in words… Like it was just like they were going through a long line of people. Like "ok next, ok what's wrong with you? ok have you tried sleeping? Ok next, have you tried getting outside, eat more vegetables?" It was like going through a line up and scream something at you to cure you… but they didn't get to the root of anything. I feel like going more in-

depth with patients and try to analyze and identify where it started could help with the outcome (Participant 3).

Youth also feared that they would say something wrong to their counsellor that would lead to an admission to inpatient psychiatry. One youth noted that it was their parents who made them believe this may happen and they should "watch what they say." This misinformation is embedded in the stigma that surrounds mental health on the island, and a possible fear that their child may be admitted to the hospital.

> I was scared if I was like feeling really sad, and if I was to say something, I was afraid they would put me in the mental ward. At first, that's what I thought. My parents would say 'you better watch what you say when you go in there'. I'm like, 'don't say that to me cuz that makes me more anxious' (participant 4).

Finally, rurality also had an effect on youth feeling mistrustful of the health care system. One participant noted living in a small area leading to fear of others finding out about their mental health problems: "Um jus

t I'm scared to be judged [when accessing services] and I'm scared like because Cape Breton is such a small area… like you can't…I don't know, it's hard to trust people" (Participant 7). When asked if the youth thought it would be easier to access services in their hometown, a very rural part of Cape Breton, instead of Sydney, where the youth currently resided, the youth replied: "No, because they are not like… he's like we had the same doctor since the 60s, like he's ancient and he's not someone who I would talk about my problems with, cuz he's my family doctor" (Participant 7). The youth continued to note:

> Um I just seen how bad it is in Cape Breton… like how um hard it is to have a mental health issue especially where I'm from… it's such a small area that like everyone, like knows when something is wrong… like it's not a secret and I think like ah growing up with my brothers, it was really hard cuz they were both very …like they go manic and they… you know and um, I wouldn't know, like how to cope with it I guess… and grew up around mental health issues all my life, so I wouldn't want to go see a family doctor because of that, if that makes sense. Like I want to talk to someone, I just don't know who (participant 7).

This youth also discussed not feeling as though talking to their family doctor (GP) was adequate mental health care. Similar findings were reported by Ray and colleagues (Ray et al., 2014) noting that rural youth report a perceived lack of confidentiality in health care due to services being delivered by only one provider. Literature suggests that a lack of trust may stem from the perception that primary health care providers are insufficiently prepared to provide mental health care (Hardin, et al., 2018). However, rural areas also face a lack of specialized youth services, again leading to mistrust and decreased use of the healthcare system as specialized services are not available (Ray, et al., 2014).

Research has found that youth's general lack of trust to be the reason for not using the health care system for mental health related problems (Majumder, et al., 2014). Lack of treatment adherence, for counselling sessions or a medication regime, also can be traced back to a lack of trust in health care providers (Bauer et al., 2014). A 2018 study found that transportation to, and from, appointments with HCP predicted the level of trust in the professional among rural living youth (Hardin, et al., 2018). Rural youth who had

transport difficulties to, and from, appointments with HCP had lower levels of trust than youth who had reported no transport issues to and from appointments (Hardin, et al., 2018). Transport for some youth in my study was an issue, due to poor public transportation. Further, as discussed previously, rural living youth are two times more likely to have a successful suicide attempt than urban dwelling youth. This suggests that depressive symptoms are significantly more problematic among rural living youth (Hardin, et al., 2020). It is imperative that approaches are found to build trust and ensure timely interventions for youth living in rural areas regarding the care they receive from rural health care services for all mental health problems.

Lack of trust of the health care system in Cape Breton has been identified as a large gap in the continuity of care for youth on the island. Youth fear HCP reactions and, unfortunately, feel misunderstood by those attempting to provide care leading to negative relationships between provider and patient, and in turn, not being provided with a safe and comforting space for care (relationality/spatiality). Negative past personal experiences, and experiences of others, have determined whether youth will attempt to access care when needed, a worrisome issue especially when taking aforementioned statistics of rural suicide into consideration (temporality). Youth in Cape Breton deserve to feel trust, support, and receive high levels of confidentiality from the health care system; however, participants do not believe this is being delivered to youth on the island. As a healthcare provider, I acknowledge that those providing care are most definitely highly trained and educated individuals who are only able to provide services with the resources being provided by the government. I also acknowledge as a health care provider, this is not enough, and strongly feel the need to listen to first voice

recommendations. It is of utmost importance that increased funding is provided to youth mental health services and commitment to address this issue is needed to assist and support our next generation on the island.

Need for Education: Youth and Parents/Guardians

Youth participants believed there was a need for more open discussions about mental health on the island to normalize mental health problems. Further, youth participants believed that they needed more education surrounding mental health and mental health disorders and gave some valuable insight into ways that this should be accomplished on the island. The following quotes illustrate youths' concerns about the lack of education for youth and adults and discuss the need for parental education and assistance when seeking mental health services and normalizing conversations surrounding mental health problems.

> Knowing that there is stuff out there that you can go to would make it easier. I think they should talk about it in elementary and junior high, especially before it gets to a certain point in high school. I think it makes it harder because… like it's really stigmatized by some people, especially people of older parents, or like they're raised by their grandparents… like they're stuck in the mind set like there's nothing wrong with you. You don't have to take a pill to be happy. If kids hear that, they're not going to want to take a pill every day. I think if it's talked about more, or open minded, it would be easier for people to reach out and get services, they don't even know they need (participant 6).

Additionally, youth reported:

> I think in terms of making it [services/supports] hard to access, well there's a couple of things, 1: There's not a whole lot of support options available I find,

> …and those that are, are not really well advertised …and the other thing is that just the population in general, it's kind of a generalization, but a lot of people are older and I feel the whole discussion around mental health in general is just not something that's discussed enough… and so, I think by changing stigma and actually having that discussion, and opening up about mental health issues, and increasing awareness about the resources that are there, I think it would make it easier to access it (Participant 5).

One participant noted the following when asked what could potentially help youth access mental health supports or services. This youth identified that they are not an adult, and they need assistance with identifying and booking treatment.

> Being educated on where you can get them [services/supports]. I feel like me personally sometimes it was like googling where can I go see someone …and now I'm a lot closer with my parents, I can say 'I need to see someone'… cuz I mean, being an adult is hard, I'm not about to find that out on my own. And they never hesitate to help me… but people that are alone, or don't have the parent or guardian figure in their lives… (Participant 3).

Youth discussed feeling that there is a need for more education at a young age, noting they did not believe children and youth are being educated enough about mental health in general, leading to misconceptions about mental health problems and mental illness:

> "No, I don't think they're meeting the needs at all. I don't think that like I don't think they talk about it first of all. They should be talking about it at a young age and I feel like it's getting to that point now we are considering mental health more in education but when I was young, they never talked about it. I never knew what

> mental health was, I just thought it meant you were crazy. I think it should be implemented more in school at a younger age and I think there should be more preventative measures. Like in Cape Breton it's all about crisis." (Participant 2).

Youth stressed the importance of increased advertizement of mental health services on Cape Breton Island. Many youths discussed, as noted above, believing that they needed assistance from a parent to find the correct services. Most youth had trouble identifying services for themselves, and were unaware of community-based services that are available. One youth stated: "I find the ones that do exist [community-based programs] around here and I haven't heard of almost any of them. I think they need to be advertized more. I think just increasing awareness is really key" (Participant 5). Youth also noted that they believed a lot of youth may feel nervous to seek out these services as they are not sure what to expect. Many youths believe these feelings might be mitigated by increasing advertizing of the limited, but available, services. This could lead to increased conversations surrounding mental health on the island and, in turn, a decrease in stigmatization.

> I was starting to feel a little overwhelmed again and I wanted to go back through EAP (employee assistance program) because I knew it was covered and I knew they had multiple [counselors] that worked at the company… so I asked around for good names because I had been through two or three of their employees and they were not helpful …but the one I'm seeing now is super great …but I feel like no one knows about these services, or they don't know enough about them. Some people are nervous to go and talk about it because they don't really know what to expect and I feel that if people were educated enough… if there were

> advertizements in any way shape or form would be so much more beneficial (Participant 3).

Another youth noted that they "wouldn't know where to start" when discussing accessing services and support for mental health, and encouraged the use of advertizing services, and an increase in mental health funding.

> I think considering what we have, which is next to nothing, I think that it's great that the mental health professionals and initiatives kind of start up any sort of help, I think it's great and they're doing the best job they can …but really, it's pretty horrible all… in terms of the demand, and actually what we have. I think there definitely needs to be more advertizing and kind of increasing awareness of services that are available because when I started, I knew next to nothing. If it wasn't for my parents or guidance counsellor, I wouldn't know where to start right. I think, in general, there needs to be way more resources and funding and all that good stuff needs to be funnelled into Cape Breton and the whole mental health sector for sure (Participant 5).

As discussed previously, transportation to services is a large issue on the island. Youth noted that more services are needed for youth in communities outside of Sydney, to increase access to those with transportation issues. Youth discussed the issues regarding rural youth not being aware of the services in Sydney, leading to a knowledge gap. Promotion of community-based resources could increase mental health literacy in youth on the island, especially in more rural living youth.

> I think they need like more psychiatrists and psychologists that are actually willing to talk to kids earlier on so that they don't prolong it and then end up

> having to go on medication for however long they need it. There's nothing wrong with medication, but if it can be prevented before it gets to that point, it should be. Kids in rural areas, they might not have transportation to Sydney to see like adolescent mental health. It should be in more communities, not just Sydney based. Like I grew up in [community] so we didn't even know there was a boys and girls club.... So, any kids that live on the outskirts they don't know about it. They can't access what they don't know about (Participant 6).

As illustrated in previous quotes from youth, participants believed that support and services were not adequately promoted to youth leading to youth not knowing where to find services or supports. This finding is consistent with previous studies regarding youth mental health (Church et al., 2020; Francis et al., 2006; Sheffield et al., 2004). It is important to note that youth believed that they did not know how to go about identifying mental health supports or services, or how to book appointments with these services. Many youths noted that they needed assistance from their parents/guardians to find the correct service or support for their needs. This then requires parents and guardians to have an understanding of mental health problems, how to identify when their child needs formal support, or services, and how to identify and access the correct service for their child. Previous studies have found that parents of youth with mental health problems assist their children with identifying supports, treatment adherence, coping skills, money, and transport to services as well as organization of appointments (de Haan et al., 2002; MacDonald, et al., 2005; McCarthy et al., 2008). As Mizzi and colleagues (Mizzi, et al., 2020) have noted, family psychoeducation programs can assist parents to gain insight and acceptance, as well as increase problem solving and communication skills, to learn about

signs and symptoms of mental health disorders, recovery, medications, prevention, and early signs of relapse and coping skills. This consequently increases positive familial support while increasing mental health literacy.

An increase in mental health literacy not only for youth, but parents and guardians, would affect youths' lifeworlds while living on Cape Breton Island. With increased parental support in relation to their child's mental health, relationality would improve: youth would feel an increase in support from their families, positive communication between parent and child would increase, and stigmatization and misconceptions would decrease. With this decrease in misconceptions and stigmatization within the community, one can assume that youth may be more comfortable accessing services, discussing their mental health problems with service providers, and sharing their story with others leading to a more positive, and supportive environment to grow and learn. Increased education may bring about corporeal changes in youth, as youth may view themselves more positively, increasing self confidence levels, and decreasing self-stigmatization. These improvements bring about temporal changes, not just for current Cape Breton youth, but will, over time, build a supportive and understanding island for future generations of children and youth.

Personal Growth

The final theme that emerged from the data was *Personal Growth*. Youth participants interviewed for this study noted experiencing significant trauma and mental health problems that have affected every facet of their lives. Despite these adversities, the youth showed great courage, strength, and growth within themselves. Two sub themes emerged from this theme: *Resilience and Reciprocity*.

Resilience

Resilience is described as a personal ability to cope and adapt to adversity (Thompson, et al., 2018). Participants in my study had overcome many hardships in their short lifetimes. The following quotes depict resilience within the youth participants, and their personal growth throughout their journey with their mental health problems:

> Um I think it made me, I've always been, always been a soft and an empathic person but it has made me even more empathic towards people. It kind of shaped the career path I wanted to go on. I want to be a clinical psychologist and I want to work in the mental health field. Um I think it just makes me think about everything, what someone is…actually maybe they're struggling too. It affected my school and social life when I was not in a good place. I think it made me a better and stronger person. I don't know, I think that if I could, I would definitely try to get rid of it… but it has made me more insightful." (Participant 2).
>
> Another youth discussed self-love and the journey towards accepting themselves as they are:
>
> > Well, I'm pretty… like I believe everything that kind of happens for a reason. At the same time, where I feel so so so bad for hurting all those people, I am actually really grateful too because it really changed me. For a little while I felt really bad about myself and stuff, but I'm grateful that like I went on this kind of little journey and that I can look at life the way that I look at it now… I don't know it's just um I'm like I like myself today. I don't know, I'd say I love myself, but I like and I think I'm pretty cool. I can look in the mirror today and I can smile and say "you know what, you're not too bad (Participant 1).

Finally, one participant discussed that they have learned to cope with, and react to, other stigmatizing comments about their mental health.

> In the end, it probably made me a better person cuz I took a lot of time for myself to learn how to cope with… like how to like react what others would say to me. I learned how to not take it personally, I guess (Participant 8).

As discussed previously, many participants endured adverse traumatic experiences throughout their lives. Youth experienced large accidents, parental divorce, serious childhood illness, and being part of the adoption system, to name a few events. Although all of these youth faced adversity, I was able also to see their potential, strength, and determination to overcome life's obstacles. Many youths were able to establish a routine, self-reflect, along with seeking, and continue to seek, relevant support and services that are able to assist them in their journey towards wellness. Youth noted being able to take adversities in stride, and often believed that their experiences made them stronger, insightful or more confident. In addition, older participants were able not only to manage their mental health problem, but also gain admission into university or college, and set their minds toward careers that would allow them to help others in similar situations to theirs. Their resilience was astonishing. Some participants have found their own resilience and some are still finding theirs, but it was apparent in each of them, even if they were not yet able to see it within themselves. Youth participants, when discussing their mental illness and their adversities faced throughout their mental health journey noted that they had become more insightful, or have become a better person, due to what they have learned about themselves. As noted above, one participant had even

found their future career path because of their illness. Youth participants did an outstanding job at remaining optimistic about their mental health.

The literature suggests that resilience is influenced by familial, interpersonal, and community/societal factors. Interpersonal factors that affect an individual's resilience are the ability to problem solve, regulate the self, and adapt (Thompson, et al., 2018). Resilience within a family is related to having at least one adult support and the family's socioeconomic resources. Finally, community/societal factors are related to supportive relationships with community supports and peers; however, these are based on access to social supports in the area (Thompson, et al., 2018). Participants in my study displayed some of the interpersonal factors, some participants were noted to have more protective factors than others. Most youth had familial support; however, some participants did not, which lead to great challenges with access to services, socioeconomic issues, and over all mental health care. Youth who had familial resilience had greater access to services such as EAP, through their parents' medical benefits. Further, many participants, living in CBRM, had issues with community/societal factors as the youth living in an underserved area of the province.

Reciprocity

The final subtheme to be discussed in this chapter is reciprocity. Many youth participants noted wanting to give back to others who may be feeling the same as they do, or once did. This type of relationship could be similar to that of a youth peer worker and a youth with a mental health problem who is seeking support. As discussed previously, youth who choose to be a peer worker may provide emotional support, education, and guidance to other youth, similar to desires of youth participants in my study (Simmons et al., 2020). No studies were found that solely focused on reciprocity and youth with

mental health problems. The Mental Health Commission of Canada outlines in their "Speaker Toolkit" how an individual with lived experience with mental health problems can organize their thoughts in an effort to begin sharing their story with individuals or groups of people. This toolkit notes the importance of sharing one's own story in relation to anti-stigma campaigns (No Date). One participant noted that they decided to participate in the current study as they wanted to help others who may be in a similar situation to what they have lived through. This participant noted feeling a strong desire to share their story, in hopes of assisting others and how their personal narrative has changed over time.

> Ok yeah, so at first it was kind of my adoption story and not fitting in with my family and like I would tell other kids that story and they could relate not fitting in with their family and maybe deadbeat parents… like I wasn't raised with them, but I had them, and I would talk to kids and stuff like that… but I don't know, like I think today sharing my story is… I go really deep with it now. I never used to. I used to say 'I'm adopted' but now I go into it and I explain it, and like I think I never really wanted to see that side of me before and… but I want, today to help anyone that I can, and if I can say like three little words that can make someone else's head click, that's what I want. Before I was embarrassed, shameful, and guilty… but I'm like, ok say here's the best way to explain this. I would tell people that I'm fucked up and stuff, but I wouldn't say 'yeah I used to steal, yeah I used to have a drug problem'. I would tell my story, but I would keep it very clean cut… like so I still look like I was on top of the world… but today I understand not only is it important for myself to really dig deep to get that

> story out, but it's important to other people too… because I'm basically lying to myself telling my story and lying to other people. I don't know if that makes sense. I don't know I just want to help anyone I can today you know. That's why I did this. I saw this, I just… in my heart, I really wanted to do this just in case there is a possibility that it could help someone out there. You know (Participant 1).

Other participants used volunteer work and their paid jobs to give back, or assist others, with mental illness. Participants were strong advocates at their schools, sitting on mental health committees, bringing mental health organizations to students at university, and volunteering with vulnerable youth, for whom participants noted being able to see a younger version of themselves, bringing relatability to their work. Another youth also noted temporal changes in wanting to share their own mental health story, noting hesitancy at first due to fear of stigmatization.

> I didn't want to be open about my mental health at first because I didn't want people to be like... that I was looking for attention or I was "crazy" …but I started just to be super open because I knew… like if there are other students at school feeling the way I did I wanted them to know that someone else feels the same way (Participant 2).

Participants' reciprocity had brought about strong relations (relationality) and safe spaces (spatiality) for other youth in which they find themselves. Their openness and honesty helped critical conversations to begin in a community where supports are lacking and where mental health is still highly stigmatized and undiscussed due to aforementioned cultural factors.

Member Checking

The nine youth participants, who consented to the optional member checking process during informed consent, were recontacted by the researcher via email or text message. The study specific email was used to recontact the participants. Included in the email, or text, was a brief plain language overview and description of the six themes and sub-themes (see Appendix K). Participants were asked to reply to the email noting whether they saw themselves represented in the findings. Participants were made aware that they may not see themselves represented in every theme as the themes were extracted from all ten analyzed interviews, but the researcher was hopeful that they would find themselves represented in some. Unfortunately, the nine youth who did consent to the member checking process, did not respond to the researcher's email. The lack of response could be due to the age group of the participants and, of course, the heaviness of the research topic. As for the age of the participants, the younger age of participants could have affected their willingness to reply to the member checking email or text. Youths' interests often change rather quickly, which could have led to youth being uninterested in participating in the member checking process. Indeed, the emotional response to the research topic also could have caused the participants to be reluctant to respond to member checking, which was optional for the participant and this was reiterated in the email sent regarding member checking.

In summary, throughout the data collection process youth participants discussed their lived experiences when living with a mental health problem on Cape Breton Island and what internal and external factors were affecting them and their mental health. Participants were able to identify services and supports they used and why, as well as discuss issues surrounding why they may not have accessed services that are available to

assist them through their mental health journey. Youth were able to provide insight into how services are currently meeting needs, or can change to be able to meet the needs of youth in Cape Breton. The following chapter will discuss this study's research questions and objectives in relation to what these critical findings mean for the future. Finally, recommendations for the future of youth mental health care on Cape Breton Island and for future research regarding youth mental health care in underserved areas of your province.

Chapter IV: Discussion

Youth mental health care on Cape Breton Island has been found to have shortcomings that are negatively affecting youth living on the island. The final chapters will discuss how the findings address the studies research questions as well as recommendations for youth mental health care on Cape Breton Island and future research. Finally, implications regarding the recommendations will be discussed and related to van Manen's lifeworld existentials.

Throughout the research process, the following four research questions were proposed and answered through interviews with 10 Cape Breton youth. The first questions to be discussed are as follows:

- What mental health supports, or services (formal or informal) have youth used (if any), for what reason, and their resulting lived experiences?
- If supports or services were not used, why not, and their resulting lived experiences?

Youth discussed many different types of services and supports used throughout their mental health journey including: general practitioner (GP) or nurse practitioner (NP) for prescription medications and support; Employee Assistance Program (EAP) counselors, child and adolescent mental health services, psychiatrists, social workers; school-based services such as guidance counselors and school health nurses; community based programs; alcoholics anonymous and recreational activities where youth found support from peers. Youth had many thoughts regarding services that they had accessed. Most youth had mixed feelings about their experiences with counselling/therapy sessions,

some noting negative issues with their practitioner (i.e., not feeling comfortable, feeling misunderstood), or not trusting the healthcare professionals. However, some youth participants reported several positive experiences with the counselling/therapy services that they had accessed during which they learned helpful coping mechanisms, or had positive outcomes, through therapy techniques such as Cognitive Behavioural Therapy. Youth who sought support from their GP or NP acknowledged the time constraints that these practitioners often face; however, they reported positive experiences and noted feeling supported and cared for. Most youth accessed these services with assistance from a parent or guardian after the youth, or their loved ones, identified a need to seek out care for their mental health. Youth identified that not all youth have a parent, or guardian, to help with this task. Further, some youth lacked, or still lack, support from their families regarding their mental health problems. For some youth, this continues to be an ongoing issue; while for others, parents were able to educate themselves in an effort to assist their child, and now have some understanding of what struggles their child may be facing internally. Youth recognized needing assistance from an adult to assist with identifying, and accessing, services as youth lacked the knowledge about available services or supports in their area, or the knowledge regarding how to book an appointment. Youth who did not use any services noted that this lack of knowledge was a large part of why they did not identify/access services. Some other participants identified reasons as to why some youth believed they were unable to identify/access mental health services: including, not having a parent or guardian to assist with these tasks, long wait times before accessing services, a lack of a promotion of existing services or supports, and finally, they feared stigmatization and held negative preconceived notions about the

mental health services on Cape Breton Island. Overwhelmingly, similar to previous research, youth believed that, currently, there is a lack of support for youth who have mental health problems on the island and much improvement is needed to adequately address this gap in the health care system for youth (Church et al., 2020., Malla et al., 2020, Wilson &Usher, 2015, Zayed et al., 2016)

The second research question to be discussed that was addressed throughout this research study is the following:

- From the perspective of participants, in what ways are mental health services and supports meeting, or not meeting, the needs of youth with mental health problems on Cape Breton Island? In what ways do these services and supports need to improve?

Youth participants overwhelmingly reported that they believed mental health services were not meeting the needs of youth on Cape Breton Island. Indeed, youth believed that, in general, there are not enough mental health services and supports available on the island. In addition, this lack of services is perpetuating the long wait times that youth face when trying to access publicly funded services. These findings are similar to existing literature surrounding youth mental health (Church et al., 2020., Hauenstein, et al. 2006, Malla et al., 2020). Youth thought that Nova Scotia Health needs to engage in recruitment of more mental health care professionals who specialize in child and adolescent mental health care (such as psychiatrists, mental health nurses, school psychologists) and to focus more on *promotion and prevention* rather than only on *intervention* that often is offered too late. Youth also discussed the need for more school based mental health services and education in junior high and high school. An increase in

service providers, such as school health nurses could lead to ease of access to mental health services and education could lead to normalize mental health problems, as well as provide youth with information regarding where to find support and formal mental health services in order to assist themselves, or their friends, when needed. Finally, given that youth lacked information regarding available services, they noted the need for more promotion of local supports and services so that youth and parents/guardians could be more aware of available resources on the island.

The final research question to discuss examined the overall lived experience of youth:

- What are the lived experiences of youth who self-identify as having self-identified, self- defined mental health problems for at least six months?

This question was answered through actively listening to youth participants, giving youth a safe space to tell their own story regarding their mental health problems, and examining the factors that affect youth's mental health experiences as a whole. Youth had unique experiences with their mental health problems while living on the island; however, their stories had many similarities as depicted in the six common themes extracted from the data. While the answers to the above research questions provided a subjective view of youths' lived experiences and their struggle with mental health problems; they also expressed, through their stories, their strength and resilience. The youth demonstrated great determination, resilience, and courage in the face of hardship. Many youths lived through traumatic experiences, lacked familial support, and carried internalized guilt in relation to their mental health. They also felt stigmatized in their community as well as within their families, and had multiple challenges finding

relevant services and supports due to living in an under resourced area of the province; yet these youth persevered. Although participants' lived experiences were not always positive, youth were still able to identify reasons to persevere through their mental health journey, from having supportive friends, co-workers and, for some, families willing to educate themselves to assist and grow alongside them. Some youth had found support in their GP, NP, and mental health professions, as well as from their teachers, professors, and university communities. Youth were able to identify hope within their little island; including hopefulness that their voices would be able to assist another youth in need and that speaking up about their own lived experiences would begin a conversation to normalize mental health issues in a community where stigmatization often keeps youth silent.

Recommendations

In an effort to bring about change and normalize conversations surrounding youth mental health on Cape Breton Island, the following recommendations are being made regarding mental health literacy, expansion and promotion of mental health services, and use of community-wide trauma informed care.

Narrowing the Mental Health Literacy Gap: Youth and Parents

Cape Breton youth have a knowledge gap when it comes to awareness of where to find mental health support and services and identifying the proper service to use as well as how to make an appointment with the service. Youth attributed this to a lack of education in schools about mental health and mental health services in the community, as well as services and supports not promoting the assistance they offer. An increase in school-based education programs regarding mental health and mental health services should be provided beginning in elementary schools when children are 4-12 years

old. Elementary based learning could start off with social and emotional learning (SEL), which could continue to build into more advanced SEL programming in junior high and high schools providing a foundation for information regarding general mental health disorders and *where and how* to find services or supports in the area when youth are in junior high and high school.

Social Emotional Learning is defined by the Collaborative for Academic, Social and Emotional learning (CASEL) as "the process through which all young people and adults acquire and apply the knowledge, skills and attitudes to develop healthy identities, manage emotions, achieve personal and collective goals, feel and show empathy for others, establish and maintain supportive relationships, and make responsible and caring decisions" (CASEL, 2020). The skills that are taught through SEL programs are not only applicable to a child's school life, but are skills that are generalizable to their daily, and future lives (Payton et al., 2000). Social Emotional Learning empowers children and youth to develop patterns that positively affect social and emotional skills, providing them with the tools they need to manage and overcome adversity, become resilient, and to participate in a successful, fulfilling, and healthy lifestyle (Leary & Li, 2017). Evidence has found critical long-term changes with SEL including increased academic performance, positive social behaviours and relationships, and a decrease in behavioural problems and psychological distress (CASEL, 2020). Globally, many countries have implemented SEL to increase academic outcomes as well as promote positive mental health and wellbeing (NCFLB, 2008). Countries such as the United States, United Kingdom, Israel, Singapore, Colombia, Australia, and the Nordic countries - such as Finland, Sweden, and Norway - have adopted SEL with great success. British Columbia

was the first Canadian province to implement SEL into the school system although it has not been made mandatory by the province (NCFLB, 2008). Further, a 2014 study introduced SEL (PATHS) into two elementary schools in Nova Scotia, one in Cape Breton and one in the South Shore of the province which proved to have positive impact on students language, reading, and math skills when compared to the control school (Rahbari, Jacques, Hughes, 2014). Social Emotional Learning would be an excellent foundation for more specific mental health education in junior high and high schools; therefore, it is recommended that social emotional learning be implemented using Positive Action, and a Social Emotional Learning program for kindergarten to grade 12 in the education system in CBRM.

The Positive Action Program (Positive Action, 2021) is a SEL program for kindergarten to grade 12 students that uses a philosophy that is based on individuals feeling good about themselves when they carry out positive actions. The program emphasises positive thoughts and feelings which lead to positive actions within the self and enhance children's learning (Positive Action, 2021). This program teaches students to develop their own self-concept through learning to take care of their body and mind, teaching problem solving skills, how to manage feelings, social skills, self-honesty, and learn to set short and long-term goals to work towards self-improvement. These skills are taught in 7 units throughout the year and each grade level builds on the same units. Research has found that the Positive Action Program reduces absenteeism, and improves behaviour, conflict resolution skills, mental health, parental involvement, health education and students' overall self-concept (Positive Action, 2021). Further, the program has been proven to reduce bullying, violence, obesity, drug and alcohol use, and

school suspensions (Positive Action, 2021). A 2013 study of 14 Chicago schools, over a 6-year period found that students in Positive Action schools had a higher life satisfaction, and lower depression and anxiety, when compared to students in schools without the Positive Action Program (Lewis et al., 2013). Additionally, research has found that the program has increased academic motivation, had a positive effect on reading and decreased absenteeism in African American male students moving from grade 7 to 8, and on math for female students and students from low-income homes (Bavarian et al., 2013).

Using SEL as a foundation at all grade levels, it is further recommended that Nova Scotia implement a more structured mental health program within junior high and high schools. Youth in my study did not think that they were being adequately educated about mental health and mental health problems within school curriculum. They also believed that this education needed to start early, specifically in junior high, at an age when literature suggests many mental health disorders begin (Das et al., 2016). In 2013, the province of Nova Scotia, in partnership with Teen Mental Health and Sunlife Financial, began to implement the "Mental Health and High School Curriculum Guide" to increase the mental health literacy of teachers and high school students in grade 9 or 10 (Teen Mental Health, 2013). The guide provides teachers with modules and lesson plans to increase mental health literacy for both educators and their students. The modules focus on mental health stigma, understanding mental illness, experiences of mental illness, seeking help and support, and the importance of positive mental health (Teen Mental Health, 2013). This was originally implemented between 2012-2013 when all grade 9 "healthy living" teachers were trained and the guide was embedded into the

"healthy living" curriculum. "healthy living 9" is a compulsory course for grade 9, requiring 20 minutes of course work a day, focusing on mental health, sexual health, injury prevention, substance misuse, and healthy relationships. Unfortunately, participants in the current study, some of whom would have received this course based on their current age, reported not having enough education and conversation surrounding mental health in junior high and high school. With only 20 minutes per day being spent on these topics, it is not surprising that students reported they did not receive adequate mental health education. Only ten percent of a student's day is being spent on "healthy living 9", which covers a broad array of topics; therefore, much less than 10% of this time is being spent solely on mental health literacy (Province of Nova Scotia, 2014). In addition, following this course, the province has not outlined a plan regarding how mental health information is presented to students in high schools. The high school mental health curriculum could be integrated within SEL programming, such as Positive Action, which has previously shown to have positive effects on youth's mental health (Positive Action, 2021).

Research suggests that school-based programing for increasing mental health literacy may be the most efficient way to target youth (Church et al., 2020). It is recommended that this guide be reviewed and expanded, to ensure that it covers all key topics and stakeholders identified, and that all teachers are implementing this in their grade 9 *Healthy Living* classes. It is imperative that the guide include discussions about anxiety and depression but also mental illnesses that are still not so commonly accepted in today's society such as bipolar disorder, schizophrenia and schizoaffective disorder. These discussions may increase normalization surrounding illnesses that, unfortunately,

are often negatively portrayed in the media and broader society. This guide should not only be implemented in grade 9, but also in grades 10, 11 and 12, in which students are facing much stress about their future studies, goals and aspirations, as recommended by youth participants in my study. Further, evaluation of the grade 9 *Healthy Living* mental health curriculum should be conducted to assess if students, not just teachers as previously evaluated, are grasping, retaining and able to make use of the mental health content presented. The way this material is presented is key to youth being able to connect what is taught in class to their own emotions. Youth should be provided with scenario-based learning to strengthen this link and reinforce comprehension of what is being taught in lectures. For example, scenarios could include a situation that the students are able to understand, can relate to and could instruct youth to have a discussion with their peers lead by a series of questions that relate to the scenario. The questions could have students identify support people, services and positive coping mechanisms youth could use in real life, if needed. It is imperative that comprehensive mental health education be taught throughout junior high and high school to increase mental health literacy, awareness of services and support available to youth – both in-school and in the community - and knowledge surrounding how to access available mental health services.

In addition to the above recommendations, youth in school should be notified of services and supports, both in the school and within the community, at the beginning of each semester to ensure that they are very aware of where to find support and formal mental health services for themselves, or their peers who may be in need of support. This information could be provided by school guidance counsellors, school health nurses, or mental health curriculum trained teachers. Schools should also ensure proper means of

mental health awareness are used, such as flyers and posters, within the school as well as on the school's website. Having local supports or services come into schools and provide students with presentations regarding their programming, could be useful in increasing awareness and student understanding of what the service provides for youth, which, in turn, could decrease anxiety surround reaching out to participate in programing. Further, youth in my study suggested that peer support was very important to feeling accepted in physical spaces in their communities. As discussed in previous chapters, formal peer support has been proven to increase mental health outcomes and quality of life (Bellamy et al, 2017). Further, peer mentorship programming has been found to be an effective way to encourage positive youth development (Kuperminic et al., 2019). Using formal peer mentorship programing between senior high school students (mentor) and lower grade high school students (grade 9/10) and junior high school students (mentees) who are transitioning, or about to transition, to high school could also promote positive mental health in schools. Mentors may be able to connect and guide younger students at a time that can cause much stress for youth, leading to a sense of belonging, connection, and support from their peers. It also may be useful to have local public figures, who have lived experience with mental illness, to speak at school assemblies about the experiences and challenges they have faced but have been able to overcome. These presentations could touch on what services/supports have assisted them in managing their illness and what youth should do if they are feeling similarly. This type of presentation could demonstrate to youth, who may be silently suffering, that they are not alone, and that individuals with mental illness can be successful, and lead productive, fulfilling lives. By narrowing the mental health literacy gap in youth, this, in turn, could increase resilience,

positivity, affect self confidence levels, and increase use of mental health services earlier, hopefully leading to more positive mental health outcomes. Finally, youth will take this knowledge into adulthood. Holding this knowledge and understanding about mental health and associated disorders, today's youth, in turn, will be able to support and guide the next generation on the island.

Parental Education. As discussed in previous chapters, some youth in this study believed that their parents or guardians were not able to understand and support them as they believed was needed. There is a need for an increase in parental mental health literacy to adequately support youth on Cape Breton Island. In Cape Breton, many families face adversity such as addiction, unemployment, and poverty leading to low parental education and socioeconomic status which may affect parenting strategies leading to adversity within families. Adversity also is often related to low parental education which may affect parenting strategies that affect youth mental health. A supportive family in a youth's life is a strong predictor for increased physical, social, emotional, and intellectual health, as well as academic achievement (Positive Action, 2021). Parents need to be aware of what supports and services are available to assist their child if they face mental health problems, including both publicly and privately funded resources such as community programs, EAP, and child and adolescent mental health services. Using SEL in schools to engage parents in bringing SEL into the home, as well as schools providing parents with education regarding mental health could increase mental health literacy within youths' home environments.

Using SEL in a program like Positive Action, has been found to increase parental involvement in youths' lives and leads to a more supportive environment for youth

(Positive Action, 2021). Positive Action gives parents the knowledge and skills to think creatively and critically, problem solve, be healthy, and teaches family management, coping, and parenting skills. Positive Action also involves families by providing "Family Kits" in which families can participate in 15-minute lessons at home to increase parenting skills, as well as positive actions, thoughts and feelings. Schools also are able to provide "Family Class" for at risk/high need families. Students and parents have separate classes at the same time, then work together on an activity together as a family. This can promote positive dynamics, relationships, and communication (Positive Action, 2021).

In addition to engaging parents/guardians into SEL programming, school boards often use "parent portals" where parents are able to access their student's grades, attendance notices, etc. To increase knowledge regarding specific mental health problems, and what parents can do if they believe their child needs help, schools could implement modules on the parent portal to provide parents with education and support. Modules could include general information regarding mental health and common mental health problems seen in the age group of their child, followed by signs and symptoms that may increase early identification by parents. It would also be helpful to include within the modules, where parents and guardians are able to find assistance for their child if needed, potentially leading to earlier identification of mental illness in youth.

Spreading the Word: Increasing Local Mental Health Services and Supports

Youth participants in this study overwhelmingly reported the need for additional school mental health services and community-based support as well as the need to promote organizations so service users are better able to self-identity, and ultimately better access these services. As previously discussed, most youth did not know where to turn when it came to mental health services, booking appointments or accessing support.

While there are limited formal services on the island, and long wait times especially for publicly funded services, the services that are available, as well as community-based supports, such as Caper Base and other after school programming that could provide youth with resources and support, need to be promoted on multiple platforms, and in engaging ways, directed at youth. It is important to note that some community-based programs in the CBRM do some forms of advertising to youth (i.e., on social media); however, they do not focus too much on public relations as their programming is, more often than not, at capacity. In personal communication with Chester Borden the director of the Whitney Pier Youth Club, he noted that they have used social media, public service announcements at the local Cineplex Theater before the beginning of movies, and worked with community partners; however, more than this is not needed due to limited number of youths being able to join based on capacity of their programing (2020). Mr. Borden also noted that he, himself, is not aware of every service available to youth in CBRM. He believes that more public relations/advertizement of available services is needed; however, he noted that when there is a three-year waitlist to get into a community-based program, this can be very discouraging to families and youth (2020). This could lead to a feeling of hopelessness and lack of support in the community, again, making it very clear that more resources are needed in the area where many factors, such as unemployment, poverty, and addiction cause stressors for many families. It is recommended that Nova Scotia Health assesses the current situation in Cape Breton and consider expanding formal mental health services for youth on the island. Further, more government funding is needed to expand school-based and community-based promotion and preventative programming for youth, to decrease these

long wait times to join programming and making these types of programs available to all youth living in CBRM who wish to participate. Mr. Borden spoke of this in a conversation surrounding his non-profit Boys and Girls Club:

"CBRM needs a lot more assistance. I think the key is prevention. We wait until after the fact and we try to provide services but it's too late. It's easier to raise strong children than to fix broken men. We can't wait until kids are addicted. It's hard getting them back. Why is there only one Boys and Girls club on the island? We are the only one. The closest one is in Truro (2 hours away). As you are aware, there are issues in the other communities, North Sydney, Glace Bay. I know a lot of these communities could benefit from a Boys and Girls Club and we are about prevention, but it seems people don't want to pay for prevention. I don't see enough money put into prevention." (personal communication, Chester Borden, 2020).

The Government of Nova Scotia should commit to increased recruiting of mental health service providers for rural and under severed areas of Nova Scotia delivering incentives for providers to work in rural areas if needed. Further, due to the lack of specialized mental health providers, General Practitioners and Nurse Practitioners are often the first point of contact with the health care system. These professionals should be provided with proper support, training, and assessment skills to assist youth who are seeking mental health care. Also, considering the recent global pandemic, COVID-19, now more than ever there is a need for health services to use e-health. Increasing mental health services to online platforms and using service providers from other parts of the province, could fill gaps in care and increase access to mental health care for youth. Nova Scotia has committed to using 5.9 million of the mental health care budget for virtual

mental health and addictions care (CBC, 2020). Providing funding, or allocating healthcare budget for services, such as virtual care, will support the expansion of accessible promotion/prevention and treatment-based measures, while also aiding in identifying mental health problems sooner, and keeping youth close to home while using services or receiving treatment. Such action should lead to more positive health outcomes for youth in Cape Breton.

With regards to promotion of services that are currently available to youth, using my study as an example, youth of this age group (16-22) were very receptive to social media campaigns for participant recruitment. Social media is such a large part of youths' everyday life. Facebook, Instagram snap chat, twitter, YouTube and Tiktok are all social media platforms that could be utilized to publicly advertise mental health services and support youth. The current study used Facebook and Instagram pages to recruit participants and recruitment took only one week with a waitlist produced. Sponsored posts were not used; however, the public, and local youth organizations did share the studies' social media content. It is recommended that social media be used to advertise formal mental health services and supports that are available to youth on Cape Breton Island. Currently, many youth-based organizations are using social media pages to post updates about programming on their page. This is an excellent use of social media for youth who are currently using the services; however, this does not necessarily promote the service to potential new users, unless service users are interacting with the post (liking, sharing, commenting or bookmarking). Using advertizement of services through sponsored posts on social media may increase retention of service users and allow

potential users to obtain information about the services prior to use, which could decrease generalized anxiety surrounding accessing new services.

Approximately 70% of healthcare organizations in the USA use social media such as Facebook, Twitter or Youtube as a form of promotion, fundraising, education, and communication with their communities (Ventola, 2014). Further, a 2014 study found that 57% of service users identified an organization's strong social media presence would influence their choice of services to use, while 81% of service users believed that social media presence was an indication that health services actually use new technologies (Peck, 2014). Taking into consideration the impact social media has on public perception of services, increasing mental health services social media presence, coupled with SEL and increased mental health education in schools, could lead to increased awareness and, in turn, increased use of mental health services/supports on the island. These forms of mental health promotion potentially could lead to more positive mental health outcomes for Cape Bretoners.

Need for Community-wide Trauma and Violence Informed Approaches

Trauma is prevalent in today's society. In Canada, 76% of Canadians report at least one traumatic experience throughout their lifetime and 32% of adults report childhood traumatic experiences (Ameringen, et al., 2008; Government of Canada, 2018). On a global scale, 1 in 3 women experience physical and/or sexual violence in their lifetime (Government of Canada, 2018). The current research has identified that youth have varying levels of trauma history in their short lives. Participants identified circumstances of significant loss, experiencing foster care, and abusive relationships to name a few traumatic events discussed in their interviews. The pervasiveness of trauma experienced by Cape Breton youth has led to the recommendation for Trauma and

Violence Informed Approaches to be provided within healthcare systems, schools and, on a broad scale, communities, not only for youth but also for adults living with them.

The government of Canada defines Trauma and Violence Informed Approaches as “policies and practices that recognize the connections between violence, trauma, negative health outcomes and behaviours" (2018). Trauma and violence informed approaches enable those who have trauma and violence histories and who are seeking care/services to do so in an environment that increases safety, resilience, and control (Government of Canada, 2018). The goal of trauma informed approaches is to minimize the risk of harming those seeking services, by decreasing the risk of re-traumatization, not to treat trauma. According to the Government of Canada, to implement trauma and violence informed approaches, system designs must be changed to include an understanding of how trauma and violence affects lives and behaviors, to create emotionally and physically safe environments, use strength based and capacity building approaches to support coping, and building resilience and providing opportunity for connection, choice, and collaboration (Government of Canada, 2018). It is of utmost importance that healthcare systems, community-based supports and services and education systems are using trauma and violence informed approaches when engaging with youth on Cape Breton Island.

Healthcare: Moving Towards Trauma and Violence Informed Care (TIC). Literature suggests that there is a strong link between traumatic experiences in childhood and poor health outcomes in adulthood (Chapman et al, 2004). Adverse Childhood Experiences (ACEs) are traumatic events such as abuse, violence, and growing up in a home with mental health and substance misuse problems present that potentially can have a negative

impact on one's health and mental health in adulthood (CDC, 2019). These adverse events can affect brain development and have an effect on how one manages stress (CDC, 2019). Further, one in six adults has experienced more than 4 ACE's in their lifetime (CDC, 2019). In 1998, the first ACE study was conducted and found a "strong and cumulative" relationship between exposure to ACE's and the risk for multiple leading causes of death in adulthood such as, heart, lung and liver disease, cancer, and skeletal fractures (Felitti, et al., 1998, p. 251).

Since this original ACE study, much research has been conducted regarding lifetime traumatic experience and the link to physical health in adulthood. A 2014, a population-based study found that 'injurious trauma' was associated with all physical health conditions assessed in the study, such as, obesity, arthritis, diabetes, hypertension, cardiovascular disease, and gastrointestinal disease (Husarewycz, et al., 2014, p.30). Additionally, the greater number of traumatic events reported by an individual was related to an increased risk of multiple physical health conditions (Husarewycz, et al., 2014). A 2016 study (Campbell, et l., 2016) also found that ACE's are associated with increased odds of displaying "risky behaviour, morbidity and disability in adulthood." The study further found that as exposure to adverse events increases, so do adulthood risky behaviours and morbidity.

Not only does traumatic experience affect an individual's physical health, there is a strong link between trauma and mental health disorders. Literature suggests that increased prevalence of childhood traumatic events is linked to substance use disorders and mental health problems in adulthood (Wu, et al., 2013). A 2013 study found a "1.2-1.5-fold increase" of risk of PTSD, IV drug use, tobacco use, STDs, homelessness,

physical health problems and poor quality of life (Wu, et al., 2013). Further, a 2011 study found that PTSD is associated with increased rates of mood, substance misuse, and anxiety disorders (Pietrazak, et al., 2011). A 2014 study, as discussed above, found that "assaultive trauma" and witnessing traumatic events, showed the strongest link to PTSD (Husarewycz, et l., 2014, p.30).

It is abundantly clear that traumatic experiences are linked to poor physical and mental health problems, which often lead to the need of hospitalization, or frequent contact with the healthcare system and health care professionals working within the system. In turn, this leads to individuals with extensive trauma histories being cared for within healthcare systems, in a multitude of service areas. The IWK Health Science Center has become a national leader in TIC since 2015, educating 2500 internal and external partners (Lynch, 2018). Youth being seen for mental health problems at the IWK likely will be seen by a healthcare professional trained in TIC. While the IWK is making waves in this area, the rest of the province's hospitals and Nova Scotia Health (NSH) services, in which rural youth are likely to be seen for care, are falling behind. NSH does have an existing framework to guide Trauma Informed practice in Mental Health and Addictions Services in the province; however, no policy exists to guide frontline healthcare professionals regarding TIC at this time (NSH, 2015). Further, as an employee of NSH since 2018, I have received no formal education regarding TIC while working within NSH. Instead, much of my own knowledge regarding trauma and violence informed care was provided through my master's program and my own desire to use TIC to guide my own practice. It is imperative that healthcare systems and adjunct services, within hospitals and community-based programs, adopt trauma and violence

informed care, and train staff appropriately to be able to assess and screen patients for ACE's and other forms of trauma which could potentially be affecting behaviour that influences individuals' physical and mental health. Trauma informed care cannot only be employed within mental health and addictions services but needs to be widespread throughout health service systems to ensure that service users are not facing re-traumatization when seeking any form of healthcare.

Universities and colleges and other post-secondary education training organizations also have a role to play in educating future health care workers about the impacts of trauma informed care and beginning the training process in trauma informed care practices. A 2020 study found that a TIC symposium for medical students lead to increased knowledge of the relationship between ACE's and outcomes of health, increased knowledge surrounding trauma informed care, increased understanding surrounding ways to incorporate TIC into patient care interactions and clinical practice concepts (Chokshi, et al., 2020). From a nursing perspective, a 2020 mixed methods study regarding the implementation of TIC curriculum in nursing programs found that curricula increased knowledge surrounding TIC, the students' ability to define TIC, ability to identify trauma symptoms and triggers, and confidence in ability to provide TIC (Cannon et al., 2020). Students identified that they would use TIC as a "standard precaution" assuming that all patients may have experienced trauma and the importance of universal screening. Nursing students also identified that trauma could affect patient behaviours and noncompliance with treatment, leading students also to think of how trauma may be affecting their patients' daily lives (Cannon et al., 2020). Finally, nursing students identified that in the future, they would like to learn more from survivors of

trauma, recognizing the importance of learning from first voice perspectives (Cannon et al., 2020). From nurses and doctors, to dentists and physiotherapists, all healthcare workers need to begin learning about trauma informed care in their academic settings in preparation for a smooth transition into trauma informed systems in which they will work, or potentially advocate for, in their future endeavours.

Trauma Informed Practice in Education Systems. Nova Scotia youth spend 8 hours a day 5 days a week in classrooms in our province and, in addition, many students spend countless hours participating in school based extracurricular activities. With the prevalence of traumatic experience in childhood, as described above, it is imperative that not only healthcare but Nova Scotia's education systems use trauma informed approaches in schools, commonly called trauma informed practices. Trauma Informed Practices (TIPs) are support models that take into consideration the pervasiveness of traumatic experiences in childhood and the impact that this has on children's wellbeing. Education systems that use TIPs value and make commitment to the safety, choice, control and empowerment of their students, and are able to address the developmental impact of trauma such as mental health concerns, and attachment or learning disorders (Record-Lemon and Buchanan, 2017). Further, TIPs not only can provide general support without the disclosure of the specifics regarding traumatic experiences, but also can provide trauma specific support or services such as “assessment, psychoeducational programs, and/ or trauma-focused interventions” (Record-Lemon and Buchanan, 2017, p. 288). Research suggests that TIPs increase social and emotional development, well-being, and academic achievement (Record-Lemon and Buchanan, 2017).

In the United States, 17 states have schools that have successfully adopted trauma informed practice in a cluster, district, or state level (Overstreet and Chafouleas, 2017). As of 2016, Massachusetts, Washington, and Wisconsin have state-wide trauma informed schools (Overstreet and Chafouleas, 2016). A 2012 study found that teachers face challenges when supporting students with trauma histories and found that TIPs lead to increased role clarity, knowledge surrounding trauma informed practice, and support that can decrease these challenges. Further, research suggests that, at present, social emotional health is not addressed in education programs for teachers, leading to teachers learning to manage students' challenging behaviours on the job which increases the risk of student re-traumatization due to potential negative reactions, such as zero tolerance policies, to these challenging behaviours (Overstreet and Chafouleas, 2016; Phifer and Hull, 2016).

Research suggests that by age 17 years, 2 of 3 school aged children/youth will have had a traumatic experience in their life (Perfect, et al., 2015). The need for the implementation of trauma informed schools, not only in Cape Breton but throughout Canada, is imperative. For trauma informed approaches to be implemented effectively into education systems, all staff members within the school need to be provided education and training regarding trauma informed approaches, and must be able to realize the pervasiveness of trauma in youth's lives, along with the effect that this has on student learning. Further, universal trauma screening must be used for early identification of students who may be at risk for learning, or behavioural difficulties, as well as re-traumatization. Screening should be followed by referral to, or connection with, professional prevention and intervention supports or programs along with links to stakeholders within the community (Chafouleas, et al., 2015). Once referrals/connections

are made, the youth and their family (if youth would like) should be included in all care and treatment decisions. In addition, an excellent complement to trauma informed approaches in classrooms could be Positive Action, the SEL program discussed above, as it is aligns with trauma informed approaches and the Substance Abuse and Mental Health Services Administration (SAMHSA). Positive Action creates a positive and safe environment for students that extends to families and communities, as well as promoting and fostering an environment for trustworthiness, transparency, peer support, collaboration between school, homes, and communities, and focusing on empowerment of students (Positive Action, 2021). Implementation of trauma informed approaches in healthcare systems, education systems and community will be discussed in the following section.

Implementation of Trauma Informed Approaches. Substance Abuse and Mental Health Services Administration (SAMHSA) is a leader in the development of trauma informed approaches and a framework that can be adapted for multiple service systems and public health agencies along with supporting communities, stakeholders, and service users (2014). SAMHSA has developed "the four R's" as key assumptions for a trauma informed approach. The 4 R's are as follows:

1. **Realization**- within an organization, individuals at all levels must have realization regarding trauma, and have an understanding of how trauma has an effect on individuals, as well as families, groups, organizations and the communities in which they exist.
2. **Recognize**- individuals working with organizations must have the skills to recognize signs of trauma. In addition, organizations must train employees

on how to identify signs of trauma as well as how to use trauma screening and assessment tools.

3. **Respond**- organizations and systems must be able to apply a trauma informed approach to all levels and areas for cohesive services/care. This includes changing behaviours, language, policy, and procedure to a trauma informed approach.
4. **Resist Re-traumatization**- Staff/health care professionals should be acknowledged and be trained to identify how some practices, within the systems they work, create an unsafe and uncomfortable environment for those with trauma histories leading to triggers of negative memories, re-traumatization and interfere with recovery (i.e., use of restraints/ seclusion rooms).

SAMHSA also has developed six key principles, on a trauma informed approach to use in conjunction with the 4 R's, that can be applied to multiple system and organization settings. The six principles are as follows:

1. **Safety**- physical, psychological, interpersonal safety of staff and service users. It is imperative that the definition of safety is understood by staff from the perspective of the service users.
2. **Trustworthiness and Transparency**- transparency of operations leading to, and maintaining, trust within the organization.
3. **Peer Support**- imperative to building trust, safety, hope and resilience in service users from first voice experience of trauma survivors.

4. **Collaboration and Mutuality**- everyone within an organization or system has a role to play in a trauma informed approach.
5. **Empowerment, Voice and Choice**- strength-based approaches must be used when working with service users within a program, organization, or system such as shared decision making and goal setting.
6. **Cultural, Historical and Gender Issues**- organizations and systems must remove cultural biases and stereotypes held by individuals within the system; must be able to offer services with consideration for gender, cultural tradition, and historical trauma; and ensure that policy, procedures and organizational practices reflect the needs of clients they serve, racially, ethically and culturally.

Using the guiding principles and the 4'rs of trauma informed approaches, it is recommended that Nova Scotia Health, centres for education, and community-based programing (for youth and adults alike) move toward a trauma and violence informed model within their organization and develop policies to guide practice within the organizations. As previously mentioned, at this time, Nova Scotia Health does not have a policy regarding trauma informed care in mental health and additions or in primary health care settings. The SAMHSA outlines guidance for implementing trauma informed approaches across service sectors and systems. The ten implementation domains are as follows: Governance and Leadership; Policy; Physical Environment; Engagement and Involvement; Cross Sector Collaboration; Screening; Assessment, and Treatment Services; Training and Workforce Development; Progress Monitoring and Quality Assurance; and Financing and Evaluation (2014). Moving towards implementation of

trauma and violence informed care within multiple community-based supports, services, and organizations will lead to notable systemic changes within healthcare and education systems. These changes will ensure that youth and their families feel safe, supported and cared for in times of need, and in their everyday lives within their community. This, in turn, will lead to happier, healthier individuals and families for generations to come in Nova Scotia.

In summary, the following is a list of the ten recommendations coming from this study for future youth mental health education and care on Cape Breton Island. Note that "youth voice" was used to depict recommendations that the ten youth participants believed were imperative to the delivery of youth mental health care on Cape Breton Island.

1. **Youth Voice:** Urgent need for *funding* and *implementation* of additional mental health services and supports for youth on Cape Breton Island.
2. **Youth Voice**: Timely *implementation* of additional school based mental health providers and services.
3. *Implementation* of Social Emotional Learning in public school classrooms: Kindergarten- Grade 12.
4. **Youth Voice**: Need for *increased* mental health education for junior high and high school students in Nova Scotia.
5. Urgent need for *review* and *expansion* of Nova Scotia's current high school mental health curriculum.

6. *Implementation* of parental mental health education through Social Emotional Learning programs, and school-based platforms such as parent portal modules.
7. **Youth Voice:** *Promotion* of existing formal and informal mental health services/supports on Cape Breton Island.
8. **Youth Voice:** Urgent *recruitment* of child and adolescent mental health professionals by Nova Scotia Health and the Nova Scotia Government.
9. *Implementation* of province-wide use of Trauma and Violence Informed Approaches within the healthcare, education, and community-based services.
10. Urgent need for *development* and *implementation* of policy surrounding Trauma Informed Care within Nova Scotia Health.

Chapter V: Conclusion

The purpose of this interpretive phenomenological study was to gain a deeper understanding of the lived experiences of youth, ages 16-21 years, who live in Cape Breton Regional Municipality (CBRM) with a self-identified and self-defined, prolonged, mental health problem and what they do about these concerns (i.e., accessing, or not accessing, services or supports) while on Cape Breton Island. This research aimed to assist in filling the gaps in knowledge regarding youth experiences with self-identified and defined mental health problems and services and supports in an underserved area of Nova Scotia, while also identifying services that are, in the participants opinion, imperative to youth's mental health care that may, or may not, exist on the island. To achieve this, 10 interviews were conducted with youth living in CBRM who had lived experience with mental health problems. From these ten interviews, thematic analysis was conducted, and 6 themes emerged from the data collected. The 6 themes and subsequent subthemes are as follows:

1. Trauma
2. Familial Relationships
    a. Familial Support
    b. Lack of familial support
3. Positive Relations
    a. Social support
    b. Service support
    c. Peer Support

4. Negative Internalized Feelings

    a. Guilt

    b. Fear of Stigmatization

    c. Lack of Self-confidence

5. Service Gaps

    a. Lack of youth specific supports

    b. Lack of trust in the health care system

    c. Need for education (youth and parents)

6. Personal Growth:

    a. Resilience

    b. Reciprocity

This study has added to the knowledge base surrounding youth mental health in rural areas. Findings clearly note that participants believe there are shortcomings within our healthcare system along with a lack of mental health services in rural and underserved areas. Participants also felt under-supported by services and, at times, by their own families. They noted numerous difficulties with identifying services within their communities that may have been able to assist them with their mental health problems. This study is only the first step in identifying the need for services and resources that address these issues to support our youth. In the face of a global pandemic (Covid-19), the importance of supporting youth has never been greater. Leading into life post global pandemic, first and foremost, it is imperative that there is an increase in accessible, timely, trauma informed, mental health services for youth in Nova Scotia, especially in underserved and rural areas where there is a significant lack of support and

available services. As discussed previously, the largest theme identified in this study was trauma. The hardships and traumatic experiences that all youth had faced played major roles in their mental health and, in their journey forward. Also taking into consideration how the global pandemic has affected youth in relation to trauma, it is imperative, as discussed in previous chapters, that community-wide services, supports and education use trauma informed approaches to foster a welcoming and safe environment for youth to receive care which, in turn, will lead to better health outcomes and positive recovery (Rousseau and Miconi, 2020). Making community-wide systemic changes towards trauma and violence informed care for education, healthcare services and community-based organizations will affect youth's lifeworlds, (relationality, spatiality, temporality and corporeality) by providing youth with a caring, safe and positive environment to live, learn, grow and excel for generations to come.

Youth participants called for the implementation of more youth focused mental health services/supports in schools and within the community on the island which, in turn, will lead to more timely access to care and mental health treatment. In addition, it has been identified that an increase in awareness regarding what services/supports already exist and are available to youth is needed. Youth reported facing challenges when attempting to identify services and support for their mental health and often needed a parent or guardian to assist them with this task. Public and private services and supports in Cape Breton must consider increasing promotion of their services to youth, specifically through social media, to increase awareness of where to find mental health services. Further, youth also must be provided with proper mental health education in school and must be equipped with the knowledge and tools to be able to identify and connect with

services if needed. Using Social Emotional Learning in conjunction with a mental health curriculum in schools there could be multiple positive effects not only on youths' mental health, and ability to identify when they need to seek out help when they are struggling, but also on their academic achievement, self-concept, and resilience. Finally, parents also need to be educated regarding mental health problems in youth, how these problems may present, how to support their child who may be facing these challenges, and how to find, and access, the supports and services available for their child in their community. The ten aforementioned recommendations in combination with strong advocacy and collaboration, policy change, increase of necessary resources, such as funding and recruitment of health care workers, could, in turn, help to normalize the conversation surrounding mental health on Cape Breton Island. This will aid in the breakdown of barriers that are impeding youth from talking to a friend, or confiding in their parents, and seeking support from school health services, healthcare services, or community-based supports in a time of need.

As noted earlier, there is clear evidence that youths' lifeworld can see great improvement with implementation of these recommendations. For example, an increase in mental health education for youth and parents, though implementation of a mental health curriculum and SEL, will lead to better relationships, particularly between youth and parents (relationality), a safe, caring, and supportive learning environment (spatiality), and could lead to positive growth, resilience, and improved physical and mental health (corporeality). In regards to temporality, these changes, if implemented effectively, over time could lead to happier, healthier, and more self-aware youth for generations to come. Commitments by relevant stakeholders such as the Department of

Education and the Department of Health and Wellness, are needed to ensure community members are given the tools they need to support, nurture, and guide today's youth, as they will be tomorrow's teachers, politicians, policy makers, and health care professionals, guiding the next generation.

It is reasonable to assume that youth in Cape Breton are not the only youth in our province who may be feeling silenced, unsupported, and frustrated about the lack of services and supports when one needs mental health care. Many youths in Nova Scotia are living in rural areas, from the highlands of Cape Breton to Yarmouth County, and those in need are all facing long wait times for mental health services in their community. There must be a timely effort to increase youth community-based and school-based mental health services in our province. The stories told by youth in Cape Breton may be translated to other underserved areas of our province. Change is not only needed in Cape Breton, but province wide, to ensure that we are supporting youth with timely access to trauma and violence informed mental health care, collaborative practice, and by normalizing the conversation around mental health problems.

Limitations

While this study has many critical findings, it is important to identify the limitations of this study. First, the study required only a small sample and while participants were recruited very quickly, only one participant identified as male. This could be due to females more commonly engaging in seeking behaviours when compared to males (Wiens et al., 2020). Due to the larger number of youth participants identifying as female, and myself, the researcher, also identifying as female, employing a feminist lens could have captured other important data that were not identified in the current study. In addition, as mentioned, this study had a small sample size of 10 participants. A

larger sample size could have resulted in additional findings. It is also important to note that participants were all living within the community, self-identified as having a mental health problem, and it was not a requirement for the participants to disclose whether they had a formal mental health diagnosis. Many youths disclosed that they, in fact, did have a formal diagnosis, as discussed previously; however, not all youth were formally diagnosed. Finally, this study did not focus on experiences of service providers, and while I had one interview with a community service provider, the study lacks a full provider perspective regarding youth mental health on the island.

Knowledge Translation

As an imperative part of the research process, study findings will be disseminated through publication in a peer reviewed scholarly journal, presentations to local stakeholders and presentations at professional conferences. Publication will take place as soon as possible in relation to completion of the project. A plain language summary of results in infographic format will be sent to study participants who requested the study results during the informed consent process to increase attention and comprehension of study results. A written summary of study results also will be distributed to relevant stakeholders such as: The Department of Education, Department of Health and Wellness, Nova Scotia Health, mental health clinicians, community-based supports and services in Cape Breton who work with youth, and government bodies responsible for policy making and funding for health services.

Future Research

In terms of future research, studies may wish to focus on other rural areas of our province/country to identify what challenges youth in other rural areas are facing in terms of their mental health and changes needed. Comparing rural youth perspectives to urban

youth perspectives in Nova Scotia/Canada may also identify where gaps exist within our healthcare system and where more resources are needed and what types for youth with mental health needs. Future researchers may be interested in using feminist theory to examine youths' perspectives acknowledging that this study had more of a female perspective then male. This perspective could allow for more understanding surrounding youth mental health and its relation to factors such as power, privilege, and oppression. Future research also is needed that focuses on service providers to identify where they think there are shortcomings within the system for rural youth, where improvements can be made and key stakeholders needed to increase services and support, along with where funding should be allocated in the future.

In conclusion, I would finally like to thank the youth participants who so bravely volunteered to allow me to hear their story. They have shown great courage to talk to a complete stranger about their own struggles with mental health problems and the hardships that their short life has thrown their way. I think it is important to highlight the extraordinary resilience that the participants have demonstrated. From all they have been through, the hardships, trauma and heartbreak, these youth persevered to reach their goals, to graduate from high school, to push through university courses, to choose to put their health first, and for some, to choose to live. I am honoured to have had the opportunity to speak with ten of Cape Breton's youth, the future leaders of our Island. I believe our next generation will be in good hands.

References

Ally Centre of Cape Breton. (2019). About Us. Retrieved from: https://www.allycentreofcapebreton.com/about-us/

American Psychological Association. (2014). Adolescents: a unique period of challenge and opportunity for positive development. Retrieved from: https://www.apa.org/pi/families/resources/newsletter/2014/12/adolescence-development

Anderson, M., Standen, P., & Noon, J. (2005). A social semiotic interpretation of suicidal behavior in young people. *Journal of health psychology*, 10(3), 317-331.

Audu, I. A., Idris, S. H., Olisah, V. O., & Sheikh, T. L. (2013). Stigmatization of people with mental illness among inhabitants of a rural community in northern Nigeria. *The International journal of social psychiatry*, *59*(1), 55–60. https://doi.org/10.1177/0020764011423180

Baren, J., Mace, S., Hendry, P., Dietrih, A., Grupp-Phelan, J., & Mullin, J. (2008) Children's mental health emergencies- Part 1: challenges in care: definition of the problem, barriers to care, screening, advocacy, and resources. *Pediatric Emergency Care*, 24 (6). 399-408.

Barnett P., & Gotlib I. (2001) Psychosocial functioning and depression: distinguishing among antecedents, concomitants, and consequences. Psychol Bull. 1988; 104:97–126.

Bauer, A.M., Parker, M.M., Schillinger, D. *et al.* Associations Between Antidepressant Adherence and Shared Decision-Making, Patient–Provider Trust, and Communication Among Adults with Diabetes: Diabetes Study of Northern California (distance). *J GEN INTERN MED* **29,** 1139–1147 (2014). https://doi.org/10.1007/s11606-014-2845-6

Bavarian, N., Lewis, K. M., Dubois, D. L., Acock, A., Vuchinich, S., Silverthorn, N., Snyder, F. J., Day, J., Ji, P., & Flay, B. R. (2013). Using social-emotional and character development to improve academic outcomes: a matched-pair, cluster-randomized controlled trial in low-income, urban schools. *The Journal of school health*, *83*(11), 771–779. https://doi.org/10.1111/josh.12093

Because Your Mind Matters (n.d). Finding Help. Retrieved from: https://becauseyourmindmatters.ca/

Bellamy, C., Schmutte, T., & Davidson, L. (2017). An update on the growing evidence base for peer support. Mental Health and Social Inclusion. 21. 10.1108/MHSI-03-2017-0014.

Broadbent, M., Jarman, H., & Berk, M. (2002). Improving competence in emergency mental health triage. *Accident & emergency nursing*, 10(3), 155-162.

Briere, J., Weathers, F. W., & Runtz, M. (2005). Is dissociation a multidimensional construct? Data from the Multiscale Dissociation Inventory. *Journal of traumatic stress*, *18*(3), 221–231. https://doi.org/10.1002/jts.20024

Brody, D.J., Pratt, L.A., Hughes, J. (2018). Prevalence of depression among adults aged 20 and over: United States, 2013–2016. NCHS Data Brief, no 303. Hyattsville, MD: National Center for Health Statistics. Retrieved From: https://www.cdc.gov/nchs/data/databriefs/db303.pdf

Boys and Girls Club of Cape Breton (2019). Whitney Pier Youth Club. Retrieved from: https://www.bgccb.ca/

Cabot Shores. (2010). History of Cape Breton Island. Retrieved from: https://cabotshores.com/history-of-cape-breton-island-272

Campbell, J. A., Walker, R. J., & Egede, L. E. (2016). Associations Between Adverse Childhood Experiences, High-Risk Behaviors, and Morbidity in Adulthood. *American journal of preventive medicine*, *50*(3), 344–352. https://doi.org/10.1016/j.amepre.2015.07.022

Canadian Broadcasting Network (2019). Nova Scotia's Health care 'crisis' is Canadas's crisis too. Retrieved from: https://www.cbc.ca/news/health/doctor-shortage-cancer-video-nova-scotia-health-yarmouth-ontario-hospital-1.5113552

Canadian Broadcasting Network. (2018). *Premier booed in Cape Breton over decision to close 2 hospitals, expand 2 others*. Retrieved from: https://www.cbc.ca/news/canada/nova-scotia/cape-breton-hospital-closure-1.4720484

Canadian Broadcasting Network. (2021). N.S. mental health budget largest in history, but advocates say more in needed. Retrieved from: https://www.cbc.ca/news/canada/nova-scotia/nova-scotia-mental-health-budget-2021-2022-1.5964294

Canadian Institute for Health Information (2020). Child and youth mental health in Canada-Infographic. Retrieved from: https://www.cihi.ca/en/child-and-youth-mental-health-in-canada-infographic

Canadian Television Network News Atlantic. (2919). Closed hospitals in Cape Breton cause overcrowding, long waits at Sydney ER. Retrieved from: https://atlantic.ctvnews.ca/closed-hospitals-in-cape-breton-cause-overcrowding-long-waits-at-sydney-er-1.4244444

Cannon, L. M., Coolidge, E. M., LeGierse, J., Moskowitz, Y., Buckley, C., Chapin, E. & Kuzma, E. K. (2020). Trauma-informed education: creating and pilot testing a nursing curriculum on trauma-informed care. *Nurse education today*, *85*, 104256.

Cape Breton Post. (2019). Cape Breton regional hospital expansion plans announced. Retrieved from: https://www.capebretonpost.com/news/local/cape-breton-regional-hospital-expansion-plans-announced-294846/

Cape Breton Post. (2019). Website for mental health wait times in NS gets 1st update since 2017. Retrieved from: https://www.cbc.ca/news/canada/nova-scotia/nova-scotia-health-authority-mental-health-wait-times-1.4957110

Cape Breton Post. (2018). Health authority officials say they‘re looking at Cape Breton Hospitals mortality rate. Retrieved from: https://www.capebretonpost.com/news/local/health-authority-officials-say-theyre-looking-at-cape-breton-hospitals-mortality-rate-265050/

Cape Breton Post. (2017). Cape Breton teens to be sent to IWK for inpatient mental health services. Retrieved from: https://www.capebretonpost.com/news/local/cape-breton-teens-to-be-sent-to-iwk-for-inpatient-mental-health-services-171906/

Cape Breton Post. (2019). Temporary closures of ER in northern Cape Breton cause for concern: MLA. Retrieved from: https://www.capebretonpost.com/news/local/temporary-closures-of-er-in-northern-cape-breton-cause-for-concern-mla-290419/

Carona, M., Macarty C., Richardson, L. (2013). Screening adolescents for depression. *Contemporary Pediatrics*, 24-30.

Caper Base (no date). A little about caper base. Retrieved from: http://www.caperbase.com/about.html

Capital Health District Health Authority. (2014). Consent to treatment. *Policy and procedure*. Retrieved from:http://policy.nshealth.ca/Site_Published/Provincial/document_render.aspx?documentRender.IdType=6&documentRender.GenericField=&documentRender.Id=50984

Carstensen, K., Lou, S., Groth Jensen, L., Konstantin Nissen, N., Ortenblad, L., Pfau, M., & Vedel Ankersen, P. (2017). Psychiatric service users' experiences of emergency departments: a CERQual review of qualitative studies. *Nordic Journal of Psychiatry*, *71*(4), 315–323. https://doi.org/10.1080/08039488.2017.1288759

Centre for Addiction and Mental Health (2019). Psychosis: overview. Retrieved from: https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/psychosis

Centre for Addiction and Mental Health (2020). Trauma: overview. Retrieved from: https://www.camh.ca/en/health-info/mental-illness-and-addiction-index/trauma

Centre for Disease Control and prevention (2019). Vital signs: adverse childhood experiences. Preventing early trauma to improve adult health. Retrieved from: https://www.cdc.gov/vitalsigns/aces/pdf/vs-1105-aces-H.pdf

Chapman, D. P., Whitfield, C. L., Felitti, V. J., Dube, S. R., Edwards, V. J., & Anda, R. F. (2004). Adverse childhood experiences and the risk of depressive disorders in adulthood. *Journal of affective disorders*, *82*(2), 217–225. https://doi.org/10.1016/j.jad.2003.12.013

Children's first Canada. (2021). Campaign code pink. Retrieved from: https://childrenfirstcanada.org/campaign/code-pink/

Chinman, M., George, P., Dougherty, R. H., Daniels, A. S., Ghose, S. S., Swift, A., & Delphin-Rittmon, M. E. (2014). Peer support services for individuals with serious mental illnesses: assessing the evidence. *Psychiatric Services*, *65*(4), 429–441. https://doi.org/10.1176/appi.ps.201300244

Chafouleas, S., & Johnson, A., & Overstreet, S., & Santos, N. (2016). Toward a Blueprint for Trauma-Informed Service Delivery in Schools. School Mental Health. 8. 10.1007/s12310-015-9166-8.

Chokshi, B., Walsh, K., Dooley, D., Falusi, O., Deyton, L., & Beers, L. (2020). Teaching Trauma-Informed Care: A Symposium for Medical Students. *MedEdPORTAL*, *16*, 11061.

Church, M. Ellenbogen, S., Hudson, M. (2020). Perceived barriers to accessing mental health services for rural and small city Cape Breton youth. Social work in mental health 18(4),1-17. DIO: 10.1080/15332985.2020.1801553

Cloutier, P., Thibedeau, N., Barrowman, N., Gray, C., Kennedy, A., Leon, S., & Cappielli, M. (2017). Predictors of repeated visits to a pediatric emergency department crisis intervention program. *Canadian Journal of Emergency Medicine*, 19(2), 122-130.
Collaborative for Academic, Social and Emotional Learning (CASEL) (2020). What is SEL? Retrieved from: https://casel.org/what-is-sel/

Cope, D. G. (2014). Methods and Meanings: Credibility and Trustworthiness of Qualitative Research. *Oncology Nursing Forum*, *41*(1), 89–91. https://doi.org/10.1188/14.ONF.89-91

Copeland, W. E., Keeler, G., Angold, A., & Costello, E. J. (2007). Traumatic events and posttraumatic stress in childhood. *Archives of general psychiatry*, *64*(5), 577–584. https://doi.org/10.1001/archpsyc.64.5.577

Creswell W. J., & Poth N. C. (2018) Qualitative inquiry & research design: choosing among five approaches (4th ed.) Thousand oaks, California: Sage publications

Crouch, L., Reardon, T., Farrington, A., Glover, F., Creswell, C. (2019). "just keep pushing": Parents' experiences of accessing child and adolescent mental health services for child anxiety problems. *Child: Care, Health and Development,* 45(4), 491-499. Dio: https://doi.org/10.1111/cch.12672

Cronholm, P., Barg, F., Pailler, M., Wintersteen, M., Diamon,G., & Fein, J. (2010). Adolescent Depression: views of health care providers in a pediatric emergency department. *Pediatric emergency care*, 26(2), 111-117.

Curry, P., Hiltz, J., Buckle., A. (2019). Nursing Potential: optimizing nursing and primary healthcare in Nova Scotia. Nova Scotia Nurses Union. 1-136. Retrieved from: http://www.nsnu.ca/site/media/nsnu/Nursing%20and%20Primary%20Healthcare%20Report(1).pdf

Darawsheh, W. (2014). Darawsheh, W. (2014). Reflexivity in research: promoting rigour, reliability and validity in qualitative research. International Journal Of Therapy & Rehabilitation, 21 (12), 560-568. International Journal of Therapy & Rehabilitation. Retrieved From: https://www.researchgate.net/publication/273143235_Darawsheh_W_2014_Reflexivity_in_research_promoting_rigour_reliability_and_validity_in_qualitative_research_International_Journal_Of_Therapy_Rehabilitation_21_12_560-568

Das, J. K., Salam, R. A., Lassi, Z.S., Khan, M. N., Mahmood, W., Patel, V., & Bhutta, Z. A. (2016). Interventions for adolescent mental health: an overview of systematic reviews. *Journal of adolescent health,* 59*,* S49-S50.

Day, C., Carey, M., Surgenor, T., (2006). Childrens key concerns: piloting a qualitative approach to understanding their experience of mental health care. *Clinical Child Psychology and Psychiatry* 11(1), 139-155. DOI: 10.1177/1359104506056322

de Haan, L., Peters, B., Dingemans, P., Wouters, L., & Linszen, D. (2002). Attitudes of patients toward the first psychotic episode and the start of treatment. *Schizophrenia bulletin*, *28*(3), 431–442. https://doi.org/10.1093/oxfordjournals.schbul.a006951

Department of Education and Early Childhood Development. (2019). What is School Plus? Retrieved from: https://www.ednet.ns.ca/schoolsplus/en/what-schoolsplus

Dion, J., Kennedy, A., Cloutier, P., & Gray, C. (2010). Evaluating Crisis intervention services for youth within an emergency department: A view from within. *The child care in practice group*, 16(3), 241-256.

Dowling, M. (2007). From Husserl to van Manen: A review of different phenomenological approaches. International Journal of Nursing Studies 44(1), 131-142. Dio: https://doi.org/10.1016/j.ijnurstu.2005.11.026

Eaton, K., Ohan, J.L., Stritzke, W.G.K. *et al.* Failing to Meet the Good Parent Ideal: Self-Stigma in Parents of Children with Mental Health Disorders. *J Child Fam Stud* **25,** 3109–3123 (2016). https://doi.org/10.1007/s10826-016-0459-9

Elser, H., Rehkopf, D. H., Meausoone, V., Jewell, N. P., Eisen, E. A., & Cullen, M. R. (2019). Gender, Depression, and Blue-collar Work: A Retrospective Cohort Study of US Aluminum Manufacturers. *Epidemiology (Cambridge, Mass.)*, *30*(3), 435–444. https://doi.org/10.1097/EDE.0000000000000993

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American journal of preventive medicine*, *14*(4), 245-258.

Fitton, V., Ahmedani, B., Harold, R. (2013). The role of technology on young development: implications for policy, research and practice. Child and adolescent social work journal, 30(5). Doi: 10.1007/s10560-013-0296-2

Forman-Hoffman, V. L., Middleton, J. C., Mckeeman, J. L., Stambaugh, L. F., Christian, R. B., Gaynes, B. N., … Viswanathan, M. (2017). Quality improvement, implementation, and dissemination strategies to improve mental health care for children and adolescents: a systematic review. *Implementation Science*, *12*(1). doi: 10.1186/s13012-017-0626-4

Francis, B., Boyd, C., Aisbett, D., Newnham, K., & Newnham, K. (2006). Rural adolescents' attitudes to seeking help for mental health problems. Youth Studies Australia, 25(4), 42–49.

Georgetown University Centre for Child and Human Development (2014). Trauma informed care: perspective and resources. Retrieved from: https://trauma.jbsinternational.com/issue-brief-1-understanding-impact-trauma.pdf

Giannotti, J. A., & Edward, K. (2014). Challenges in acute care of people with co-morbid mental illness. *British Journal of Nursing*, *23*(13), 728–732. https://doi-org.ezproxy.library.dal.ca/

Gidugu, V., Rogers, E. S., Harrington, S., Maru, M., Johnson, G., Cohee, J., & Hinkel, J. (2015). Individual peer support: a qualitative study of mechanisms of its effectiveness. *Community mental health journal*, *51*(4), 445–452. https://doi.org/10.1007/s10597-014-9801-0

Gill P, Stewart K, Treasure E, & Chadwick B. (2008). Methods of data collection in qualitative research: interviews and focus groups. *British Dental Journal*, *204*(6), 291–295. Retrieved from http://ezproxy.library.dal.ca/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=105672230&site=ehost-live

Global News (2019). Nova Scotia paramedics sounding the alarm over ambulance wait times. Retrieved from: https://globalnews.ca/news/4850641/nova-scotia-paramedics-ambulance-wait-times/

Gloff, N. E., LeNoue, S. R., Novins, D. K., & Myers, K. (2015). Telemental health for children and adolescents. *International Review of Psychiatry*, *27*(6), 513–524. https://doi-org.ezproxy.library.dal.ca/10.3109/09540261.2015.1086322

Google Maps. (no date). Cape Breton Island. Retrieved from: https://www.google.ca/maps/place/Cape+Breton+Island/@46.2752555,-60.9726648,9z/data=!4m5!3m4!1s0x4b681cb852711fed:0x3e1469e4521d2713!8m2!3d46.2486851!4d-60.851817

Google Maps (no date). Cape Breton Regional Municipality. Retrieved from: https://www.google.ca/maps/place/Cape+Breton+Regional+Municipality,+NS/@46.0589215,-60.429419,10.01z/data=!4m5!3m4!1s0x4b6635f220fe8455:0x7245c88404342cf6!8m2!3d46.0241793!4d-60.2044627

Gotovac, S., Espinet, S., Naqvi, R., Lingard, L., & Steele, M. (2018). Evaluating Training Programs for Primary Care Providers in Child/Adolescent Mental Health in Canada: A Systematic Review. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, *27*(2), 99–111.

Government of Canada (2019). Economic profile series: Cape Breton, Nova Scotia. Immigration, refugees, and citizenship Canada. Retrieved from: http://publications.gc.ca/collections/collection_2021/ircc/Ci4-193/Ci4-193-3-2019-eng.pdf

Government of Canada (2021). Trauma and violence-informed approaches to policy and practice. Retrieved from: https://www.canada.ca/en/public-health/services/publications/health-risks-safety/trauma-violence-informed-approaches-policy-practice.html

Government of Nova Scotia. (2021). Wait times: mental health and addictions child and adolescents wait-times trends. Retrieved from: https://waittimes.novascotia.ca/procedure/mental-health-addictions-child-and-adolescent-services#trends

Government of Nova Scotia (2021). Wait times: mental health & addictions adult services. Retrieved from:https://waittimes.novascotia.ca/procedure/mental-health-addictions-adult-services

Grupp-Phalan, J., McGuire, L., Husky, M., Olfson, M. (2012). Randomized controlled trial to engage in care of adolescent emergency department patients with mental health problems that increase suicide risk. *Pediatric emergency care,* 28(12),1263-1268.

Hamm, M., Osmond, M., Curran, J., Scott, S., Ali, S., Hartling, L., & Newton, A. S. (2010). A systematic review of crisis interventions used in the emergency department: recommendations for pediatric care and research. *Pediatric emergency care*, 26(12), 952-962.

Hardin, H. K., McCarthy, V. L., Speck, B. J., & Crawford, T. N. (2018). Diminished Trust of Healthcare Providers, Risky Lifestyle Behaviors, and Low Use of Health Services: A Descriptive Study of Rural Adolescents. *The Journal of School Nursing*, *34*(6), 458–467. https://doi.org/10.1177/1059840517725787

Hardin, H. K., Alchami, H. K., & Connell, A. (2021). Depressive Symptoms and Trust of Healthcare Provider in Rural Adolescents: Relationships and Predictors. *Issues in mental health nursing*, *42*(3), 208–215. https://doi.org/10.1080/01612840.2020.1789783

Hauenstein, E. J., Petterson, S., Rovnyak, V., Merwin, E., Heise, B., & Wagner, D. (2007). Rurality and mental health treatment. *Administration and policy in mental health*, *34*(3), 255–267. https://doi.org/10.1007/s10488-006-0105-8

Healthy Minds Cooperative. (no date). About. Retrieved from: https://www.healthyminds.ca/about

Honey, A., Fraser, V., Llewellyn, G., Hazell, P., & Clarke, S. (2013). Parental influence on the mental health-related behaviour of young people with mental illness: Young people's perceptions. *Advances in Mental Health, 12*(1), 63–74. https://doi.org/10.5172/jamh.2013.12.1.63

Husarewycz, M. N., El-Gabalawy, R., Logsetty, S., & Sareen, J. (2014). The association between number and type of traumatic life experiences and physical conditions in a nationally representative sample. *General hospital psychiatry*, *36*(1), 26–32. https://doi.org/10.1016/j.genhosppsych.2013.06.003

Inglis, D. J. A. (2010). A feminist phenomenological study of skin to skin contact with mothers and nurses in NICU. Dalhousie University. Thesis Canada. Retrieved form: https://central.bac-lac.gc.ca/.item?id=MR63637&op=pdf&app=Library

IWK health Centre (2021). Overview of Mental health and Addiction Services. Our services. Retrieved from: https://www.iwk.nshealth.ca/mental-health/overview-mental-health-and-addiction-services

IWK Health Centre. (2021). Community Mental Health and Addictions. COmmmunity Mental Health and Addictions. Retreived from: https://www.iwk.nshealth.ca/mental-health/community-mental-health-and-addictions#:~:text=The%20IWK%E2%80%99s%20Central%20Referral%20service%20will%20help%20determine,is%20to%20discuss%20the%20mental%20health%20and%20/mental-health/overview-mental-health-and-addiction-services

Joensuu, M., Väänänen, A., Koskinen, A., Kivimäki, M., Virtanen, M., & Vahtera, J. (2010). Psychosocial work environment and hospital admissions due to mental disorders: a 15-year prospective study of industrial employees. *Journal of affective disorders*, *124*(1-2), 118–125. https://doi.org/10.1016/j.jad.2009.10.025

Kawachi, I., & Berkman, L. F. (2001). Social ties and mental health. *Journal of urban health : bulletin of the New York Academy of Medicine*, *78*(3), 458–467. https://doi.org/10.1093/jurban/78.3.458

Kids Help Phone. (2019) Who we are. Retrieved from: https://kidshelpphone.ca/

Kelly, Y., Zilanawala, A., Booker, C., & Sacker, A. (2018). Social media use and adolescent mental health: findings from the UK Millennium Cohort Study. *EClinicalMedicine*, *6*, 59–68.

Kuperminc, G. P., Chan, W. Y., Hale, K. E., Joseph, H. L., & Delbasso, C. A. (2020). The Role of School-based Group Mentoring in Promoting Resilience among Vulnerable High School Students. *American Journal of Community Psychology*, *65*(1/2), 136–148. https://doi.org/10.1002/ajcp.12347

Lambert, M. (2007). Presidential Address: What we have learned from a decade of research aimed at improving psychotherapy outcome in routine care. Psychotherapy Research - PSYCHOTHER RES. 17. 1-14. 10.1080/10503300601032506.

Laing House. (2019). About us. Retrieved from: https://www.lainghouse.org/

Leary, K., & Li, B. (2017). Social and Emotional Learning. *Research Brief.* Communities in schools. Retrieved From: https://www.communitiesinschools.org/media/filer_public/82/36/82362394-5440-457e-b541-e809e7563212/sel_brief_updated52018.pdf

Le Grange, D., Hoste, R. R., Lock, J., & Bryson, S. W. (2011). Parental expressed emotion of adolescents with anorexia nervosa: outcome in family-based treatment. *The International journal of eating disorders*, *44*(8), 731–734. https://doi.org/10.1002/eat.20877

Lewis, K. M., DuBois, D. L., Bavarian, N., Acock, A., Silverthorn, N., Day, J., Ji, P., Vuchinich, S., & Flay, B. R. (2013). Effects of Positive Action on the emotional health of urban youth: a cluster-randomized trial. *The Journal of adolescent health: official publication of the Society for Adolescent Medicine*, *53*(6), 706–711. https://doi.org/10.1016/j.jadohealth.2013.06.012

LeVasseur, M. T., Kelvin, E. A., & Grosskopf, N. A. (2013). Intersecting identities and the association between bulling and suicide attempt among new york city youths: Results from the 2009 new york city youth risk behavior survey. American journal of public health, 103(6), 1082-1089.

Lindow, J. C., Hughes, J. L., South, C., Minhajuddin, A., Gutierrez, L., Bannister, E., Trivedi, M. H., & Byerly, M. J. (2020). The Youth Aware of Mental Health Intervention: Impact on Help Seeking, Mental Health Knowledge, and Stigma in U.S. Adolescents. *The Journal of adolescent health: official publication of the Society for Adolescent Medicine*, *67*(1), 101–107. https://doi.org/10.1016/j.jadohealth.2020.01.006

Livingston, J. D., & Boyd, J. E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: a systematic review and meta-analysis. *Social science & medicine (1982)*, *71*(12), 2150–2161. https://doi.org/10.1016/j.socscimed.2010.09.030

Lopez, K. A., & Willis, D. G. (2004). Descriptive Versus Interpretive Phenomenology: Their Contributions to Nursing Knowledge. *Qualitative Health Research*, *14*(5), 726–735. https://doi.org/10.1177/1049732304263638

Lynch, E (2018). Trauma informed care: how the IWK is a leader in an international movement. Retrieved from: https://youriwk.com/2018/11/08/trauma-informed-care-how-the-iwk-is-a-leader-in-an-international-movement/

MacDonald E., Sauer K., Howie L., & Albiston, D. (2005) What happens to social relationships in early psychosis? A phenomenological study of young people's experiences, Journal of Mental Health, 14:2, 129-143, DOI: 10.1080/09638230500060052

MacKinnon L. (2020). Layers of Decline: Deindustrialization and its impact in post-industrial Cape Breton. University of Toronto Press. Retrieved form: https://blog.utorontopress.com/2020/07/21/mackinnon-layers-of-decline/

Majumder, P., O'Reilly, M., Karim, K., & Vostanis, P. (2015). 'This doctor, I not trust him, I'm not safe': The perceptions of mental health and services by unaccompanied refugee adolescents. *International Journal of Social Psychiatry*, *61*(2), 129–136. https://doi.org/10.1177/0020764014537236

Malla, A., Shah, J., Iyer, S., Boksa, P., Joober, R., Andersson, N., Fuhrer, R. (2018). Youth Mental Health Should Be a Top Priority for Health Care in Canada. *Canadian journal of psychiatry. Revue canadienne de psychiatrie*, *63*(4), 216–222. doi:10.1177/0706743718758968

Marynowski-Traczyk, D., & Broadbent, M. (2011). What are the experiences of Emergency Department nurses in caring for clients with a mental illness in the Emergency Department? *Australasian Emergency Nursing Journal*, *14*(3), 172–179. https://doi-org.ezproxy.library.dal.ca/10.1016/j.aenj.2011.05.003

Matthews, T., Danese, A., Wertz, J., Odgers, C. L., Ambler, A., Moffitt, T. E., & Arseneault, L. (2016). Social isolation, loneliness and depression in young adulthood: a behavioural genetic analysis. *Social psychiatry and psychiatric epidemiology*, *51*(3), 339-348.

McCann, T., Lubman, D. (2012). Young people with depression and their experience accessing an enhanced primary care service for youth with emerging mental health problems: a qualitative study. BMC psychiatry 12(96). Retrieved from: https://bmcpsychiatry.biomedcentral.com/articles/10.1186/1471-244X-12-96#Bib1

McCarthy, W. C., & Frieze, I. H. (1999). Negative aspects of therapy: Client perceptions of therapists' social influence, burnout, and quality of care. *Journal of Social Issues, 55*(1), 33–50. https://doi.org/10.1111/0022-4537.00103

McCormick, L. K., Crawford, M., Anderson, R. H., Gittelsohn, J. (1999). Recruiting adolescents into qualitative tobacco research studies: Experiences and lessons learned. *The Journal of School Health, 69*(3), 95-9. doi:http://dx.doi.org.ezproxy.library.dal.ca/10.1111/j.1746-1561.1999.tb07215.x

McCarthy, J., Downes, E. J., & Sherman, C. A. (2008). Looking back at adolescent depression: A qualitative study. *Journal of Mental Health Counseling, 30*(1), 49-66. Retrieved from http://ezproxy.library.dal.ca/login?url=https://www.proquest.com/scholarly-journals/looking-back-at-adolescent-depression-qualitative/docview/198689594/se-2?accountid=10406

McLean K. N. (2012). Mental health and well-being in resident mine workers: out of the fly-in fly-out box. *The Australian journal of rural health*, *20*(3), 126–130. https://doi.org/10.1111/j.1440-1584.2012.01267.x

Menschner, C., Maul, A. (2016). Key ingredients for successful trauma-informed care implementation. Retreved from: https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf

Mental Health Commission of Canada. (2019). Children and youth: what is the issue? Retrieved from: https://www.mentalhealthcommission.ca/English/what-we-do/children-and-youth

Mental Health Commission of Canada. (2018). Healthcare providers and their role in understanding stigma. Retrieved from: https://www.mentalhealthcommission.ca/English/news-article/13410/healthcare-providers-and-their-role-understanding-stigma

Mental Health Commission of Canada. (2021). Opening Minds. Retrieved from: https://www.mentalhealthcommission.ca/English/opening-minds

Mental Health Commission of Canada. (no date). Speaker toolkit: Sharing your personal story. Retrievedfrom:https://www.mentalhealthcommission.ca/sites/default/files/MHCC%252520Headstrong%252520Speaker%252520Toolkit_0.pdf

Mizzi, A., Honey, A., Scanlan, J. N., & Hancock, N. (2020). Parent strategies to support young people experiencing mental health problems in Australia: What is most helpful?. *Health & social care in the community*, *28*(6), 2299–2311. https://doi.org/10.1111/hsc.13051

Mojtabai R, & Olfson M. (2020) National trends in mental health care for US adolescents. *JAMA Psychiatry.* 2020;77(7):703–714. doi:10.1001/jamapsychiatry.2020.0279

Montemayor, R., & Van Komen, R. (1980). Age segregation of adolescents in and out of school. *Journal of Youth and Adolescence, 9*(5), 371–381. https://doi.org/10.1007/BF02087675

Muise, D. A. (2015). Cape Breton Island. *The Canadian Encyclopedia*. Retrieved from: https://www.thecanadianencyclopedia.ca/en/article/cape-breton-island

National Post. (2018). Nova Scotia says hospital emergency departments closing more often. Retrieved from: https://nationalpost.com/pmn/news-pmn/canada-news-pmn/nova-scotia-says-hospital-emergency-departments-closing-more-often

Nilsen, T., Eiseman, M., & Kvernmo, S., (2013) Predictors and moderators of outcome in child and adolescent anxiety and depression as systematic review of psychological treatment studies. *European Child & Adolescent Psychiatry*, 22(2), 69-87.

Northampton Centre for Learning Behaviour (NCFLB) (2008). New International SEL Report. *Social and Emotional Education: An International Analysis.* Retrieved from: http://www.ncflb.com/wp-content/uploads/2013/02/SEL-worldwide.pdf

Nova Scotia Archives. (2019). Industrial Cape Breton, 1890-1920. Retrieved from: https://archives.novascotia.ca/genealogy/industrial-cape-breton

Nova Scotia Department of Finance. (2020). Labour market trends. Finance and treasury board. retrieved from: https://novascotia.ca/finance/statistics/topic_news.asp?id=16118#:~:text=Comparing%20August%202020%20with%20August,points%20to%2015.9%20per%20cent.

Nova Scotia Department of Seniors. (2017). Shift: Nova Scotia's action plan for an ageing population. Halifax: *Province of Nova Scotia*. P. 1-28. Retrieved from: https://novascotia.ca/shift/shift-action-plan.pdf

Nova Scotia Government (2021). Number and Rates of suicide fatalities in NS by year, sex and zone of residence. *Population and demographics.* Retrieved from: https://data.novascotia.ca/Population-and-Demographics/Numbers-and-Rates-of-Suicide-Fatalities-in-NS-by-Y/n3dv-9n4b

Nova Scotia Government and General Employees Union. (2018). Spell it out. Retrieved from: https://spellitout.ca/

Nova Scotia Government and General Employees Union. (2019). Media release: NSGEU nurses safety survey results. Retrieved from: https://nsgeu.ca/home_page/media-release-nsgeu-nurses-safety-survey-results/18815/

Nova Scotia Health. (2015). Implementing a trauma- informed practice framework in nova scotia. For the mental health and addictions service system. Retrieved from: http://www.tricountywomenscentre.org/uploads/5/7/6/6/5766610/15-43429-tip_framework-web.pdf

Nova Scotia Health. (2017). Milestones on Our Journey. Transforming mental health and addictions in Nova Scotia: A provincial model for promoting positive mental health, care and support. Retrieved from: http://www.nshealth.ca/sites/nshealth.ca/files/milestones_on_our_journey_-_1.8mb.pdf

Nova Scotia Health. (2018). Programs and services: Child and adolescent outpatient clinical services. Retrieved from: http://www.nshealth.ca/service-details/Child%20and%20Adolescent%20Outpatient%20Clinical%20Services

Nova Scotia Health. (2018). Programs and services: Early Psychosis Program. Retrieved from: http://www.nshealth.ca/service-details/Early%20Psychosis%20Program%20(Child%20and%20Adolescent)

Nova Scotia Health. (2018). Programs and services: child and adolescent services (Cape Breton). Retrieved from: http://www.nshealth.ca/service-details/Child%20and%20Adolescent%20Services%20(Cape%20Breton)%20-%20Child%20Youth%20and%20Family%20(Antigonish-Strait%20Richmond)

Nova Scotia Health. (2018). Programs and services: Community supports for child and youth services. Retrieved from: http://www.nshealth.ca/service-details/Community%20Supports%20for%20Children%20and%20Youth%20service

Nova Scotia Health. (2018). Programs and services: Mental Health Mobile Crisis Telephone Line. Retrieved from: http://www.nshealth.ca/service-details/Mental%20Health%20Mobile%20Crisis%20Telephone%20Line

Nova Scotia Health. (2021). Finding a primary care provider in Nova Scotia- May 2021. Retrieved from: https://www.nshealth.ca/sites/nshealth.ca/files/finding_a_primary_care_provider_in_nova_scotia_report_may_2021.pdf

Overstreet, S., & Chafouleas, S. M. (2016). Trauma-informed schools: Introduction to the special issue. Retrieved form: https://link.springer.com/content/pdf/10.1007/s12310-016-9184-1.pdf

Parrish D. E., Duron J. F, Oxhandler H. K. (2017). Adolescent Recruitment Strategies: Lessons Learned from a University-Based Study of Social Anxiety, *Social Work Research*, Volume 41, Issue 4, 213–220, https://doi-org.ezproxy.library.dal.ca/10.1093/swr/svx016

Payton JW, Wardlaw DM, Graczyk PA, Bloodworth MR, Tompsett CJ, & Weissberg RP. (2000). Social and emotional learning: a framework for promoting mental health and reducing risk behavior in children and youth. *Journal of School Health*, *70*(5), 179–185. https://doi-org.ezproxy.library.dal.ca/10.1111/j.1746-1561.2000.tb06468.x

Peck J. L. (2014). Social media in nursing education: responsible integration for meaningful use. *The Journal of nursing education*, *53*(3), 164–169. https://doi.org/10.3928/01484834-20140219-03

Pendse, S. R., & Nugent, N. R. (2017). Mental health challenges and opportunities in rural communities. *Brown University Child and Adolescent Behavior Letter*, 33(6), 1-7. Retrieved from: https://doi.org/10.1002/cbl.30217

Perfect, M.M., Turley, M.R., Carlson, J.S., Yohanna, J., GIllies, M.P.S., School-Related Outcomes of Traumatic Event Exposure and Traumatic Stress Symptoms in Students: A Systematic Review of Research from 1990 to 2015. *School Mental Health* 8, 7–43 (2016). https://doi.org/10.1007/s12310-016-9175-2

Persson, S., Hagquist, C., & Michelson, D. (2016). Young voices in mental health care: Exploring children's and adolescents' service experiences and preferences. *Clinical Child Psychology and Psychiatry*, *22*(1), 140–151. https://doi.org/10.1177/1359104516656722

Phifer, L. W., & Hull, R. (2016). Helping students heal: Observations of trauma-informed practices in the schools. *School Mental Health: A Multidisciplinary Research and Practice Journal, 8*(1), 201–205. https://doi.org/10.1007/s12310-016-9183-2

Pietrzak, R. H., Goldstein, R. B., Southwick, S. M., & Grant, B. F. (2011). Prevalence and Axis I comorbidity of full and partial posttraumatic stress disorder in the United States: results from Wave 2 of the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of anxiety disorders*, *25*(3), 456-465.

Plant, L. D., & White, J. H. (2013). Emergency room psychiatric services: A qualitative study of nurses' experiences. *Issues in Mental Health Nursing*, *34*(4), 240–248. https://doi.org/10.3109/01612840.2012.718045

Province of Nova Scotia. (2021). Nova Scotia population estimates by county and census subdivision. *Economics and Statistics Division.* Retrieved from: https://novascotia.ca/finance/statistics/archive_news.asp?id=16471

Province of Nova Scotia (2021). Healthy living 9: course outline. Retrieved from: https://curriculum.novascotia.ca/english-programs/course/healthy-living-9

Positive Action (2021). Introduction to positive action. retrieved from: https://www.positiveaction.net/introduction#unit-1-:-self-concept

Positive Action (2021). Program uses. Retrieved from: https://www.positiveaction.net/uses

Positive Action (2021). Evidence- based parenting class curriculum & programs. Retrieved from: https://www.positiveaction.net/parenting-curriculum

Puskar K., Bernardo L., Ren D., Haley T., Tark K, Switala J.,& Siemon, L. (2010) Self-esteem and optimism in rural youth: Gender differences, Contemporary Nurse, 34:2, 190-198, DOI: 10.5172/conu.2010.34.2.190

Rahbari, N., Jacques, S., Hughes, J. (2014). The effect of the PATHS curriculum on school-aged children's academic performance across development. Dalhousie University. https://www.researchgate.net/publication/264416458_The_effect_of_the_PATHS_curriculum_on_school-aged_children's_academic_performance_across_development

Ramshawh, H., Chavira, D., Kanegaye, J., Ancoli-Isreal, S., Madati, P., Stein, M., & Stein, M., B. (2012). Screening for adolescent anxiety disorders in a pediatric emergency department. *Pediatric Emergency Care,* 28(10), 1041-1047.

Ray, K. N., Bogen, D. L., Bertolet, M., Forrest, C. B., & Mehrotra, A. (2014). Supply and utilization of pediatric subspecialists in the United States. *Pediatrics*, *133*(6), 1061–1069. https://doi.org/10.1542/peds.2013-3466

Reed, F., Fitzgerald, L. (2005). The mixed attitudes of nurse's to caring for people with mental illness in a rural general hospital. International journal of mental health nursing 14(4), 249-257. Retrieved From: https://doi.org/10.1111/j.1440-0979.2005.00389.x

Record-Lemon, R. M., & Buchanan, M. J. (2017). Trauma-Informed Practices in Schools: A Narrative Literature Review. *Canadian Journal of Counselling and Psychotherapy*, *51*(4). Retrieved from https://cjc-rcc.ucalgary.ca/article/view/61156

Reflexivity. (2019). In Cambridge University Dictionary. Retrieved from: https://dictionary.cambridge.org/dictionary/english/reflexivity

Reinke, W. M., Stormont, M., Herman, K. C., Puri, R., & Goel, N. (2011). Supporting children's mental health in schools: Teacher perceptions of needs, roles, and barriers. *School Psychology Quarterly, 26*(1), 1–13. https://doi.org/10.1037/a0022714

Relays CBRM (2021). About us. Retrieved from: http://relayscbrm.ca/

Robinson, L. R., Holbrook, J. R., Bitsko, R. H., Hartwig, S. A., Kaminski, J. W., Ghandour, R. M., Peacock, G., Heggs, A., & Boyle, C. A. (2017). Differences in Health Care, Family, and Community Factors Associated with Mental, Behavioral, and Developmental Disorders Among Children Aged 2-8 Years in Rural and Urban Areas - United States,

2011-2012. *Morbidity and mortality weekly report. Surveillance summaries (Washington, D.C. : 2002)*, *66*(8), 1–11. https://doi.org/10.15585/mmwr.ss6608a1

Rost, K., Smith, G. R., & Taylor, J. L. (1993). Rural-urban differences in stigma and the use of care for depressive disorders. *The Journal of Rural Health*, *9*(1), 57-62.

Rousseau C, Miconi D. Protecting youth mental health during the COVID-19 pandemic: a challenging engagement and learning process. *J Am Acad Child Adolesc Psychiatry*. 2020;59(11):1203-1207. doi:10.1016/j.jaac.2020.08.007

Rüsch, N., Todd, A. R., Bodenhausen, G. V., & Corrigan, P. W. (2010). Biogenetic models of psychopathology, implicit guilt, and mental illness stigma. *Psychiatry research*, *179*(3), 328-332.

Simmons, M. B., Grace, D., Fava, N. J., Coates, D., Dimopoulos-Bick, T., Batchelor, S., ... & Montague, A. E. (2020). The experiences of youth mental health peer workers over time: A qualitative study with longitudinal analysis. *Community mental health journal*, 1-9.

Substance abuse and mental health services administration (2014). Concept of trauma and guidance of a trauma-informed approach. Retrieved from: https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf

Schneider, S. O'Donnell, L., Stueve, A., & Coulter, R. (2012). Cyberbullying, school bulling, and psychological distress: A regional census of high school students. American journal of public health, 102(1), 171-177.

Schroeder, S., Tan, C. M., Urlacher, B., & Heitkamp, T. (2021). The Role of Rural and Urban Geography and Gender in Community Stigma Around Mental Illness. *Health Education & Behavior*, *48*(1), 63–73. https://doi.org/10.1177/1090198120974963

Searcey van Vulpen, K., Habegar, A., & Simmons, T. (2018). Rural School-Based Mental Health Services: Parent Perceptions of Needs and Barriers. Children & Schools, 40(2), 104–111. https://doi.org/10.1093/cs/cdy002

Shah, J., Das, P., Muthiah, N., Milanaik, R. (2019). New age technology and social media: adolescent psychosocial implications and need for protective measures. Current opinion in pediatrics. 31(1): 148-156. DIO: 10.1097/MOP.0000000000000714

Shaw, B., Krause, N., Chatters, L., Connell, C., & Ingersoll-Dayton, B. (2004). Emotional Support From Parents Early in Life, Aging, and Health.. Psychology and aging. 19. 4-12. 10.1037/0882-7974.19.1.4. retrieved from: http://www.sakkyndig.com/psykologi/artvit/shaw2004.pdf

Sheffield, J., Fiorenza, E., & Sofronoff, K. (2004). Adolescents' willingness to seek psychological help: Promoting and preventing factors. Journal of Youth and Adolescence, 33(6), 495–507. doi:10.1023/B:JOYO.0000048064.31128.c6

Spitz, A., Winkler Metzke, C., & Steinhausen, H. C. (2020). Development of Perceived Familial and Non-familial Support in Adolescence; Findings From a Community-Based Longitudinal Study. *Frontiers in psychology*, *11*, 486915. https://doi.org/10.3389/fpsyg.2020.486915

Strongest Families Institute. (2018). Who we are. Retrieved from: http://strongestfamilies.com/

Summerhurst, C., Wammes, M., Wrath, A., &. Osuch, E. (2017). Youth perspectives on the mental health treatment process: what helps, what hinders? *Community Mental Health Journal*, 53(1), 72-78. Retrieved from: https://doi-org.ezproxy.library.dal.ca/10.1007/s10597-016-0014-6

Tembo, A. C. (2016). Phenomenological Inquiry as a Methodology for Investigating the Lived Experience of Being Critically Ill in Intensive Care. Journal Intensive and Critical Care, 2(1) p. 1-4. Retrieved from: http://criticalcare.imedpub.com/phenomenological-inquiry-as-a-methodology-for-investigating-the-lived-experience-of-being-critically-ill-in-intensive-care.pdf

Teen Mental Health (2013). Mental health & high school curriculum guide. Training report for Nova Scotia. Retrieved from: http://mentalhealthliteracy.org/wp-content/uploads/2014/08/mental_health_curriculum_guide_training_NS_final_July_25_2013.pdf

The Centre for Addiction and Mental Health (2021). Addressing stigma. Retrieved from: https://www.camh.ca/en/driving-change/addressing-stigma

The Chronical Herald. (2018). Head of mental health commission says suicide in Nova Scotia a 'hidden crisis'. Retrieved from: https://www.thechronicleherald.ca/news/local/head-of-mental-health-commission-says-suicide-in-nova-scotia-a-hidden-crisis-244275/

The Globe and Mail (2018). The tricky issue of consent in adolescent mental health care. Retrieved from: https://www.theglobeandmail.com/life/the-tricky-issue-of-consent-in-adolescent-mental-health-care/article24569021/

The Provincial Centre of Excellent for Child and Youth mental health at CHEO (2010). Access & wait times in child and youth mental health: A background paper. P. 1-50. Retrieved from: http://www.excellenceforchildandyouth.ca/sites/default/files/resource/policy_access_and_wait_times.pdf

The Star. (2019). Code Crisis: Inside the quagmire that is the Halifax emergency department. Retrieved from: https://www.thestar.com/halifax/2018/04/23/code-crisis-inside-the-quagmire-that-is-the-halifax-emergency-department.html

The Telegram. (2019). Dire diagnosis for Cape Breton doctors. Retrieved from: https://www.thetelegram.com/in-depth/doctor-shortage/dire-diagnosis-for-cape-breton-doctors-257209/

Thomas, E., & Salzer, M. (2017). Associations between the peer support relationship, service satisfaction, and recovery-oriented outcomes: a correlational study. Journal of Mental Health. 27. 10.1080/09638237.2017.1417554.

Thompson, E.-G., Knowles, S. F., & Greasley, P. (2019). Understanding resilience in young people with complex mental health needs: A Delphi study. *Clinical Child Psychology and Psychiatry*, *24*(3), 405–416. https://doi.org/10.1177/1359104518794789

Thompson, L. K., Sugg, M. M., & Runkle, J. R. (2018). Adolescents in crisis: A geographic exploration of help-seeking behavior using data from Crisis Text Line. *Social Science & Medicine*, *215*, 69–79. https://doi-org.ezproxy.library.dal.ca/10.1016/j.socscimed.2018.08.025he

Tuffour, I (2017). A Critical Overview of interpretative phenomenological analysis: a contemporary qualitative research approach. *Journal of healthcare communications*. Volume 2 No. 4(52) retrieved from: http://healthcare-communications.imedpub.com/a-critical-overview-of-interpretative-phenomenological-analysis-a-contemporary-qualitative-research-approach.pdf

Tyerman, J. J. (2014). *Registered nurses' experiences of care for individuals with mental health issues in the emergency department.* Retrieved from http://ezproxy.library.dal.ca/login?url=https://search.proquest.com/docview/1564022123?accountid=10406

Undercurrent youth centre (2021). Undercurrent programs. Retrieved from: http://undercurrentyc.com/undercurrent-programs/

United Nations Department of Economic and Social Affairs. (2013). Definition of youth. *United nations youth. p. 1-3. Retrieved from:* Retrieved from: https://www.un.org/esa/socdev/documents/youth/fact-sheets/youth-definition.pdf

UNICEF (2018). Adolescent Overview: *Investing in a safe, healthy, and productive transition from childhood to adulthood is critical*. Retrieved from: https://data.unicef.org/topic/adolescents/overview/

Van Ameringen, M., Mancini, C., Patterson, B., & Boyle, M. H. (2008). Post-traumatic stress disorder in Canada. *CNS neuroscience & therapeutics*, *14*(3), 171–181. https://doi.org/10.1111/j.1755-5949.2008.00049.x

Vandyk, A., Young, L., MacPhee, C., & Gillis, K. (2018). Exploring the Experiences of Persons Who Frequently Visit the Emergency Department for Mental Health-Related Reasons. *Qualitative Health Research*, *28*(4), 587–599. https://doi.org/10.1177/1049732317746382

van Manen, M. (1990). Researching lived experience: human science for an action sensitive pedagogy. London, Ontario: The Althouse Press

van Manen, M. (2016) Researching lived experience: human science of an action sensitive pedagogy. Second edition. New York, New York. Routledge.

Varcarolis, E. (2013). Essentials of psychiatric mental health nursing: A communication approach to evidence-based practice. Missouri (MO): Elsevier.

Varcarolis, E (2015). Manual of psychiatric nursing care planning: assessment guides, diagnosis, psychopharmacology. Missouri (MO): Elsevier.

Ventola C. L. (2014). Social media and health care professionals: benefits, risks, and best practices. *P & T: a peer-reviewed journal for formulary management*, *39*(7), 491–520. https://childrenfirstcanada.org/code-pink/kids-are-in-crisis-canadas-top-advocates-and-experts-unite-to-declare-codepink/

Waldron, E. M., Howard, K. R., & Reinecke, M. A. (2019). The long-term effect of trauma history on adolescent depression treatment. *Psychological Trauma: Theory, Research, Practice & Policy*, *11*(7), 751–759. https://doi.org/10.1037/tra0000457

Weist, M., Ambrose, M.G., & Lewis, C. (2006). Expanded School Mental Health: A Collaborative Community-School Example. *Children & Schools, 28*, 45-50.

Wiens, K., Bhattarai, A., Pedram, P., Dores, A., Williams, J., Bulloch, A., & Patten, S. (2020). A growing need for youth mental health services in Canada: examining trends in youth mental health from 2011 to 2018. *Epidemiology and psychiatric sciences*, *29*, e115. https://doi.org/10.1017/S2045796020000281

Wilson, R. L., & Usher, K. (2015). Rural nurses: a convenient co-location strategy for the rural mental health care of young people. *Journal of Clinical Nursing*, *24*(17/18), 2638–2648. https://doi-org.ezproxy.library.dal.ca/10.1111/jocn.12882

Woods, H., & Scott, H. (2016). Sleepyteens: Social media use in adolescence is associated with poor sleep quality, anxiety, depression, and low self-esteem. *Journal of Adolescence*, *51*, 41–49. doi:10.1016/j.adolescence.2016.05.008

World Health Organization (2014). Mental health: a state of well-being. Retrieved from: https://www.who.int/features/factfiles/mental_health/en/.\

World health Organization (2019). Maternal, newborn, child and adolescent health: Adolescent development. Retrieved from: https://www.who.int/maternal_child_adolescent/topics/adolescence/development/en/

World Health Organization (2019). The WHO special initiative for mental health (2019-2023): Universal health Coverage for Mental Health. Retrieved from: https://apps.who.int/iris/bitstream/handle/10665/310981/WHO-MSD-19.1-eng.pdf?ua=1\

World health Organization (2021). Mental health: overview. Retrieved from: https://www.who.int/health-topics/mental-health#tab=tab_1

Wu, N. S., Schairer, L. C., Dellor, E., & Grella, C. (2010). Childhood trauma and health outcomes in adults with comorbid substance abuse and mental health disorders. *Addictive behaviors*, *35*(1), 68–71. https://doi.org/10.1016/j.addbeh.2009.09.003

Yap, M. B., Reavley, N., Mackinnon, A. J., & Jorm, A. F. (2013). Psychiatric labels and other influences on young people's stigmatizing attitudes: Findings from an Australian national survey. *Journal of affective disorders*, *148*(2-3), 299–309. https://doi.org/10.1016/j.jad.2012.12.015

Yap, M. B. H., Reavley, N. J., & Jorm, A. F. (2013). Associations between stigma and help-seeking intentions and beliefs: Findings from an Australian national survey of young people. *Psychiatry Research*, *210*(3), 1154-1160.

Youngblade, L. M., Theokas, C., Schulenberg, J., Curry, L., Huang, I. C., & Novak, M. (2007). Risk and promotive factors in families, schools, and communities: a contextual model of positive youth development in adolescence. *Pediatrics*, *119 Suppl 1*, S47–S53. https://doi.org/10.1542/peds.2006-2089H

Zayed, R., Davidson, B., Nadeau, L., Callanan, T. S., Fleisher, W., Hope-Ross, L., Steele, M. (2016). Canadian Rural/Remote Primary Care Physicians Perspectives on Child/Adolescent Mental Health Care Service Delivery. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, *25*(1), 24–34.

Appendix A

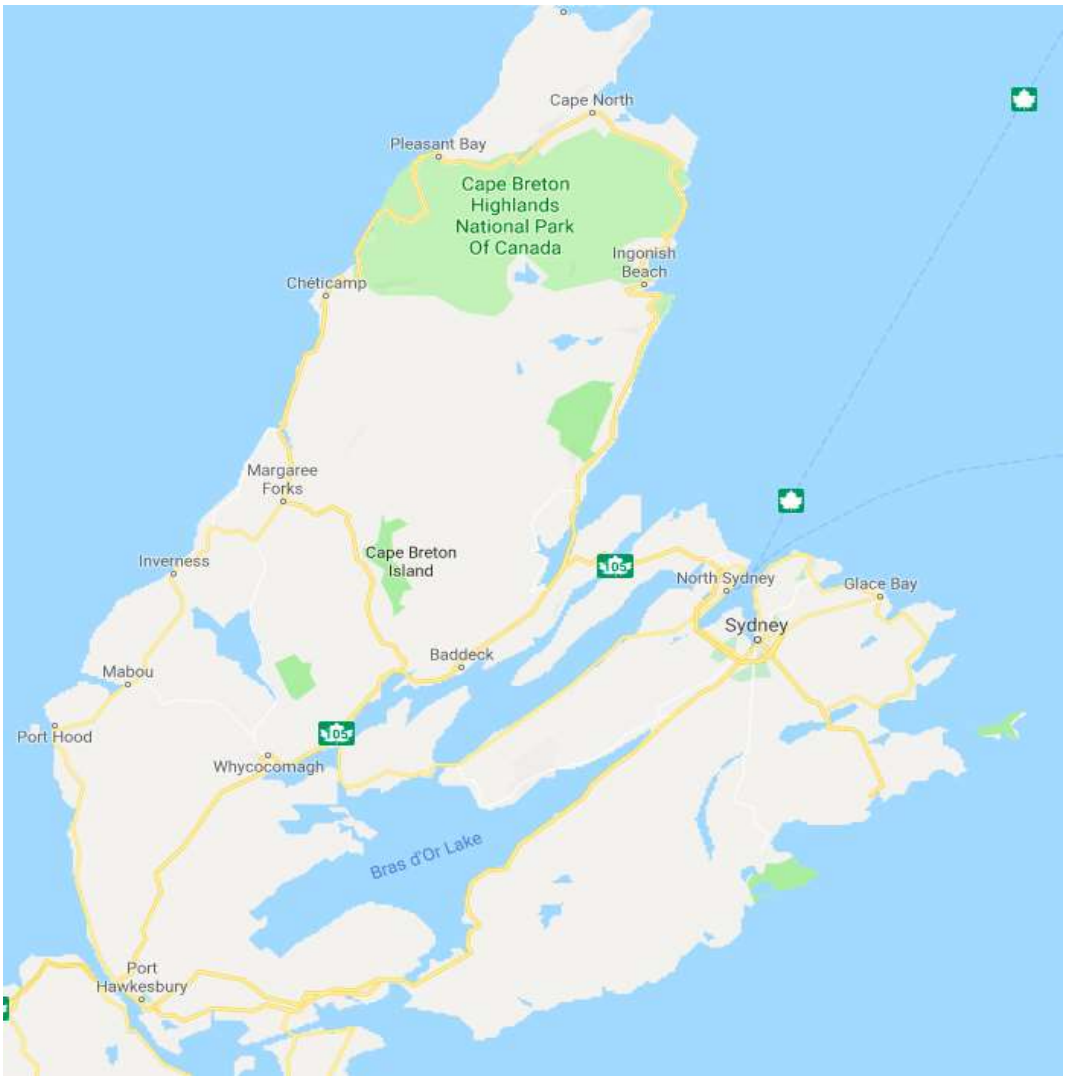

Figure 1. Map of Cape Breton Island (Google Maps, nd.).

Figure 2. Map of Cape Breton Regional Municipality as outlined in red. Although CBRM does cover a large part of the island, the distances between areas within CBRM are usually within a 1-hour drive. For example, the distance between Sydney and Big Pond is 38.1 Km (33-minute drive), Sydney to Louisburg is 34.5 Km (29 minute drive), and Sydney to Christmas island is 59.6 Km (47 minute drive) (Google Maps, n.d).

Appendix B


YOUTH MENTAL HEALTH RESEARCH
VOLUNTEERS NEEDED!
$30.00
FOR YOUR TIME AND CONTRIBUTION!
SEE MORE DETAILS BELOW
DALHOUSIE UNIVERSITY
MSSU USSM


YOUTH MENTAL HEALTH RESEARCH
VOLUNTEERS NEEDED!
cbyouthstudy@gmail.ca
(902) 304-6432
@cbyouthstudy
@cbyouthstudy
We are looking for Cape Breton youth who have experienced a mental health problem for at least six months at a time (no diagnosis necessary).
Participation would involve a 1-1.5-hour conversation about your experience with your mental health problem and how you have been managing it while living on Cape Breton Island.
PAYMENT
$30.00 in appreciation for your time and information!
WHO CAN PARTICIPATE?
Youth 16-21 years in age who live in CBRM.
WHEN?
Meeting place and time will be mutually agreed upon.
CONTACT
Please call, text, email, or Direct Message Maeridith Guy, RN to participate or for more information
MSSU USSM
DALHOUSIE UNIVERSITY

Appendix C

Semi- Structured Interview Guide

1. **Help me understand your mental health problem?**
    - How long have you been experiencing these symptoms?
2. **Can you tell me about how your mental health problem has affected you as an individual?**
    - Can you help me understand how your mental health problem has affected your basic needs such as sleep, your safety, how you feel emotionally (are you tired, sluggish foggy, hyperactive, anxious etc.) and physically (headache, upset stomach etc.).
3. **Can you describe how your mental health problem has affected your relationships with yourself?**
    - Can you describe how you feel about yourself?
    - Can you describe how you feel about your self-confidence?
4. **Has your mental health affected your relationships with others?**
    - Can you describe for me how your mental health problem has affected relationships with friends, family, coaches, teachers, etc.?
    - Has a change in your relationships with these people changed your daily life?
5. **Can you tell me about how your experience has affected your daily routine?**
    - Can you describe a normal daily routine?

- How has your mental health problem affected this routine? (i.e. going to school, studying, participation in extra curriculars, sports, hobbies, work, going out or staying home?).

6. **Some people identify that they feel stigmatized/shamed by others for having a mental health problem. Have you ever experienced such reactions? From whom?**
    - Can you describe for me how stigmatization has affected you personally?
7. **People who have been feeling similar to how you have been feeling often talk to someone about their mental health problem. Have you talked to anyone about your mental health problem?**

    ***If Yes*:**

        - Who?
        - Can you describe why you chose this person/these people to talk to?
        - Can you describe how the situation of reaching out for help went and how it made you feel?

    If No:

        - Can you help me understand why you have chosen to not reach out for help?
        - As you reflect on your situation, do you think that talking to someone would be beneficial for you or not? Why?
        - Do you believe that stigmatization of mental health problems is a factor that has prevented you from talking to someone about your mental health?

8. **Have you ever, or would you ever, seek formal health care services for your mental health problem?**

   If yes

   Can you tell me what service/support you reached out to - Who was involved in this service (health care professionals, parents, guidance counsellors, after school program youth workers, coaches)?

   - Can you describe your experience with the service/support you accessed?
   - Help me understand whether that this service was beneficial for you and your mental health or not?
   - Has anything stopped you from accessing formal mental health services/supports and if so, can you tell me about it?

9. **What are your thoughts about mental health services in Cape Breton?**

   - Can you help me understand your thoughts and feelings about accessing mental health services on Cape Breton Island – what makes it better and what makes it worse?

10. **Do you think there are the right kinds of services or supports available for your mental health needs? Do you think that there is a need for more mental health supports and services in CBRM?**

    - Can you tell me about the types of mental health supports or services that you would like to see for people your age in Cape Breton?

Appendix D

Consent Form for Youth Interviews

Study Title: The Lived Experience of Youth Mental Health Care on Cape Breton Island

Investigator: Maeridith Guy, RN, BScN
Master of Science in Nursing Student
Dalhousie University
Halifax, NS
Maeridith.Guy@dal.ca

Research Supervisor: Jean Hughes, RN, PhD
Professor, School of Nursing
Dalhousie University
Halifax, NS
Jean.Hughes@Dal.ca

Introduction

My name is Maeridith Guy and I am a Registered nurse with the Nova Scotia Health Authority. Currently, I am a graduate student at Dalhousie University completing my Master of Science in Nursing. I would like to invite you to participate in the research I am conducting as part of my Master's Thesis research.

Participation in this study is voluntary. You will be in no way forced, or coerced, into participating in this study. You are able to withdraw at any point of the interview process without consequence. The following document will describe the research study including the purpose of the research, and possible harms and benefits of participating. Any questions you may have can be directed to me or my thesis supervisor, Dr. Jean Hugues.

Purpose of study

The purpose of this research is to explore the lived experiences of youth (16-21) with a self-identified mental health problem persisting for at least 6 months and identify the supports and services they have, or have not, accessed on Cape Breton Island. I am asking your permission to interview you about your experience with a mental health problem while living in Cape Breton. The interview should not exceed more than 1.5 hours. I am looking to gain a deeper understanding of the lived experiences of youth who have a mental health problem and live on Cape Breton Island; identify which mental health supports, and services youth are using the least and most and why; and explore how Cape Breton's youth feel about access and availability of mental health supports and services. I will be asking you to answer questions, in as much detain as possible, regarding these topics. If you would like a report of this study, please check yes at the bottom of this consent form and provide your email or mailing address to which results will be forwarded.

Study Design and Participation

The research study design involves one interview lasting 1– 1.5-hour with a Cape Breton youth age 16-19 years to gain deeper understanding of their experience with mental health

problems. Participation is voluntary. In person interviews will be scheduled for a mutually agreeable time and place between researcher and participant. The interview will take place in a private room in a public building (e.g., library, community centre). Interview questions will be focused on your experience with your personal mental health problem, how this problem has affected your daily living followed by a discussion of the services and supports that you have - or have not -accessed. Participants will be given $30.00 cash payment for their contribution to the research. If you agree to participate, written consent will be obtained from you before the interview process. Participants can withdraw from the interview at any time during the interview process. Your name, and any other personal identifying information, will be kept confidential. Your name will not be used within the written study reports.

After analyzing the interviews, I would like to recontact you to ensure that I interpreted our conversation correctly. This process is called "Member Checking." This is optional. If you would agree to be contacted again, by me, to review the interpretation of our interview, please check "yes" at the bottom of this consent form and provide the best way to contact you (e.g., phone number (text) or email address). Contact will end between you and Maeridith Guy after the member checking process. If you do not agree to participate in the member checking process, contact will end after the interview.

Who can Participate in this study?
You can participate in this research study if you:

1. Live in the Cape Breton Regional Municipality
2. Are between the ages of 16-21 years.
3. Have a self-identified mental health problem that has persisted for at least 6 months. No formal diagnosis is necessary to participate.
4. Able to converse in English
5. Agree to be interviewed with audiotape for 1-1.5 hours.

Who conducts this research?
Maeridith Guy will be the primary researcher of this study. My study is approved by Dalhousie University Ethics Review Board and my thesis committee which includes, Jean, Hugues, RN, PhD (supervisor), Megan Aston, RN, PhD, and Laura Carnegy, RN, MN. This study is funded by the Maritime Spor Support Unit (MSSU).

Possible Harms/Discomforts
There are no anticipated harms involved with your participation. However, you may be at risk of phycological distress or discomfort due to the sensitivity of the research subject. You have the right to refuse to answer questions during the interview. If you no longer wish to participate in the interview, the interview will stop immediately with no consequence. After the interview process, you will be provided with a list of supports who can be contacted if needed or to keep for future use. If you decide to withdraw from the study at the end of the interview, all information prior to this point will be destroyed (any notes, and audio-tape, contact information). If you do not withdraw from the study, at the end of the interview, the data will be transcribed and anonymized making it impossible to withdraw from the study at this point.

Possible Benefits
You may not directly be benefited from participating in this study; however, your invaluable participation and contribution may help youth your age in the future, not only in Cape Breton but in other areas of Nova Scotia in which youth have similar mental health problems. This research may help health care professionals understand youth experiences with mental health problems more clearly and assist with service allocation in the future on cape Breton Island.

Confidentiality
Your confidentially is of outmost importance. Your name, or other personally identifying information, will not be used in any written reports, presentations or publications of this study. A pseudonym (fake name) will be used to replace your real name within the written reports, included quotes, presentations and publications of this study. No direct quotes will be used that could possibly be used to identify you. Interview transcripts, research notes and audio recordings will be kept in a locked cabinet at Dalhousie University for 5 years, and then destroyed. Only myself and my supervisor will have access to this cabinet.

The information obtained in this study will be strictly confidential unless required by law (example: if a participant discloses information that they intend to harm themselves or others or in cases of suspected child abuse). If the researcher requires to disclose information about you, I will attempt to inform you.

Questions/Problems or Concerns
If you have any questions specific to this study at any time, do not hesitate to contact me, or my thesis supervisor, Dr. Jean Hughes. If you have a general question about research, please contact the Dalhousie University Research Ethics Board at (902) 494-3423

DALHOUSIE UNIVERSITY

Consent Form for Youth Participant Interviews

"The Lived Experience of Youth Mental Health Care on Cape Breton Island"

Please check "**Yes**" or "**No**" to the following questions. Please note, to participate in this interview you must Check "Yes." A copy of this consent form will be provided to you for your records.

Do you agree for the researcher to audio-tape the interview process?

Yes _____ No_____

I have read the above document regarding the study "the Lived Experience of Youth Mental Health care on Cape Breton Island" I have been given the opportunity to discuss the above information. All my questions have been answered satisfactorily and I consent to take part in this research study. I understand that my participation is voluntary, and I can withdraw from the interview process at any time.

_____ _____

Signature of Participant **Date/Time**

I have explained the above document and the requirements of this study including the consent process. I judge the above individual understands the study requirements and understand that this study is voluntary and that they are able to withdrawal at any time during the interview process.

_____ _____

Signature of Principal Investigator **Date/Time**

Do you agree to be contacted to participate in the Member Checking process?

Yes_____ **No**_____

Phone Number or Email Address:

_____

Would you like to receive a summary of the results of the study?

If yes, provide an Email Address: _____

Appendix E

Resources for Participants

Kids Help Phone- 24//7**,** national support service that offers confidential, professional counselling, information, referrals to youth in English and French.

- Text CONNECT to 686868 to speak with a crisis responder
- Call- 1-800-668-6868
- Live chat with a Kids Help Phone counselor on the Kids Help Phone website or the *Always There* App available for iOs and Android platforms.
  https://kidshelpphone.ca/live-chat/
- The kids help phone website has a wide range of resources on multiple topics, including mental health support.
  https://kidshelpphone.ca/?_ga=2.178951396.1193164206.1572446189-656111034.1571186476

811- reliable health information about general health issues and mental health problems, provided by a registered nurse 24/7, 365 days of the year. 811 nurses can also provide information about services in your area.

- Dial 8-1-1
- Services in English and French
- https://811.novascotia.ca/

211- provides nova Scotians with reliable information about community and social services, 24/7, 365 days a year.

- Dial 2-1-1
- http://ns.211.ca/

Mental Health Mobile Crisis Telephone Line- a provincial service that provides Nova Scotians of all ages, who are experiences a mental health crisis or mental health distress, with crisis intervention. Services are available 24/7 356 days of the year. The crisis line also provides support to families and friends though education about management of mental health crisis.

- Dial 1-888-429-8167

Ally Centre Cape Breton- the Ally Center of Cape Breton provides a primary health care clinic to those who live with a stigmatized illness such as HIV, HCV, mental health and addition, homelessness, those who are in trouble with the law, sex trade workers, those escaping domestic violence, and individuals who are part of the LGBTQ+ community. Youth and adults can access this service.

- Monday and Thursdays 8:30 am- 2:30 pm.
- 150 Bentick Street, Sydney Nova Scotia.
- General Inquires: (902) 567-1766

Cape Breton University Students:
CBU provides free and confidential personal counselling services in the Learning Commons on campus. CBU's clinical social workers work with students for a variety of reasons including mental health concerns. Appointments can be made Monday through Friday during office hours as well as Monday evenings.

- Monday -Friday 9:00 am -4:30 pm (Monday evening hours)
- Drop in services- Wednesday 1:00pm-3:30 pm (first come first serve).

Nova Scotia Community College Marconi Campus Students:
Nova Scotia Community Collage provides students with counselling services to support student's well-being and mental health. Student have access to confidential one-on-one counselling services delivered by professional counselors.

- Call the Student Services team: 902-563-24-64
- Email: Marconi.info@nscc.ca

Cape Breton Regional Hospital Emergency Department: For emergency services please go to the CBRH Emergency Department. Open 24/7, 365 days a year.

- 1482 George Street, Sydney, Nova Scotia

Appendix F

Youth Participant Response Script/Screening Questions

Dear Name here,
Thank you for considering participating in this research study. My name is Maeridith Guy and I am a Master of Science in Nursing student at Dalhousie University. I am the head researcher of this study. I am conducting research that focuses on Cape Breton youth who have a mental health problem that you have identified, and you define, that you have been experiencing for at least 6 months.
Participation would include a 1-1.5-hour conversation about your experiences with your mental health problem while living on Cape Breton Island. If you choose to be part of this research, we will meet at a mutually agreed upon time and place. The conversation will be held in a private room in a public building. Further, if you would like to look at the consent before our conversation, I am able to send the form via email at least 24 hours before our interview.
Before moving forward, just a reminder that I am only able to accept youth who are between ages 16-21 and youth who live within the CBRM and speak English. I understand that talking about mental health problems is not easy and I really appreciate youth taking time to share their experience. If you have any questions or feel that you want to be part of this study, do not hesitate to contact me.

I look forward to hearing from you,

Maeridith Guy, RN

Appendix G

Letter of Interest Youth Community Supports/Services

Dear_____,

My name is Maeridith Guy and I am a Master of Science in Nursing student at Dalhousie University. I am completing my masters research which focuses on the lived experience of youth mental health in Cape Breton. The objectives of my study are to:
a) Gain a deeper understanding of the lived experiences of youth, ages 16-21 living on Cape Breton Island who have a self-identified, self-defined, prolonged (at least six months) mental health problem;
(b) Identify which mental health supports and services youth are using - or not using – and why;
(c) Explore the experiences resulting from their decision to use, or not use, supports and/or services; and
(d) Explore how Cape Breton youth perceive mental health services and supports are meeting the needs of youth and how these services and supports can improve?

I have identified that I need to know more about prominent youth support/services within the community. I am writing to you today to ask for your participation in my research study. I am asking to have an up to 1 hour conversation with the director/coordinator of your support/service in which answers will be given to general questions such as: the ages of youth that are using your service, information about your programming, and how your service is able to meet the needs of youth etc. I am able to meet in person, or hold the interview via phone. I will have to ask you to sign a consent form prior to answering the interview questions.

If you are interested in participating in my research, or have any questions, do not hesitate to contact me at this email or at (902)- 317-2705.
Your time is greatly appreciated.
Kind regards,
Maeridith Guy, BScN, RN.

Appendix H

Consent Form for Service Provider Interviews

Study Title: The Lived Experience of Youth Mental Health Care on Cape Breton Island

Investigator: Maeridith Guy, RN, BScN
Master of Science in Nursing Student
Dalhousie University
Halifax, NS
Maeridith.Guy@dal.ca

Research Supervisor: Jean Hughes, RN, PhD
Professor, School of Nursing
Dalhousie University
Halifax, NS
Jean.Hughes@Dal.ca

Introduction

My name is Maeridith Guy and I am a Registered nurse with the Nova Scotia Health Authority. Currently, I am a graduate student at Dalhousie University completing my Master of Science in Nursing. I would like to invite you to participate in the study I am conducting as part of my Graduate studies.

Participation in this study is completely voluntary. You will in no way be forced into participating in this study. You are able to withdraw at any point of the interview. The following document will describe the research study including the purpose of the research, and possible harms and benefits of participating. Any questions you may have can be directed to me or my thesis supervisor, Dr. Jean Hughes (jean.hughes@dal.ca).

Purpose of study

The purpose of this research is to explore the lived experiences of youth (16-21) with a self-identified mental health problem that has continues for at least 6 months and identify the supports and services they have, or have not, used on Cape Breton Island. I have identified the need to interview community-based youth service/support providers to further my understanding surrounding your program/organization. I am asking your permission to interview you about your community-based youth service/support. My objectives include:

1. Gaining a deeper understanding of which mental health supports, and services youth are using the least and most and why;
2. In what ways are mental health services and supports meeting, or not meeting, the needs of youth with mental health problems on Cape Breton Island
3. In what ways do these services and supports need to improve?

I will be asking you to answer questions, in as much detain as possible, regarding these topics. If you would like a report of this study, please check yes at the bottom of this consent form and provide your email address to which results will be forwarded.

Study Design and Participation

The research study design involves 10 one-hour interviews with a Cape Breton youth age 16-21 years. Data analysis of these interviews has begun. The research team as identified a need for an up to 1-hour interview with the director/coordinator of 4-5 community-based youth mental health service/ supports in Cape Breton. Participation is voluntary. Interviews will be scheduled for a mutually agreeable time and place between researcher and participant. In person interviews will take place in public building (e.g., library, community center). Interview questions will include general questions about your community-based

service or support, the youth who attend your programming, and questions regarding how your support is meeting needs of youth and if you believe your support/service can improve. If you agree to participate, I will ask you for written consent before the interview begins (face to face interviews) or verbal consent (over the phone interviews). Contact will end between you and Maeridith Guy after the interview.

Who conducts this research?

Maeridith Guy will be the primary researcher of this study. My study is approved by Dalhousie University Ethics Review Board and my thesis committee which includes, Dr. Jean, Hugues, RN, PhD (supervisor), Dr. Megan Aston, RN, PhD, and Laura Carnegy, RN, MN. This study is funded by the Maritime Spor Support Unit (MSSU) GMS: 2476.

Possible Harms/Discomforts

There are no anticipated harms involved with your participation. If you feel discomfort, you may pause and take a break before proceeding with the interview. You have the right to refuse to answer any questions during the interview. If you no longer wish to participate in the interview, the interview will stop immediately with no consequence.

Possible Benefits

You may not directly be benefited from participating in this study; however, your invaluable participation and contribution may help youth in the future, not only in Cape Breton but in other areas of Nova Scotia in which youth have mental health problems. This research also may help health care professionals understand youth experiences with mental health problems more clearly and assist with service allocation in the future on Cape Breton Island.

Confidentiality

Your confidentially is of outmost importance. Your name, or other personally identifying information, will not be used in any written reports, presentations or publications of this study. A pseudonym (fake name) will be used to replace your real name within the written reports, presentations and publications of this study. The name of the organization you represent will not be used in any written reports of this study, however, due to the limited services that exist of the island for youth, your service may be identifiable based on answers to interview questions or description of services. Interview transcripts, research notes and audio recordings will be kept in a locked cabinet at Dalhousie University for 5 years, and then destroyed. Only myself and my supervisor will have access to this cabinet.

The information obtained in this study will be strictly confidential unless required by law or our professional obligations. If you inform us about abuse or neglect of anyone age 18 or younger, we are required by law to contact authorities. If we notice that you are at an immediate risk of harming yourself or other people, we are required by our professional code of ethics to seek assistance. If I am required to disclose information about you, I will attempt to inform you.

Questions/Problems or Concerns

If you have any questions specific to this study at any time, do not hesitate to contact me Maeridith.guy@dal.ca or my thesis supervisor, Dr. Jean Hughes Jean.hughes@dal.ca. If you have a general question about research, please contact the Dalhousie University Research Ethics Board at (902) 494-3423.

Consent Form for community-based youth Supports/Services
"The Lived Experience of Youth Mental Health Care on Cape Breton Island"

Please check "**Yes**" or "**No**" to the following questions. Please note, to participate in this interview you must Check "Yes." A copy of this consent form will be provided to you for your records.

Do you agree for the researcher to audio-tape the interview process?

Yes _____ No_____

Do you agree for the researcher to use your direct quotes from the interview process, knowing that only fake names will be used (no real names of participants) in written reports of this study?

Yes_____ No_____

I have read the above document regarding the study "The Lived Experience of Youth Mental Health Care on Cape Breton Island." I have been given the opportunity to discuss the above information. All my questions have been answered satisfactorily and I consent to take part in this research study. I understand that my participation is voluntary, and I can withdraw from the interview process at any time.

_____ _____

Signature of Participant **Date/Time**

I have explained the above document and the requirements of this study including the consent process. I judge the above individual understands the study requirements and understands that this study is voluntary and that they are able to withdrawal at any time during the interview process.

_____ _____

Signature of Principal Investigator **Date/Time**

Do you agree to be contacted to participate in the Member Checking process?

Yes_____ **No_____**

Would you like to receive a summary of the results of the study?
If yes, provide an Email Address: _____

Appendix I

Verbal Consent Signature Page

The date is _____. I have verbally reviewed the consent form with the participant and believe that they understand the consent process. They have been given the opportunity to discuss the consent process and their questions have been answered. They have been informed that participation is voluntary and that they have the freedom to not answer any question and/or withdraw from the interview at any time during the interview. I have explained that this interview will be audio-recorded for ease of data analysis and the participant is in agreement with this. They understand that the information will be kept confidential within the limits of the law. They also understand that direct quotes may be used, knowing that no personally identifiable information will be used. They understand that their organization may be able to be identified based on answers to interview questions and descriptions of organization, however the name of the organization will not be used in any written reports. They understand that they may receive a copy of this signed and dated verbal consent form via email, if they request one. I have informed them about the Member Checking process, and they can leave contact information if they agree to participate in it, knowing that it is completely voluntary and that they do not have to participate in Member Checking to participate in the interview. I have told them that there will be a summary report available to them at the end of the study, if they would like one. Furthermore, they understand they can contact me or the research ethics boards with questions or concerns.

Participant # _____

_____	_____	_____
Researcher name	**Signature**	**Date**

Contact information if participant agrees to participate in "Member Checking" process:

_____

Email address if participant would like summary of the results of the study:

_____

Appendix J

Youth Community-Based Services Questions

1. Can you describe your community-based youth support/service?

2. Can you explain some of the activities/programming offered by your service/support?

3. Can you describe how the program started and why?

4. Can you explain what type of staff work within your support or service? What are their roles?

5. Do youth need a referral to access your service and if so from who?

6. What are the requirements of youth to use the support/service? Call all youth use your service? If not, for whom is your support/service designed?

7. Who is using your support/service the most (age groups, gender etc.)?

8. Do you notice any differences within age groups – which ages use the service, why they use the service, how they interreact within the program etc.?

9. In general, how do youth find out about your program?

10. What ways do your service or support recruit youth to take part in programing? Which ways work best?

11. Has social media affected the way you connect with youth? For example, how youth find out about your program?

12. How involved are parents within your program?

13. In general, how are youth transported to your program?

14. How does your support of service affect/assist youth with mental health problems?

15. Do you feel that your support/ service are meeting the needs of youth with mental health problems in CBRM?

16. How can your service or support improve to better support youth with mental health problems in CBRM?

Appendix K

Member Checking Email

Hello,

I hope you are well, and you are staying safe in these uncertain times. This email is regarding a study you participated in between January and February 2020, titled: *The Lived Experience of Youth Mental Health Care on Cape Breton Island.* I am emailing you today as you consented to the member checking process. If you no longer wish to participate in the member checking process, please feel free to ignore this email.

I have obtained data from 10 interviews with youth for this study. Common topics and sub-topics were generated from the 10 interviews. As discussed during our meeting, the member checking process allows participants to review a brief description of the topics and sub-topics to make sure that they can see their story represented in my findings. You may not identify with all topics/subtopics as all participants had a different experience, but I do hope you are able to see yourself represented in some.

Please read through the attached document and let me know, by replying to this email, if you think the topics are representative of your experience with your mental health problem while living in Cape Breton. I would be happy to discuss or clarify any questions or concerns you may have.

I truly appreciate you sharing your experiences with me, your courage certainly did not go unnoticed.

All the best,
Maeridith Guy BScN, RN
Master of Science in Nursing Program
Dalhousie University

Topics

The following topics have been found as common among 10 participants for the study "The Lived Experience of Youth Mental Health Care on Cape Breton Island." Again, you may not see yourself reflected in every topic, but I do hope you are able to see yourself represented in some of the topics listed below. Please note that some topics are divided into "sub topics" and are listed as a., b., c. etc.

1. **Trauma**- this topic focuses on the experience of a past negative life event. For example: parents' separation or death of family/friend.

2. **Familial Relationships**-this topic focuses on participants family (parents' guardians/siblings/ grandparents). It has been divided into two "sub-topics" (see below).

    a. **Familial Support**- some families supported participants and their mental health problem, for example, by helping with finding treatment, paying for therapy, checking in on participants.

    b. **Lack of familial support**- some families did not support participants and their mental health problem. For example, family members felt uncomfortable talking about the participant's mental health problem/ignored the mental health problem, did not think the mental health problem was real, or did not help the participant to find support for mental health problem.

3. **Social Relationships**- this topic focuses on supportive relationships between participants and people within the community such as friends, co-workers, teachers, professors, teammates, or service providers. This was divided into two sub-topics as seen below.

a. **Social support**- participants identified friends, co-workers, teachers etc. who provided support and made them feel comfortable being around and talking about their mental health.

b. **Service support**- participants feeling supported and comfortable with their doctor, nurse practitioner, therapist, social worker, community program worker or other formal service provider/support workers when talking about their mental health problem.

4. **Guilt**- negative emotions that some participants had about their mental health problems. This could include feeling worried that their mental health problem was negatively affecting others (their family/friends), or feeling worried that their family felt their mental health problem was the family's fault.

5. **Fear of Stigmatization**- some participants felt stigma (negative attitudes and beliefs) from people or environments such as school, or activities/organizations, within their communities. This stigma may have caused participants to hide their mental health problem(s) from others.

6. **Lack of Self-confidence**- for many participants their mental health problem caused a decrease in their confidence levels or their self-esteem (beliefs in one's self-worth). In addition, their mental health problems caused changes in their daily life. For example, some changes included a decline in grades, or their ability to hang out with friends which, in turn, affected their confidence within themselves.

7. **Peer Support** - some participants were able to connect with, and feel supported by, others who also have a mental health problem. This peer support could come from co-workers, teammates, or friends who the participant was able to relate to as they also have

a mental health problem. This connection with another person often made someone feel accepted, safe, and comfortable.

8. **Service Gaps**- a number of common service issues were identified by participants during interviews and were divided into 3 sub-topics as seen below:

a**. Lack of youth specific supports-** participants believed that there are very few mental health services or supports for people in jr. high and high schools in Cape Breton (community programs or specific mental health services for youth). Participants noted that wait times for services are too long, private services are too expensive, and that there are more services for adults than for youth.

b. **Lack of trust in the health care system-** participants felt uncomfortable using mental health services on the island due to negative ideas about services, past negative experiences with services, or fear of a health care professional having negative reactions to their mental health problem. This lack of trust made some participants not want to use health services for their mental health problems.

c. **Need for education (youth and parents)-** Many participants noted that they did not know where to get help for their mental health problem and believed that they did not get education about mental health problems in school. They also believed that their parents needed information about mental health problems to be able to understand/ help them with their mental health. This led to the need for more education surrounding mental health problems for youth and for parents/guardians.

9. **Personal Growth**- Participants' stories reflected their internal growth of throughout their journey with their mental health problem(s)

a. **Resilience**- resilience is a person's ability to overcome obstacles in life. This sub-topic noted participants being able to reach goals and overcome hardships even though they have a mental health problem. Some examples included: graduating from high school, being accepted into university, having a job etc.

b. **Reciprocity**- reciprocity means giving back to others and, in turn, making yourself feel good about what you have done. This sub-topic noted participants wanting to give back to, or help, people who feel like them/have a mental health problem. Some examples included: speaking about their own mental health problems with others to make them feel comfortable or being involved/volunteering for organizations/ groups for mental health awareness