

**FALLING THROUGH THE CRACKS:
AN EXPLORATORY STUDY REGARDING THE PERCEIVED
BARRIERS TO MENTAL HEALTH SERVICES FOR RURAL AND URBAN
CAPE BRETON YOUTH**

by

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ABSTRACT

Objective: In this study I explore perceived barriers to mental health services for rural and urban Cape Breton youth, investigate whether there are differences in the perceptions of rural and urban youth with respect to barriers to mental health services, and analyze whether age, gender and mental health status affect perceptions of barriers to mental health services.

Method: Questionnaires measuring perceptions of barriers were administered to adolescents within 9 schools on Cape Breton Island. The Mann Whitney U Test was used to examine potential differences between rural and urban youth perceptions, and two-way ANOVAs were used to test whether age, gender or mental health status influenced perceptions of barriers to mental health.

Results: Stigma, lack of proper education regarding mental health issues and lack of awareness regarding available resources were the greatest barriers overall. Rural youth perceived individual level barriers to be of greater concern, while urban youth perceived system level barriers to be of greater concern. Rural youth who had not reported any mental health issues perceived community level barriers as less important than all other youth.

Conclusion: These findings suggest the need for increased education and awareness with respect to mental health using anti-stigma campaigns as a vehicle for promoting positive and accurate messaging. Further research using focus group designs will add depth and insight to the initial findings and will provide possible clues as to why rural adolescents with no mental health issues have a different view toward community level barriers.

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Chapter 1: Introduction and Overview

Background

On October 14, 2004, the life of Theresa McEvoy was cut short when a 16 year-old-boy, who was joy riding in a stolen car, ran a red light and slammed into Ms. McEvoy's car. The details surrounding this tragic accident would lead to a public inquiry into the circumstances leading up to Ms. McEvoy's death.

The Nunn Commission of Inquiry resulted in an extensive report entitled, "Spiralling Out of Control: Lessons Learned from a Boy in Trouble" (Government of Nova Scotia, 2006). The 381-page report chronicled the early life of the 16-year-old highlighting the many challenges he would face including the separation of his parents, frequent moves from one community to another, an early diagnosis of ADHD, early and persistent difficulties in school, family conflict, experiences of being bullied, withdrawal from school, drug and alcohol use and eventual involvement with the criminal justice system. In considering all the evidence and testimonies, Justice Nunn stated, "I learned during this inquiry the crucial role that ADHD played in his life. I cannot underestimate the effect of attention deficit on his behavior and the decisions he made nor its contribution to his lack of educational success. How different his life would have been if his ADHD had been better managed" (Government of Nova Scotia, 2006, p.56).

The story of "a boy in trouble" serves to underscore the importance of strong family supports, prevention and early intervention as well as collaboration amongst service providers as critical protective factors along the path to adulthood. Based on this information Justice Nunn provided a list of recommendations, which encompass these very themes as a way of intervening more effectively with "at-risk" youth (Government

of Nova Scotia, 2006). However, it is not sufficient to ensure “availability” of mental health resources. Throughout his upbringing, it was assumed that numerous professionals (e.g., social workers, teachers, general practitioners) would have, or should have, referred the 16-year-old boy and his family to various mental health and related support services, and yet he was still following a path of self-destruction and of harming others. We need to understand why these resources were not being accessed. In other words, what are the barriers to accessing mental health services for youth?

In response to the Nunn Commission of Inquiry and its subsequent recommendations, the Nova Scotia Department of Community Services created the Child and Youth Strategy. The Strategy is an initiative to improve services to children, youth and families through greater collaboration amongst the four government departments: Health and Wellness, Education, Community Services and Justice (Department of Community Services, 2013a). One of the programs developed through the work of the Child and Youth Strategy was the Youth Outreach Program.

In addition to fulfilling the recommendations of the Nunn Inquiry, the creation of the Youth Outreach Program aligned well with federal and provincial commitments. In 2012, The Honourable Leona Aglukkaq, Minister of Health announced, “that researchers will be tackling the issue of improving access to mental health services for Canadian children and youth thanks to federal funding” (Canadian Institute of Health Research, 2012). Similarly the first-ever mental health strategy for Nova Scotia identified children and youth as a priority (Government of Nova Scotia, 2012a).

In March 2012, the provincial Youth Outreach Program was launched in 10 sites across Nova Scotia under the division of Family and Youth Services through the

Department of Community Services. The goal of the Youth Outreach Program is to improve the immediate and long-term social, economic and health outcomes for vulnerable youth. Recognizing that youth between the ages of 16-19 no longer fall under the purview of Child Welfare Services, the Youth Outreach Program was designed to address gaps in service for this client population. The Youth Outreach Program is not intended to be clinical in nature but is guided by a holistic approach to working with youth. As the NS Mental Health and Addictions Strategy (Government of Nova Scotia, 2012a) suggests, “We need to support people with mental illness, not just treat them” (p. 10). To this end, some of the services provided through the Youth Outreach Program include: crisis management, mentoring, family work, referrals and linkages, supportive counseling, programs and workshops, accompaniment, and outreach (Government of Nova Scotia, 2012b).

One of the unique features of the Youth Outreach Program is its commitment to a youth-centred approach from start to finish including: design, implementation, delivery and evaluation. As such, youth feedback was integral to creating a set of guiding principles to effectively “meet youth where they are at” and minimize barriers to service. To achieve this, the Nova Scotia Government convened a focus group of youth to discuss their needs and provide authentic input to help shape the creation and implementation of the Youth Outreach Program. For example, some of the questions posed to youth included:

- What would you like adults to know about youth who need this service?
- What are helpful ways adults can find out this information?
- What are helpful approaches adults can take when working with youth?

- What might an adult be surprised to learn about youth? (Government of Nova Scotia, 2012b).

The results of the focus group discussions, convened by the NS government, are summarized in illustration 1 and 2 in Appendix 1.

Family Service of Eastern Nova Scotia was one of the community-based agencies chosen to house the Youth Outreach Program for Cape Breton Island. Family Service of Eastern Nova Scotia is a not-for-profit agency that has been providing individual, couple and family counseling, as well as psycho-educational and therapeutic programs since 1969. It is a well-respected agency in the community and has a long history of collaboration with other government and community-based agencies.

For the past 16 years, I have been employed with Family Service of Eastern Nova Scotia (FSENS). I have held numerous front line positions within the agency including clinical counselor, adoptions/options counselor for expecting parents and community programmer. Currently I am the Director of Professional Services for the agency and oversee all programs and services that fall within the agency's mandate, including the Youth Outreach Program. The move to a management position within the agency reignited my desire to pursue my Masters of Social Work Degree and in 2011 I was officially accepted to the MSW program through Memorial University of Newfoundland.

This thesis represents the final academic requirement for completion of my MSW. Interestingly, this project evolved from an initial mixed methods research proposal (Church, 2012) for the course "Research, Theory, Design and Analysis" into a research project for Pathways Scholarship and finally into a full thesis. My assignment for the research course presented me with two feasible options for pathways project: a

quantitative or a qualitative research study. For my thesis, I chose to proceed with the quantitative project described in the proposal (phase 1) as I felt this would provide an overview of barriers confronting youth in Cape Breton. It would also provide between-group differences in youth perceptions of barriers, for example, males compared to females, urban youth compared to rural youth, and youth living with a mental health issue compared to youth who are not. After graduation, I plan to use the quantitative study results reported in this current thesis to guide a subsequent follow-up qualitative study (phase 2) using a focus group design. The qualitative information sought will serve to broaden our understanding of the prominent barriers and between-group differences revealed in the quantitative study. This sequential mixed methods approach will minimize the limitations that are inherent with a single method design and will contribute to the overall integrity of the research program (Teddlie & Tashakkori, 2006).

This research program also recognizes the value of involving youth as key participants of the study. As key participants, youth voluntarily completed a 35-item questionnaire regarding perceived barriers to mental health services. Historically, youth have not been recognized as agents of change to the mental health system because of their lack of power relative to adults. By investigating the perceived barriers to mental health services from a youth's perspective we gain critical insight that cannot be obtained from parents or professionals. It recognizes youth as experts of their own experience and it is their perceptions that are being sought. The process of participating in this research might also serve to break down perceptual barriers to accessing mental health services and raise consciousness of issues preventing their peers from accessing services (Mullaly, 2002). While the pragmatic nature of this research approach responds to questions that

are pertinent to Family Service of Eastern Nova Scotia, and more specifically the Youth Outreach Program, it is also expected that the findings from this study will highlight key areas for further research thus impacting a wider audience of stakeholders including: youth, service providers, researchers and community members at large. Recognizing the importance of anti-oppressive practice when working with youth, the qualitative research (phase 2) will use a youth-centred approach not only to identify barriers to mental health services but also to establish a plan for transforming our current mental health system into a more effective and efficient system that more readily meets the needs of our diverse youth living in Cape Breton. Additionally, the qualitative research will gather important information regarding cultural and socioeconomic status, which will provide insight regarding the social and structural inequities of our mental health system.

The Importance of Serving the Mental Health Needs of Adolescents

Adolescence can be a thrilling time of life filled with new adventures and a quest for independence. It is a time marked by significant milestones such as: first love, graduation, first job and first time living away from home. It is a period of identity formation characterized by rapid and dramatic development, including significant biological, psychological, social and spiritual changes, culminating in the transition to adulthood (Hutchison, 2010). Cognitively, adolescents must develop the ability to contemplate the future, develop a deeper understanding of human relationships and envision the consequences of their actions (Kroger, 2004). While many young people make the transition from adolescence to adulthood without the assistance of formalized supports, those who are not fortunate to have protective factors in place are at increased risk for such issues as substance use and abuse, juvenile delinquency and threats to

physical and mental health (Hutchison, 2010). In particular, oppressed youth including those born into poverty, youth of color, youth with disabilities, female youth, lesbian, gay and transgendered youth and immigrant youth are far less likely to have protective factors in place to buffer against the myriad of risk factors that they will face on their journey to adulthood (Costello, Mustillo, Erkanli, Keeler & Angold, 2003).

The mental health of adolescents is of particular concern because adolescents represent the age group with the highest prevalence of mental health problems (Wilson, Deane, Marshall & Dalley, 2007). It is also estimated that 70% of mental health problems begin in either childhood or adolescence (Public Health Agency of Canada, 2006). Current literature indicates that the most common mental health issues experienced by adolescents today include: anxiety, behavioural, and depressive disorders (Costello, Mustillo, Erkanli, Keeler & Angold, 2003; Waddell, McEwan, Shepherd, Offord & Hua, 2005). Suicide, in particular, is an area of serious concern as it is the second leading cause of death in Canadian youth (Statistics Canada, 2009) and more than half of those youth who attempt suicide experience high levels of distress that would meet the criteria for a diagnosable mood disorder (Shaffer et al., 1996).

Although these statistics are cause for concern, it is important to avoid a reductionist view of mental health that equates mental health issues with a label or diagnosis emphasizing individual deficiencies and faults. Mental health issues must be recognized within the socio-economic, cultural and political contexts in which they exist to understand how dimensions of power contribute to the marginalization of individuals who do not adhere to socially acceptable standards of behavior. Key to managing mental health issues is to provide effective support prior to, or at the onset, of problems, rather

than waiting until a point of crisis where the individual is provided with a diagnosis and, most often, prescribed medication as a primary means of treatment (Provencher & Keyes, 2011, Morrow & Weisser, 2012). Prevention efforts need to focus on enhancing the protective factors that have been proven to safeguard against risks to healthy development. Individual characteristics, such as relaxed temperaments, ability to problem-solve, good communication skills, ability to empathize and a sense of humor lead to increased resiliency for facing life's challenges (Resnick, 2000). Equally important protective factors include familial and extra-familial relationships. Strong connections to adults, healthy family functioning, and extra-curricular activities help build confidence and shield adolescents from the inevitable risks that they must confront on their journey to independence (Resnick, 2000).

The argument for prevention and early intervention would not be complete without an exploration of the long-term impact of ineffective or unavailable mental health services. When children who struggle with mental health issues do not receive appropriate support and services as youngsters, they become more vulnerable and less resilient throughout adolescence and into adulthood (Wattie, 2003). Poor mental health impacts emotional (e.g., depression and anxiety), behavioral (e.g., aggression, inattentiveness) and social functioning (e.g., inability to make or maintain friends) (Waddell, McEwan, Shepherd, Offord & Hua, 2005). Left without professional intervention, either from the formal mental health system or from community-based service initiatives, this impaired functioning can lead to more serious consequences including family conflict, drug abuse/misuse, school failure, homelessness, involvement with the criminal justice system and suicide (Wattie, 2003).

The financial costs of untreated mental illness to society are foreboding. Friedli and Parsonage (2007) suggest that preventing conduct disorders in one child through early intervention has been found to result in a lifetime of savings of \$280,000.00. To fully appreciate the financial incentive of preventing adult mental illness, it should be noted that the economic burden of mental health in Canada is estimated to be \$51 billion per year as result of health care costs, lost productivity (disability claims and absenteeism), and reductions in health-related quality of life (Lim, Jacobs, Ohinmae, Schopflocher & Dewa, 2008). Hence, the prevention of just 1% of mental health issues in Canada represents a yearly savings of \$500 million.

Despite the high prevalence of mental health issues during adolescence, the long-term impact of untreated adolescent mental health issues on the lifetime trajectory of an individual, and the socioeconomic benefits of effective early treatment, the distressing reality is that fewer than 25% of youth who require specialized services actually receive help (Waddell, McEwan, Shepherd, Offord & Josephine, 2005). The Canadian Mental Health Association (2014) paints an even starker picture, estimating that only one-fifth of the 10-20% of youth who are affected by a mental health issue will actually receive professional help. It is therefore essential to ask, “what are the barriers to mental health services?”

Key Concepts Defined for Shared Meaning

To ensure shared meaning and avoid ambiguity, it is important to define the key concepts that will be explored throughout this study. These concepts include: adolescent, mental health, mental health problems, mental health services/supports, mental health service provider, barriers, rural and urban.

1. **Adolescent** - an individual who is in the period of human growth and development that occurs after childhood and before adulthood, from ages 10-19 (World Health Organization, 2014). The age range of adolescents included in this study were between 15-20.
2. **Mental health** - Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community (World Health Organization, 2014).
3. **Mental Health Issues** - This represents the range of behaviours, thoughts and emotions that can result in some level of distress or impairment in areas such as school, work, social and family interactions and the ability to live independently. Mental health issues range from anxiety and depressive disorders through to schizophrenia and bipolar disorder, and are often associated with a formal medical diagnosis. The type, intensity, recurrence, and duration of symptoms of mental health problems and illnesses can vary widely from person to person, as well as by type of problem or illness (Mental Health Commission of Canada, 2010). For the purpose of this study, mental health issues are not limited to mental health diagnoses in the DSM-IV but can also include any type of mental/emotional distress that impairs a youth's ability to cope.
4. **Mental health services and supports** – a specialized service offered by a professional with specific training in mental health with the goal of assisting the adolescent to achieve optimal functioning. These include Child and Adolescent

Services, Youth Health Centres, Family Service of Eastern Nova Scotia clinical counselling and youth outreach service.

5. **Mental health service providers** - any professional with specialized knowledge in the area of mental health. Examples of mental health service providers include: general practitioners, psychiatrists, psychologists, nurses and social workers. It should be noted that a restricted definition is used in this study, because the focus is on professionals and the formal support network.
6. **Barriers** - any internal or external factor that prevents an individual from accessing necessary mental health services or supports. Internal factors include the individual's attitudes, values and beliefs that would act as an impediment to accessing services. An example of an internal barrier would be a belief that accessing mental health services is a sign of weakness. External factors include community or systemic issues that prevent an individual from accessing necessary mental health services and supports. An example of a community barrier would be lack of transportation. An example of a system barrier would be wait times for receiving services (Canadian Institute of Health Research, 2011).
7. **Rural** – Statistics Canada (2011) defines rural areas as small towns, villages or other populated places with a population under 1000. Within this study, these areas included communities residing within Victoria and Inverness Counties. More specifically, rural respondents were considered those students who completed the questionnaire and who attended one of the following schools: Cabot High, Ranking School of the Narrows, Baddeck Academy, Dalbrae

Academy, Inverness Education Centre and Cape Breton Highlands Education Centre.

8. **Urban** – Statistics Canada (2011) now refers to urban areas as population centres, which are further divided into 3 groups based on the size of their population: (1) small population centres – population between 1000 and 29,999 (2) medium population centres – population between 30,000 and 99,999 (3) large urban population centres – population of 100, 000 and over. For the purpose of this study, urban refers to the medium population centre of the Cape Breton Regional Municipality and includes respondents who live in communities that feed into the following schools: Glace Bay High School, Sydney Academy and Riverview High School. The estimated population for this catchment area is 58,000 (Government of Nova Scotia, 2014).

Chapter 2: Literature Review

Introduction

This chapter provides an overview of the literature on mental health as it relates to youth, as well as the potential barriers that may prevent youth from accessing important mental health supports and services. It also examines the available literature regarding the unique challenges and barriers to mental health services for youth living in rural and remote communities. Finally, this chapter highlights key findings specific to gender, culture, age and mental health status in relation to barriers to mental health services.

Youth and Mental Health

It is estimated that 1 in 5 young people in Canada are affected by a mental illness resulting in significant strain at home, school, the community and on our healthcare system (Waddell, McEwan, Hua & Shepherd, 2002). Moreover, 70% of mental health problems have their onset during childhood or adolescence (Public Health Agency of Canada, 2006) and young people between the ages of 15-24 are more likely to report mood disorders and substance use disorders than any other age group (Statistics Canada, 2013).

Table 1 illustrates the prevalence of children's mental health disorders and populations affected (Waddell, McEwan, Shepherd, Offord & Hua, 2005). Given that this table represents children and adolescents with clinically significant disorders, Waddell and colleagues predict that children and youth affected by mental health issues is 20% or higher if less severe mental health issues are also considered. While attention-deficit hyperactivity disorder and conduct disorders rank high on estimated prevalence of children's mental disorders, the rates of these aforementioned disorders typically decrease from childhood to adolescence and again from adolescence to early adulthood

(Costello, Copeland & Angold, 2011). Based on this information, it can be argued that anxiety and depressive disorders are most prevalent amongst adolescents. Also noteworthy is the fact that rates of mental disorders have been shown to increase as an individual moves from childhood through adolescence (Nguyen, Fournier, Bergeron, Roberge & Barrette, 2005).

Table 1: Prevalence of Children's Mental Disorders and Populations Affected in Canada
a

Disorder	Estimated Prevalence(%) ^b	Age range (years)	Estimated Population ^c	Estimated Population Affected ^d
Any anxiety disorder *e,f,g,h	6.4	5 to 17	5 318 000	340 000
Attention-deficit hyperactivity disorder *e,f,g,h,I,j	4.8	4 to 17	5 675 000	272 000
Conduct disorder *e,f,g,h,I,j	4.2	4 to 17	5 675 000	238 000
Any depressive disorder *e,f,g,h,j	3.5	5 to 17	5 318 000	186 000
Substance abuse *e,f	0.8	9 to 17	3 774 000	30 000
Pervasive developmental disorders *h	0.3	5 to 15	4 477 000	13 000
Obsessive-compulsive disorders *f,h	0.2	5 to 15	4 477 000	9000
Any eating disorder *f,h	0.1	5 to 15	4 477 000	4000
Tourette syndrome *f,h	0.1	5 to 15	4 477 000	4000
Schizophrenia *f	0.1	9 to 13	2 104 000	2000
Bipolar disorder *f	<0.1	9 to 13	2 104 000	< 2000
Any disorder *e,f,g,h,I,j	14.3	4 to 17	5 675 000	811 000

a Adapted from Waddell and others

b For methods used to pool prevalence rates from studies cited below, refer to Waddell and others (5)

c Population estimates for children in each applicable age range drawn from Statistics Canada

d Estimated prevalence multiplied by estimated population

e National Institute of Mental Health Methods for the Epidemiology of Child and Adolescent Mental Disorders Study (73)

f Great Smoky Mountains Study (74)

g Quebec Child Mental Health Survey (65)

h British Child Mental Health Survey (75)

I Ontario Child Health Study (66)

j Virginia Twin Study of Adolescent Behavioral Development (76)

Note. This table was reproduced with permission from author Charlotte Waddell, as well as the Canadian Journal of Psychiatry. Refer to Appendix 2 for formal approval.

Adolescence can be a turbulent phase of development where youth are confronted with a number of decisions relating to education, employment and relationships while simultaneously trying to balance their needs with that of their parents and peers. This quest for independence and attempt to remain in good standing with parents and peers often creates significant stress as youth transition through adolescence. Nyugen et al. (2005) found that significant daily stress has been associated with both depression and anxiety disorders, thus supporting the existing research regarding the prevalence of such disorders in adolescence.

According to the Canadian Mental Health Association of Canada (2014) 3.2 million Canadians between the ages of 12-19 are at risk for developing depression. Even more staggering are the statistics regarding youth suicide revealing that suicide is the second leading cause of death among youth aged 10-19, accounting for 11% of deaths among youth aged 10-14 and 23% of deaths among youth aged 15-19 (Statistics Canada, 2012). In a study examining factors that contribute to youth suicide, there was at least one mental disorder diagnosed in 89% of the cases, with mood disorders being the most frequent diagnosis (Fleischmann, Bertolde, Belfer & Beautrais, 2005).

In many cases, youth who are diagnosed with one mental health issue experience other mental health issues as well. According to Waddell et al. (2005), comorbidity impacts more than 50% of children and youth. Similarly, concurrent disorders, the co-occurrence of mental health and substance abuse problems are also a serious health concern amongst adolescents. More than half of youth seeking help for an addiction issue also have a co-occurring mental health problem, while 15-20% of individuals seeking mental health services are also living with an addictions issue (Canadian Centre on

Substance Abuse, 2009). Acknowledging the strong correlation between mental health and addiction services, the Cape Breton District Health Authority merged the Child and Adolescent Services Program with the Addiction Services Program to provide more seamless service delivery for affected children and youth (King, 2012).

While existing literature regarding formal mental health diagnosis during adolescence is certainly cause for concern, as social workers, we must also be mindful of our commitment to social justice and the social and structural inequities that exist within our mental health system. Intersectionality is an approach which allows us to examine the intertwine between the social, economic and political processes that maintain dominant ways of understanding distress and silencing the voices of those with lived experiences (Burgess-Proctor, 2006). More specifically, sanism which is the labeling of mental illness creates a form of inequity by valuing rational thinking and socially acceptable behavior and condemning those individuals who do not conform (Morrow & Weisser, 2012). Biomedicalism is another misuse of power whereby resources (most often medication) are rationed based on an individual's diagnosis and severity of symptoms as opposed to the provision of social supports and a collaborative community response (Morrow & Weisser, 2012).

Adolescence represents a critical period for providing support around mental health issues as the increasing cognitive capacities of adolescents allow them to participate more actively and effectively in therapies, as compared to children. For example, adolescents have increased capacities for storing and retrieving information, and perhaps even more central to the therapeutic process, are able to demonstrate

increased capacities for abstract reasoning and the processing of information (Oetzel & Scherer, 2003).

Unfortunately, despite the evident need and cognitive capabilities of adolescents, it is estimated that less than 25% of children and youth receive specialized services (Waddell, McEwan, Shepherd, Offord & Hua, 2005). It is therefore essential to learn more about why young people are not accessing mental health supports, so that strategies to engage adolescent youth to promptly seek help for mental health concerns can be implemented. In light of high prevalence of comorbid drug use and mental health issues in adolescent populations, the need to reduce barriers to mental health services appears all the more important, because these impediments are liable to result in a delayed reception of therapies and support, after relatively treatable issues have evolved into complex problems. Also needed is a rebalancing of our mental health system that addresses both the social and the biomedical needs of our youth. Moreover, we need to involve youth in the transformation of our mental health system and move away from crisis driven mental health care towards a more holistic understanding of mental health.

Barriers to Mental Health Services for Adolescents

In the following section, the current literature regarding the nature of barriers to mental health services for youth are highlighted. To align with the conceptualization of barriers in the current study, this literature review will explore barriers to mental health services based on (1) individual – personal attitudes and beliefs operating at the micro level (2) system – organizational and structural issues operating at the macro level (3) community level barriers – geographic and social location issues (CIRH, 2010). In most instances, it is presumed that barriers are present at more than one level. This is followed

by an examination of whether or not barriers are thought to affect different populations of youths to the same degree.

Individual Level Barriers

Stigma, defined as negative stereotypes often resulting in discrimination toward those suffering from mental health issues (CIHR, 2010), was found to be a consistent barrier to accessing services (Gulliver, Griffiths, Christensen, 2010; Davidson & Manion, 1996, CIHR, 2010; Wilson, Deane, Marshall & Dalley, 2007). Internalization of negatively held views leads to embarrassment, fear, and susceptibility to peer pressure, creating a desire to “suffer in silence” rather than risk identifying oneself as needing support and thus being labeled as “crazy” or “insane” (Davidson & Manion, 1996; Francis, Boyd, Aisbett, Newnham & Newnham, 2006).

During early and middle adolescence, relationships with peers become increasingly important thus children and adolescents are especially susceptible to these individual barriers (Ellenbogen & Chamberland, 1997). Recent findings suggest that young people with mental health issues prefer to confide in their peers, or their parents, rather than confiding in mental health professionals when dealing with mental health challenges (Wilson, Deane, Marshall & Dalley 2008; Kuhl, Jarkon-Horlick & Morrissey, 1997; CIHR, 2010).

Concerns related to breaches of confidentiality are also in the forefront of the minds of adolescents and can act as an impediment to accessing services (Kuhl, Jarkon-Horlick & Morrissey, 1997; Wilson, Deane, Marshall & Dalley 2008; Gulliver, Griffiths, Christensen, 2010; Sareen et al., 2007). Youth who have had negative experiences with the mental health system are likely to be suspicious of mental health service providers,

thus contributing to increased concerns related to trust and confidentiality (Sareen et al., 2007; Wilson, Deane, Marshall & Dalley 2008, CIHR).

System Level Barriers

There appears to be consistency regarding the specific types of system level barriers that are reported by both service users and service providers: long wait lists, approaches to service delivery that are not youth-centred, workforce concerns, lack of education and awareness, and funding shortages (Canadian Institutes of Health Research, 2010; Wilson, Deane, Marshall & Dalley 2008; Sareen et. al, 2007; Meredith, Stein, Paddock, Jaycox, Quinn, Chandra & Burnam, 2009).

The issue of long wait times for accessing services is all too familiar across Canada. Moreover, it is suggested that a spike in teens arriving at ER departments with self-inflicted injuries and suicidal ideation has resulted in even longer wait times for outpatient services (CBC News, 2014). The length of time between the initial point of contact and the start of treatment is shown to be inversely associated with attendance and treatment engagement (Reid & Brown, 2008). Further research is needed to better understand why youth are waiting until the point of crisis before accessing services so that effective treatment options can be made available in a timely manner when there is reduced risk.

Lack of collaboration and cooperation amongst service providers has also been recognized as a significant barrier to mental health services (Reid & Brown, 2008) resulting in silo-type methods of service provision. This approach leads to fragmentation of services, as well as difficulties navigating and accessing necessary support services (Sterling, Weisner, Hinman & Parthasarathy, 2010). The Nunn Commission of Inquiry

includes a report recommending improved collaboration on responses to youth at risk. Without this collaboration, we risk only seeing a “part” of the child instead of the “whole” child, the consequence of which, is youth falling through the cracks of our systems (Government of Nova Scotia, 2006). A seamless and more integrated approach to service delivery will result in improved outcomes and less chances for youth to fall through the cracks of formalized systems of care.

In addition to a lack of youth-friendly services (ie. flexible hours, non-clinical setting, integrated services), workforce concerns are also barriers to youth seeking services. Workforce concerns can be defined as difficulty recruiting and retaining qualified professionals in the area of mental health (CIHR, 2010). One of the consequences of workforce concerns is lack of specialized mental health services, which leave much of the service delivery in the hands of general practitioners (GPs), ER departments, and, in some circumstances, police and criminal justice services (McIllwraith & Dyck, 2002).

In addition to the shortage of mental health services and supports, lack of awareness of existing resources and limited mental health education and promotion are also concerns (McIllwraith & Dyck 2002). Young people may benefit from increased awareness of the prevalence of mental health disorders during adolescence, the primary symptoms of common mental health problems, and where and how help can be accessed if required.

Not surprising, funding shortages also represent a significant systemic barrier in terms of accessing mental health services. In Ontario, not-for-profit children’s mental health agencies represent the largest providers of specialized mental health services, yet

they have not received funding increases in more than a decade (Reid & Brown, 2008). It is expected that similar trends can be found across Canada. While it is obvious that increased funding is needed to help improve access to necessary mental health services, it must be recognized that the crisis of Canada's mental health system is bigger than a dollar figure. A national action plan is needed that acknowledges the inequities of our mental health system as well as the systemic issues that contribute to competition and fragmentation of services rather than collaboration and integration of services.

Community Level Barriers

Research suggests that geography and social location are two key community level barriers that can impede access to mental health services (CIHR, 2010). Some community level barriers include: workforce shortages, lack of anonymity, lack of transportation, socio-economic status, gender, and cultural identity. These barriers will be discussed in more detail in subsequent sections. In light of Cape Breton's predominantly rural population, it is important to understand the unique demographic and cultural attributes that lead to barriers to mental health services.

The Rural Context: Barriers to Mental Health Services

Although similar barriers to mental health services can be found across all youth populations, rural adolescents – those living in remote communities in particular- appear to face distinct challenges. Many of the barriers that are present for youth in general are compounded by living in rural communities. The World Health Organization (2015) defines social determinants of health as the conditions in which people are born, grow, live, work and age. In rural communities, youth are more likely to achieve lower levels of education, have fewer employment opportunities, and experience greater poverty than

their non-rural counterparts, all of which put these youth at increased risk for poor mental health (Curtis, Waters & Brindis., 2011). Understanding the cause of these inequities, particularly how power and resources are distributed, will be critical in removing barriers for rural youth and transforming our current mental health system.

In rural communities, issues of anonymity and confidentiality are heightened due to the greater familiarity that exists between people living in rural areas (Wilson, Deane, Marshall, Dalley 2007). Although, “knowing your neighbours” is generally a community benefit, it has the disadvantage of increasing fear of gossip, particularly if there is stigma attached to having mental health issues.

As noted earlier, youth are impeded from seeking mental health services due to a culture of self-reliance and apprehension regarding the motives of adult strangers. In rural communities, it might be argued that there is an increased sense of “taking care of oneself” and not seeking support from outsiders (Francis, Boyd, Aisbett, Newnham & Newnham, 2006).

Hiring and retaining qualified mental health professionals to work in rural communities is also a significant challenge. While an estimated 30% of Canada’s population lives in rural communities, only 17% of family physicians, 4% of specialists and 17% of registered nurses practice in rural and remote communities (Kilty, 2007). There tends to be a high turnover of health professionals in rural environments (Boydell, Pong, Volpe, Tilleczeck, Wilson & Lemieux , 2004). As a result, people in rural communities feel that professionals are not committed to helping them and are simply biding their time until something better comes along. Such feelings risk increasing young people’s mistrust of formal health care systems.

Although accessing primary care can be an important first step in reducing distress and accessing support, it is not an ideal solution for youth requiring specialized mental health interventions. Furthermore, the shortage of physicians in rural communities means that physicians are often overworked and do not have adequate time to complete thorough mental health assessments and develop appropriate treatment plans.

Consequently, pharmacological interventions become the primary means of treating those presenting with psychological and emotional distress (McIlwaith & Dyck, 2002). Also, the high turnover of physicians in rural communities results in reduced continuity of service delivery (Boydell, Pong, Volpe, Tilleczek, Wilson & Lemieux, 2004). Despite these challenges, primary care is often the only available choice to youth requiring mental health support as specialized services tend to be centralized in urban centres.

Cultural Barriers to Mental Health Services

While this study does not specifically examine perceptions of barriers from a cultural perspective, it is important to have an understanding of how one's cultural background relates to barriers to mental health services. Recognizing the strong First Nations and Acadian presence that contributes to the diversity of Cape Breton Island, these two particular cultures will be highlighted as part of this literature review.

When considering the mental health of First Nations people, it is necessary to recognize the historical impact of colonization, assimilation and trauma from residential schools. By imposing our Eurocentric culture, First Nations people have been stripped of their traditions, lifestyle and right to self-determination resulting in significant health and social problems (Khan, 2008). Other factors that have contributed to the poor mental

health of First Nations people include the disproportionate rates of poverty, poor housing and lack of employment opportunities (Public Health Agency of Canada, 2006).

Of particular concern for youth in First Nations communities is the high rate of suicide. The suicide rate among First Nations youth is estimated to be 5 to 8 times the national average (Health Canada, 2013). Unfortunately, many of the mental health services available are embedded within a westernized system, are not culturally competent and do not meet the needs of First Nations people (Thomas & Bellefeuille, 2006).

Fortunately, Aboriginal people are more likely to seek professional help than non-Aboriginal Canadians (Khan, 2008). A potential explanation for this is the holistic view of health that is central to the Aboriginal culture. A further explanation is cited in a Public Health Agency of Canada document, “In contrast to the emphasis on the individual in much of Euro-Canadian society, the concept of the healthy person common to most Aboriginal cultures emphasizes relations and connections to others” (Public Health Agency of Canada, 2002, *The mental health and well-being of Aboriginal peoples in Canada*). Based on this information, it is important that access to Aboriginal healing practices be more readily available and promoted with both Aboriginal and non-Aboriginal service providers.

While the Acadian culture only represents approximately 5% of Cape Breton Island’s populations (Government of Nova Scotia, 2014) from a social justice perspective, it is still important to highlight the barriers to mental health services faced by this population. Recognizing French as the mother tongue of this population, language barriers become a primary impediment to accessing mental health services. According to

Statistics Canada (2007) 40% of Francophones living outside of Quebec expressed finding French language health care difficult to obtain due to a lack of French-speaking service providers. For Acadians living in Cape Breton, this barrier is compounded by the fact that the majority of the Acadian communities are located within rural areas of the Island, thus making it more difficult to attract bilingual service providers that have specialized mental health training.

Gender Patterns as Barriers to Mental Health Services

Thus far, many of the barriers to accessing mental health services for youth have been discussed, however, it is important to examine the impact of gender in terms of accessing services, as well as its impact on perceived barriers. There appears to be consistency in the literature that differences exist between male and female help seeking trends. Particularly, it is suggested that females seek help to a greater degree than males (Kuhl, Jarkon-Horlick & Morrissey, 1997; Chandra & Minkovitz, 2005; Cheung & Dewa, 2007). In a study by Chandra & Minkovitz (2005) it was found that girls were twice as likely as boys to report willingness to use mental health services. This study also highlighted key barriers to mental health services from the perspective of gender.

While some of the key barriers to accessing services were not impacted by gender (e.g. embarrassment, lack of trust in counselor) the study by Chandra & Minkovitz (2005) revealed a number of significant barriers that were greater for males than females. For example, boys reported higher stigma towards mental health issues than females. Boys were also reported to have less experience and knowledge with respect to mental health issues than girls. In response to a case scenario where a peer was dealing with an emotional problem, the boys were more likely to adopt a belief that the problem would go

away on its own or that the individual should figure it out themselves as opposed to seeking help.

Informal sources of support were also documented in the literature with girls being more likely to confide in peers whereas boys were more likely to confide in a parent or family member (Chandra & Minkovitz, 2005; Kuhl, Jarkon-Horlick & Morrissey, 1997). Interestingly, even after confiding in a parent first, boys continued to be less willing to access mental health services than girls. This disparity points to parental influence also impacting service usage amongst male youth and how perceived parental disapproval can act as a significant barrier to necessary services.

Specific to depression and suicidality, females were reported to be more likely to use the services of a general practitioner, social worker or counselor than males (Cheung & Dewa, 2007). Additionally, it is suggested that male adolescents are less likely to express thoughts of suicide prior to completing suicide (Cheung & Dewa, 2007).

The impact of gender differences on perceived barriers to mental health services would not be complete without discussing the influence of socialization of gender norms. Many of the barriers that prevent men from accessing important and necessary services can be explained as a product of masculine gender role socialization (Addis & Mahalik, 2003). The messages that males have been taught to believe about what it means to be male often conflict with the tasks required to seek professional help for mental distress and illness. For example, masculinity is often equated with lack of emotional expression, physical toughness and self-reliance (Addis & Mahalik, 2003). Based on this societal expectation, it is understandable why males perceive greater barriers to accessing mental health services than females.

Recognizing that parents are our children's first teachers, they must be reminded of the tremendous influence and crucial role they play in shaping attitudes and beliefs towards healthy masculinity. This will undoubtedly lead to a much more positive outlook towards help seeking and its inherent benefits. Similarly, health education curriculum presents another opportunity to influence gender attitudes toward a more accepting and healthy view of mental health services and supports.

Age Impacting Barriers to Mental Health Services

While there seems to be differing ideas about the ages that accompany the stages of adolescent development, it is generally accepted that adolescence can be broken down into three distinct phases: (1) early adolescence, (2) middle adolescence and (3) late adolescence. As the literature has shown, adolescence is a critical age for the onset of mental health issues (Public Health Agency of Canada, 2006). To understand whether barriers to mental health services are impacted by age, the trajectory for mental health issues during adolescence is explored.

A study by Davidson & Manion (2007) sought to examine the effect of time on prevalence of mental health issues for adolescents and the extent of service utilization in relation to the prevalence data. The results of this study suggest that as children and adolescents get older, the prevalence rates appear to get higher. It is thus suspected that the impact of mental health issues and disorders is cumulative over time underscoring the importance of early intervention. This finding is consistent across the literature suggesting that the transition from adolescents to adulthood is also marked by an increase in rates of disorder (Costello, Copeland & Angold, 2011).

While there is little literature available regarding age-specific help seeking trends of adolescents, Cheung & Dewa (2007) found that 40% of adolescents aged 15-18 years with depression had not sought mental health services. This number was slightly higher (42%) for youth aged 19-24 with depression. Kellam et al. (1981) found that help-seeking amongst adolescents was independent of age. Recognizing that the prevalence of mental health issues increases with age, future research is necessary to improve our understanding of age-related barriers to mental health services to ensure appropriate and timely supports and services.

From the perspective of systemic barriers (macro level issues), it has long been acknowledged that a significant gap in services exists for Nova Scotia youth between the ages of 16-19. In particular, given that the Family and Children Services Act defines a child as any individual under the age of 16 (Government of Nova Scotia, 2009), our child welfare systems are failing in their duty to protect those in late adolescence from potential abuse and neglect. Moreover, given that in most cases youth under the age of 19 are not eligible for income assistance (Government of Nova Scotia, 2013b), victims fleeing from neglectful and abusive households are left to their own devices for basic survival.

The impact of this legislation is evident in what is termed “hidden homeless” for youth in Cape Breton (Human Resources and Social Development Canada, 2008). Due to a lack of homeless shelters for youth in Cape Breton, many youth are forced to rely on friends to accommodate them. Youth who are not living at home are at increased risk for mental health concerns (Davidson & Manion, 2007). An estimated one-third of street youth suffer from depression or PTSD; they also have high rates of suicide (Raising the

Roof, 2008). This information, coupled with the fact that 17-18 year olds are considered the age group at highest risk for suicidal thoughts underscores the need for reform to our Children and Family Services Act.

The Impact of Mental Health Status in Relation to Perceived Barriers to Mental Health Services

While considerable literature is available regarding perceived barriers to mental health services, there is a paucity of research available regarding differences in perceptions of barriers for those youth who are affected by mental health issues compared to youth who are not affected. From an anecdotal perspective, it seems logical that those affected by mental health issues would be more aware of barriers to mental health services. When deciding as to whether or not they should access services, they might reflect on the potential consequences of seeking help (e.g., breach of confidentiality). There is some evidence that those affected by mental health issues perceive greater barriers. Meredith et al. (2009) examined the perceptions of depressed and non-depressed teens to better understand the perceived barriers to treatment for adolescent depression. Depressed teens were more likely to perceive barriers to care compared with non-depressed teens. For example, 16.3% of non-depressed teens “somewhat agreed” or “strongly agreed” with the barrier “Stigma-worry about family’s perceptions” compared to 45.1% of depressed teens. Other barriers that were of greater concern to depressed teens compared to non-depressed teens included: cost, worry about what others might think, trouble making an appointment, personal – other responsibilities, good care not available and don’t want care. While some of these barriers may in fact exist, Meredith et al. (2009) also point out that those suffering from depression may experience cognitive

distortions of helplessness and hopelessness that lead to the increased perception of barriers than those not suffering from depression.

Chapter 3: The Current Study

Statement of the Problem and Research Questions

Based on this review of the literature, it is reasonable to assert that our current mental health service delivery systems are not meeting the needs of youth in our communities. To ensure children and youth are provided with effective supports, services and treatment, additional research is needed to better understand the barriers to mental health services. Also based on this review, it is clear that geographical location, age, gender and mental health status of youth must be key considerations of any research exploring the barriers to mental health services.

This cross-sectional comparative study seeks to answer the following research questions:

1. What are the predominant barriers to seeking mental health services for youth living in rural and urban communities?
2. Are there any differences that exist between these two populations with respect to their perception of barriers to mental health at the system level (e.g. wait times, lack of funding), community level (e.g. lack of transportation, fear of gossip) and individual level (e.g. embarrassment, preference to rely on friends or family)?

I also investigate two secondary questions:

1. Do age, gender and mental health status affect the youth's perception of barriers at the system, community and individual levels?
2. If there are differences in the way rural and urban youth perceive barriers at the system, community and individual levels, are these differences moderated by age gender and mental health status?

I believe the value of this study is threefold:

1. To my knowledge, this is one of the most detailed measure of barriers ever created and will provide an in-depth portrait of the precise barriers experienced by this population.
2. It provides an increased understanding of the differences in barriers affecting urban and rural populations in that it will aid rural administrators in developing programs that better target the specific barriers affecting youth in their communities.
3. Investigation of differences by gender, age and mental health status will provide a nuanced contrast of the perceptions of youth in rural and urban environments. This will provide greater insight whether specific groups need to be targeted and what messages might be effective at reducing barriers.

Due to the limited research respecting barriers, particularly among rural populations, this study is largely exploratory. However, based on the research presented in the literature review, the following hypotheses are examined:

1. Rural adolescents face greater barriers to accessing mental health services than their urban counterparts. Specifically, it is hypothesized that rural youth will express more concerns regarding gossip and lack of anonymity, and a stronger belief in the importance of self-reliance and community reliance (Curtis, Waters & Brindis, 2011; Francis, Boyd, Aisbett, Newnham & Newnham, 2006).
2. The general trend will be for males to feel greater stigmatism, be less knowledgeable, and seek less help regarding mental health issues. Given this evidence of greater knowledge deficits and fears, it is expected that males will

generally perceive more prominent barriers to mental-health services (Chandra & Minkovitz, 2006).

3. Youth who are affected by mental health issues will perceive more prominent barriers to mental health services than those youth who are not affected by mental health issues (Meredith et al., 2009).

Ethical and Theoretical Considerations

As social workers, one of our core values is the pursuit of social justice. The Nova Scotia Association of Social Workers Code of Ethics (2008) states, “Social workers promote social fairness and the equitable distribution of resources, and act to reduce barriers and expand choice for all persons, with special regard for those who are marginalized, disadvantaged, vulnerable and/or have exceptional needs” (p.7).

Additionally, social workers must respect the inherent dignity and worth of all people and must practice in accordance with this belief. I believe this study aligns with the core values of the social work profession particularly with respect to promoting equity and reducing barriers to marginalized youth, and integrating their perspective and experiences in the planning of social work practice. It is expected that this research, and resulting thesis, will serve as a document that will raise awareness with key stakeholders (i.e., youth, employers, politicians, policy makers and the general public) to ensure mental health services to Cape Breton youth are accessible, effective, equitably distributed and adherent to principles of anti-oppressive practices.

This research is informed by standpoint theory; a feminist epistemology, which emerged from Marxist ideology (Best, 2008). Although rooted in feminism, standpoint theory embraces the diverse perspectives of groups who have been marginalized based on

their race and ethnicity, age, sexual orientation, gender, class and physical ability (Borland, 2015). To this end, standpoint theory is the perfect compliment to anti-oppressive practice, which seeks to empower those who have experienced oppression by challenging the dominant discourse and creating space for new knowledge, with multiple truths, that values the perspectives of “others” (Best, 2008). According to standpoint theory, less powerful members of society experience a different reality than the dominant class (Swigonski, 1994). Children and youth are one particular group who are often viewed as less powerful than their adult counterparts. Far too often, youth are not seen as having agency to affect positive change in their lives. Yet by acknowledging the agency of youth, and giving youth an opportunity to share their perceptions of our current mental health system and their views towards mental health in general, we gain “insider” knowledge about what matters to them (Levison, 2010). Youth are more aware of the social reality of their situation and, as a result, their knowledge is helpful in defining and providing insight into important areas for research, policy development and direct services that will lead to better outcomes for enhanced well-being (Harding, 1991).

The influence of standpoint theory is also present in this research by challenging conventional ideologies about mental health. Mental health services tend to be created in urban environments by dominant group members (e.g. White, English-speaking, male adults). Moreover, medicalization of distress and misbehavior become a central focus without due consideration of the social, cultural, environmental and political influences on the individual (Gomory, Wong, Cohen, & Lacasse, 2011). Consequently, services are often ineffective and systems of oppression are maintained. Conversely, according to Best (2008), “standpoint theories treat all knowledge as bounded by the cultural position,

historical place, and biography of the knower” (p. 896). Therefore, from the perspective of standpoint theory, it is essential to elicit information from those directly impacted (youth=knower) in terms of what they perceive to be the most significant failings of the mental health system in terms of how it is currently being delivered. Knowing that inequities in health and social service delivery have traditionally existed, the differences between groups in perceptions were also sought to shed light on whether and how they continue to exist.

While influences of standpoint theory are clearly evident in this study, it must be acknowledged, that this study (phase 1), as a standalone research project, does not embody all of the characteristics of standpoint theory. Similarly, although the Youth Outreach Program functions within a youth-centred framework, this particular research does not adopt this paradigm (for definition, see Nova Scotia Public Health Services, 2009). However, this study gathers knowledge that can’t be accessed through other means. Moreover, this knowledge can be integrated into a youth-centred approach as a next step. Just like their adult partners (e.g., practitioners, policy-makers), youth who are engaged in the transformation of health services can also be informed of the results of the study. Their interpretations will likely contribute unique insight on the issues. Thus, this particular study is a quantitative study embedded within a larger youth-centred approach to research-informed practice guided by standpoint theory. Phase two of this research will be qualitative in nature using focus group discussions to draw upon the expertise youths possess based on their lived experiences.

Chapter 4: Methodology

Participants

Participants were recruited from grades 10, 11, and 12 from nine public schools on Cape Breton Island, Nova Scotia, Canada. Three of the nine schools were considered schools from urban areas of Cape Breton (a population in excess of 1000), while six of the schools were considered schools from rural areas of Cape Breton (a population under 1000) (Statistics Canada, 2011). Both male and female students in grades 10, 11, and 12 from the nine schools were provided the opportunity to participate in the study. Ages of the students ranged from age 15-20. Females and youth ages 17-18 appear to be overrepresented in the sample. (see Table 2).

Table 2: Breakdown of participants based on rural/urban status, age, gender and mental health status

Variable		Number of individuals	% of Sample
Rural/Urban Status	Rural	83	57.2
	Urban	62	42.8
Age	15-16	58	40.0
	17-18	81	55.9
	19-20	5	3.4
Gender	Male	43	29.7
	Female	100	69.9
Mental Health Status	No Mental Health Issues Reported	54	37.2
	Suspected MH issues but did not seek help	33	22.8
	Sought help for MH issues	58	40.0

Students who returned both their individual and parental consent forms were eligible to complete the questionnaire. Approximately 1400 consent forms were distributed to potential participants in three urban schools; 77 were returned and 62 youth

participated in the study. A total of 516 consent forms were distributed to potential participants in six rural schools, 104 were returned and 84 youth participated in the study. Thus the participation rate (number of participants/number of consent forms sent) for the study was 7.6% (4.4% for urban schools and 16.2% for rural schools). Of the students who returned a consent form, 78% participated in the study (80.5% for urban schools and 80.8% for rural schools).

A high percentage of youth had mental health problems, as only one-quarter of urban youth and less than half of rural youth reported no problems. This is more than double the national average (Waddell, McEwan, Shepherd, Offord & Hua, 2005). Also a high percentage of rural youth (28%) did not seek help for a mental health issue, as compared to urban youth (16%). (See Table 3)

Table 3: Breakdown of Mental Health Status

Mental health Status	Rural		Urban		Total	
	#	%	#	%	#	%
No Mental Health Issues Reported	37	44.6	17	27.4	54	37.2
Suspected Mental Health issues but did not seek help	23	27.7	10	16.1	33	22.8
Sought help for Mental Health Issues	23	27.7	35	56.5	58	40.0
Total	83	100	62	100	145	100

Although demographics pertaining to socioeconomic backgrounds and ethnicity were not specifically requested, the demographics of Cape Breton Island with respect to ethnic origin point to a predominantly white population consisting of Scottish, Acadian, Irish and English cultures. Other ethnic origins that are represented within the catchment area for this study include those from Aboriginal (8.9%), African (.3%), and Asian

(1.9%) ancestries (Government of Nova Scotia, 2014). According to the census of 2006, the socioeconomic status of families within Cape Breton Island would be considered middleclass with the average family income equaling \$57, 478.33 with the median family income equaling \$49, 494.33 (Government of Canada, 2014).

Measure

A 30-item questionnaire was created by integrating known barriers based on prior research, and guided by a conceptual model presented by the CIHR(2010) , namely that there are three levels. Although other researchers have devised measures for assessing perceptions of mental health service barriers (Wilson, Deane, Marshall & Dalley, 2008; Sareen et al., 2007; Meredith et al., 2009; Kuhl, Jarkon-Horlick & Morrissey, 1997), no one measure sufficiently covers the full range of barriers as identified by the CIHR. For example, Wilson et al. assessed mental health barriers specific to GPs, Meredith et al.'s questionnaire was limited to seven broad barriers, Kuhl et al. did not sufficiently cover community level barriers and overemphasized therapy as the primary intervention. Participants were asked to indicate their agreement or disagreement with each item on a 1-5 scale (1= strongly agree; 3= neutral; 5 = strongly disagree). Thus, higher scores on this scale indicated items that were less likely to be a barrier than lower scores. Five questions gathered demographic information pertaining to age, gender, living accommodations, and mental health status.

Procedure

As this study involved research with human subjects, a proposal was submitted to, and approval obtained from, the Interdisciplinary Committee on Ethics in Human

Research (ICEHR) at Memorial University. Additionally, proposals were submitted to the local school boards in Cape Breton who also sanctioned this research study.

To find schools willing to participate in the study, I contacted each of the principals from the proposed schools to explain the nature of the research, the practical aspects of how the questionnaires would be administered and how this research could potentially benefit the individuals, schools and community. All schools that were contacted agreed to be involved in the study.

Most of the youth recruited for this study were under the age of majority, and thus it was necessary to obtain both individual and parental consent. Information packages, consisting of information letters and informed consent forms for both participants and their parents/guardians, were created for each student in grades 10, 11, and 12 of the participating schools. The information packages also contained a card with the name and contact information of a mental health professional in the event that any participant would feel a need to access such services.

A prepared statement was read out loud to the students in their classrooms, explaining the purpose of the questionnaire, as well as the potential benefits and risks of participating. It was also made clear to the students that their participation in this study was completely voluntary. Following the presentation, the information packages were distributed to each of the students with instructions to take the information home to their parents or guardians. Students wishing to participate in the study were instructed to return their signed consent forms to their teacher by a designated deadline.

A master list was created from students who had returned their signed consent forms. On the day of questionnaire administration, students from the master list were

assembled in a common space to complete the questionnaire. The questionnaires were completed in less than twenty minutes on average. No identifying information was collected on the questionnaires.

To help interpret the results of the current study, a focus group was convened consisting of social workers from Family Service of Eastern Nova Scotia who work in both urban and rural areas of Cape Breton. Backgrounds of the Family Service staff include clinical social workers as well as social workers holding positions as Youth Outreach workers. All focus group participants have extensive experience working with youth. With permission from all individuals in the focus group, the discussion was recorded. Common themes and relevant feedback were incorporated in the discussion section of this thesis.

Data Analysis

Analyses were conducted using SPSS. Descriptive statistics provide an overview of youth perceptions of barriers to mental health services. Bivariate analyses were conducted to examine potential differences between urban and rural populations in their perceptions of barriers to mental health services. Given the non-normal distribution and ordinal nature of the individual items on the questionnaire, the nonparametric Mann Whitney U test was used. Each of the 30 items on the questionnaire was tested separately.

Two-way ANOVAs were used to assess whether (1) age, (2) gender, and (3) mental health status influenced perceptions of barriers to mental health. Beyond these main effects, analyses also serve to test for interactional effects between rurality/urbanity and the three aforementioned variables. Three dependent variables, system, community, and individual level barriers, were created by calculating respondents' mean scores for

the 10 items in these subscales. This transformation resulted in composite scores with relatively normal distributions, thus rendering them suitable to parametric tests. During the calculation of the composite score, we noted that no more than 10% of items were missing. Given the low rate of missing data, all participant scores were included in the analyses. Age was a binary variable categorized as middle adolescent (ages 15 to 16) and late adolescent (ages 17 to 20). A three-level mental health status variable was created from items #4 (I have met with a doctor, psychologist or other health professional for one of the following mental health issues during the past year) and #5 (I believe I am experiencing one of the following mental health issues but have not met with a mental health professional) under Part 4 “About Me” section of the questionnaire, and was categorized as: 1-answered no to both items, 2-answered Yes to “question # 5” and No to “question # 4”, 3-answered Yes to “question #4”.

A total of nine ANOVAs were conducted, each with one interaction term: (See Table 4)

Table 4: Summary of ANOVAS at the System, Community and Individual Levels

#	Independent Variables	Dependent Variable
1	Rurality/urbanity x age	Systemic barriers
2	Rurality/urbanity x gender	Systemic barriers
3	Rurality/urbanity x mental health status	Systemic barriers
4	Rurality/urbanity x age	Community barriers
5	Rurality/urbanity x gender	Community barriers
6	Rurality/urbanity x mental health status	Community barriers
7	Rurality/urbanity x age	Individual barriers
8	Rurality/urbanity x gender	Individual barriers
9	Rurality/urbanity x mental health status	Individual barriers

Post Hoc Bonferroni was also conducted to specifically highlight what factors were contributing to the interaction effect. Differences were determined to be statistically significant at $p < 0.01$. Considering the large number of analyses, this lower than usual threshold was chosen to minimize false positive results.

Chapter 5: Results

Results

Overall, youth were more likely to view system level barriers ($M=2.3$; $SD=0.6$) and community level barriers ($M= 2.4$; $SD=0.7$) as greater obstacles to accessing mental health services than individual level barriers ($M= 3.5$; $SD=0.7$). These differences were statistically significant according to a RM-ANOVA, Wilks' Lambda = 0.30, $F(2,143) = 165.5$, $p < .0005$. In a LSD post hoc test, it was found that system barriers are greater than individual ones ($p < .0005$), and community barriers are greater than individual ones ($p < .0005$), but system barriers are not significantly different from community ones ($p = .82$).

A high proportion of youth agreed that mental health services were compromised by system level barriers (See Table 5). The percentage of youth agreeing or strongly agreeing was 50% or higher for all but two of the ten items on the subscale. Lack of awareness regarding available resources was the largest reported barrier, with 79.3% of youth agreeing or strongly agreeing with this statement. This was followed by lack of proper education regarding mental health issues, with 76.5% of youth agreeing or strongly agreeing with this as a perceived barrier. A large percentage of youth felt neutral toward certain perceived barriers including wait times (43.4%) and lack of collaboration among professionals (49.0%).

Table 5. System Level Barriers - % Responding to Each Category

Perceived Barriers	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Wait times	18.2	28.7	43.4	8.4	1.4
Lack of funding	17.9	35.9	34.5	9.7	2.1
Lack of education re mental health issues	45.5	31.0	13.8	9.0	.7

Lack of awareness of resources	40.7	38.6	13.1	6.2	1.4
Lack of qualified mental health professionals	25.5	26.2	31.0	14.5	2.8
Lack of youth friendly services	17.9	32.4	33.8	11.0	4.8
Lack of collaboration among service providers	9.8	28.7	49.0	11.9	.7
Lack of time flexibility	15.2	40.0	27.6	15.2	2.1
Lack of trust in the system	35	33.6	10.5	14.7	6.3
Inability of service providers to relate to youth	20.3	35	29.4	12.6	2.8

A similar trend can be found with respect to community level barriers where a large percentage of youth (50% or higher) either agreed or strongly agreed with eight of the ten potential barriers that were presented (See Table 6). Fear of gossip was reported as the largest community level barrier, as well as the largest barrier overall, with 80.7% of youth either agreeing or strongly agreeing that this is a barrier, followed by fear of social exclusion 73.6%. A sense of self-reliance on community, and having the same service provider in multiple roles both received high neutral values of 45.8% and 37.9% respectively.

Table 6. Community Level Barriers - % Responding to Each Category

Perceived Barriers	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Lack of transportation	18.6	34.5	27.6	15.2	4.1
Fear of Gossip	52.4	28.3	10.3	5.5	3.4
Fear of Social Exclusion	45.8	27.8	14.6	8.3	3.5
Fear of shaming my family	26.8	24.6	18.3	14.1	16.2
Lack of anonymity	25.5	30.3	30.3	10.3	3.5
Same service provider in multiple roles	20.7	26.2	37.9	11.0	4.1

A sense of self reliance on community	9.0	27.1	45.8	16	2.1
Fear of stigma from friends	29.7	33.8	18.6	13.1	4.8
Lack of consistent mental health services	22.8	33.8	29.7	10.3	3.4
Lack of confidential location/space	28.3	37.9	15.9	12.4	5.5

The results of the data at the individual level suggest that youth are less likely to see these variables as barriers to accessing mental health services (See Table 7). In particular, 82.8% of youth either disagreed or strongly disagreed with the belief that people who access mental health services are “crazy”. Youth also disagreed or strongly disagreed with the belief that accessing mental health services is a sign of weakness with 73.8% of the respondents falling into these two categories. While results for the remaining variables did not reflect such high levels of disagreement, the majority of youth responses fell within the disagree and strongly disagree categories thus affirming the view that individual level barriers are less concerning to youth than system and community level barriers.

Table 7. Individual Level Barriers - % Responding to Each Category

Perceived Barriers	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Accessing mental health services is a sign of weakness	4.8	11.7	9.7	17.2	56.6
I prefer to rely on my friends	12.4	19.3	23.4	29.0	15.9
I prefer to rely on my family	13.2	24.3	22.2	16	24.3
I would be to embarrassed	6.2	19.3	30.3	22.1	22.1
Negative experience(s) with mental health services in the past	6.9	13.8	29.7	22.1	27.6
I could handle this on my own	11.0	17.2	26.9	27.6	17.2
Stigma that is attached to mental illness	7.6	15.2	25.5	26.2	25.5

Fear that I would be put on medication	10.3	25.5	15.9	22.8	25.5
I do not trust mental health professionals	5.5	9.7	26.2	28.3	30.3
People who access mental health services are “crazy”	3.4	2.1	11.7	16.6	66.2

Comparison of perception of urban and rural youth

The second objective of this study was to contrast the perceptions of youth attending schools in urban and rural environments, with respect to their perceptions of barriers to mental health services. According to Mann Whitney U tests, statistically significant differences were noted in 5 items at the system level and 3 items at the individual level. No significant differences were noted at the community level.(See Table 8)

Table 8: Differences between rural and urban respondents at the Community Level

	Mann-Whitney U	Wilcoxon W	Z	Asymp. Sig. (2- tailed)
Transportation	2517.500	6003.500	-.230	.818
Gossip	2431.500	4384.500	-.620	.535
Social exclusion	2199.000	4090.000	-1.434	.152
Shame family	2388.500	4218.500	-.303	.762
Lack anonymity	2482.500	4435.500	-.376	.707
Multiple service roles	2261.000	4214.000	-1.302	.193
Self reliance	2445.500	4336.500	-.371	.711
Fear stigma from friends	2135.000	4088.000	-1.819	.069
Lack consistence	2237.000	4190.000	-1.398	.162
Lack confid. space	2373.500	4326.500	-.833	.405

Barriers found to be significantly different at the systems level included: wait times, inability of service providers to relate to youth, lack of collaboration, lack of flexibility and lack of trust (See Table 9). Lack of proper education approached statistical significance ($p=.014$). For variables where statistically significant differences were

established, rural respondents had a higher mean scores than urban respondents indicating that urban respondents found these particular variables to be greater barriers to mental health services than their rural counterparts.

Table 9. Differences between rural and urban respondents at the System Level.

	Mann-Whitney U	Wilcoxon W	Z	Asymp. Sig. (2-tailed)
Wait times	1612.500	3565.500	-3.883	.000
Don't relate to youth	1814.500	3767.500	-2.955	.003
Lack funding	2094.500	4047.500	-2.009	.045
<i>Lack education in MH</i>	2000.500	3953.500	-2.449	.014
Lack awareness	2304.500	4257.500	-1.149	.251
Lack MH professionals	2105.500	4058.500	-1.935	.053
Lack youth friendly services	2230.000	4183.000	-1.429	.153
Lack collaboration	1865.500	3695.500	-2.760	.006
Lack flexibility	1938.500	3891.500	-2.661	.008
Lack of trust	1696.500	3649.500	-3.469	.001

Interestingly, findings were in the opposite direction for comparisons of rural and urban responses at the individual level: Urban respondents had higher mean scores than rural respondents, thus suggesting that rural respondents found certain individual level items to be greater barriers than urban respondents. These included: the belief that accessing mental health services is a sign of weakness, preference to rely on family, and a belief that people who access mental health services are “crazy” (See Table 10).

Table 10. Differences between rural and urban respondents at the Individual Level

	Mann-Whitney U	Wilcoxon W	Z	Asymp. Sig. (2-tailed)
Sign of weakness	1946.000	5432.000	-2.782	.005
Prefer to rely on friends	2394.000	5880.000	-.734	.463
Prefer to rely on family	1588.000	4991.000	-3.941	.000
Embarrassed	2314.000	5800.000	-1.066	.287
Negative past experience	2267.000	4220.000	-1.262	.207

Prefer to handle on own	2416.000	4369.000	-.644	.519
Self stigma about Mental Illness	2316.000	5802.000	-1.057	.291
Fear medication	2219.000	5705.000	-1.452	.147
Don't trust MH professionals	2540.000	4493.000	-.137	.891
People who need MH services are “crazy”	2009.000	5495.000	-2.687	.007

Gender, Age, Mental Health Status, and Interaction

As explained in the data analysis section, three composite scores were created for system, community, and individual level barriers to accessing mental health services, and each of these composite scores was used as a dependent variable in three two-way ANOVAs, for a total of nine analyses. The objectives were to examine whether perceptions of system, community & individual level barriers vary according to (1) age, gender, and mental health status differences (i.e., Were there main effects for age, gender, and mental health status?), and (2) age, gender, and mental health status differences for only rural or only urban youth (i.e., Were there gender x rurality/urbanity, age x rurality/urbanity, and mental health status x rurality/urbanity interaction effects?). Examination of the distribution of the dependent variables indicated no major divergence from normality. Levene’s tests were non-significant, indicating the error variance is equal across all groups.

In analyses involving gender, no significant main effects for gender or gender x urbanity/rurality interaction effects were found. One analysis, however, approached the $p < .01$ threshold for statistical significance. Females ($M = 2.3$, $SD = 0.6$) perceived marginally greater community barriers to accessing mental health services than males ($M = 2.5$, $SD = 0.8$; $F(1, 140) = 3.9$, $p = .02$). In analyses involving age, no significant main

effects for age or age x urbanity/rurality interaction effects were found. Main effects for urbanity/rurality were found in analyses related to system level barriers; these are described in the next paragraph.

In analysis involving mental health status, two models yielded significant effects. While there were no main effects for either mental health status or urbanity/rurality in the analysis of influences on community level barriers, a significant mental health status x urbanity/rurality interaction effect was noted. The results of the ANOVA are summarized in Table 11 below.

Table 11: Two-Way ANOVA Contrast of Youth Perceptions of Community Level Barriers by Mental Health Status and Rurality/Urbanity

	Sum of Squares	df	Mean Square	<i>F</i>	<i>p</i>
Mental Health Status	1.483	2	.741	1.712	.184
Rural/Urban	.241	1	.241	.557	.457
Mental Health Status*Rural/Urban	4.858	2	2.429	5.609	.005
Error	60.190	139	.433		

R Squared = .139 (Adjusted R Squared = .108)

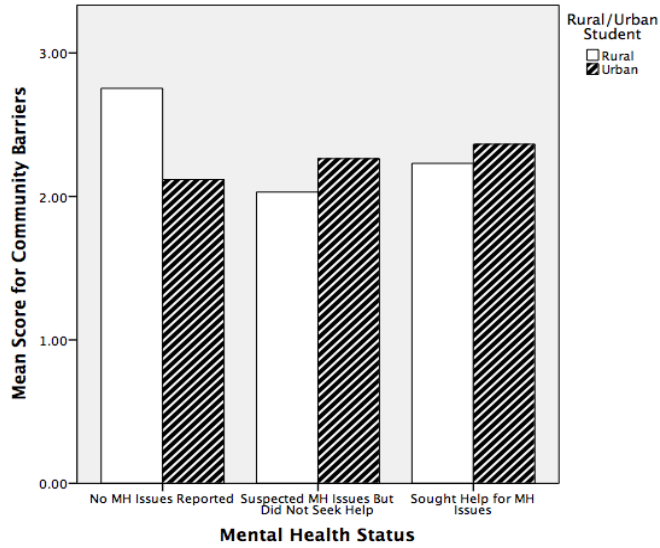
As illustrated in Figure 1 and Table 12, rural youth who have not experienced any mental health issues perceive community level barriers as less important than all other categories (i.e., urban youth with no mental health issues and both urban and rural youth with mental health issues).

Table 12: Mean Scores for System, Community and Individual Level Barriers According to Rural/Urban Status

		Rural	Urban	Total
System Level Barriers – Mean Score	No mental health problems suspected and did not seek services	2.8	2.2	2.6
	Mental health problems suspected but did not seek services	2.2	2.0	2.1
	Sought help for mental health problem(s)	2.5	2.1	2.2
	total	2.5	2.1	
Community Level Barriers – Mean Score	No mental health problems suspected and did not seek services	2.8	2.1	2.6
	Mental health problems suspected but did not seek services	2.0	2.3	2.1
	Sought help for mental health problem(s)	2.2	2.4	2.3
		2.4	2.3	
Individual Level Barriers – Mean Score	No mental health problems suspected and did not seek services	3.6	3.7	3.6
	Mental health problems suspected but did not seek services	3.3	3.3	3.3
	Sought help for mental health problem(s)	3.4	3.7	3.6
	Total	3.4	3.7	

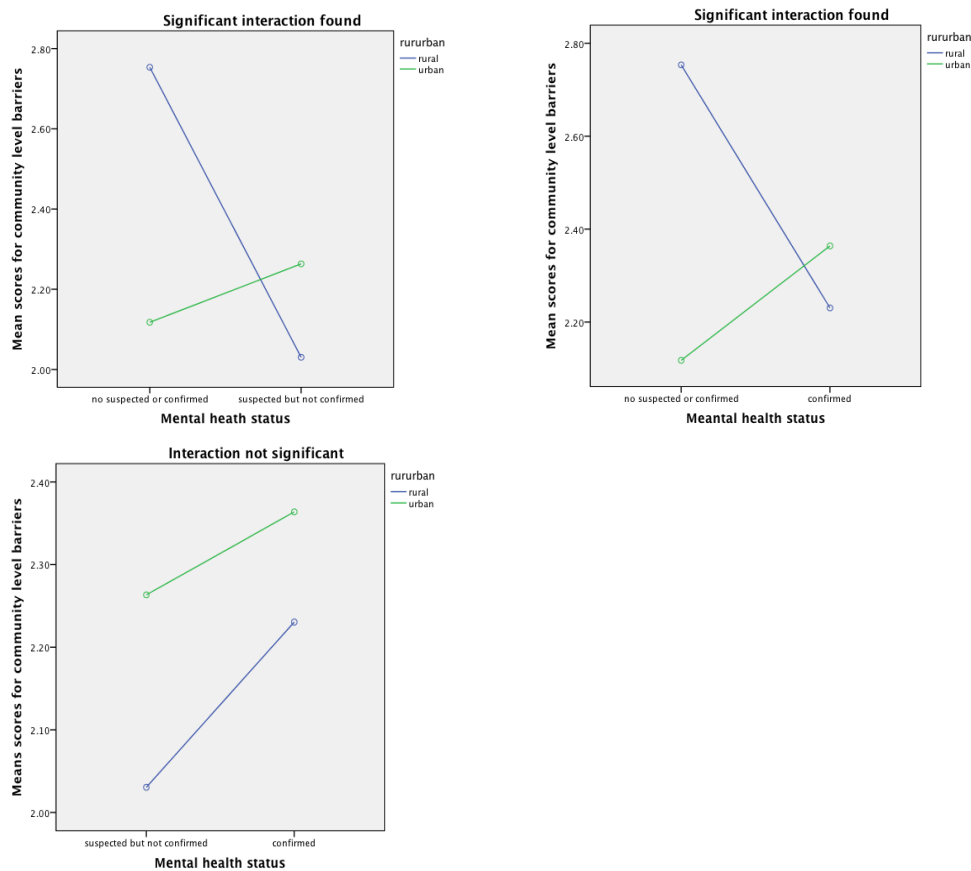
Post hoc testing confirmed this interpretation. In a series of pairwise comparisons, rural youth with no suspected mental health issues reported significantly higher scores than their urban counterparts ($p = .001$) and rural youth with suspected mental health issues ($p < .0005$) or who sought help for mental health issues ($p = .003$).

Fig. 1 – Interaction effects of community level barriers, mental health status and rural/urban status.



A second post hoc test, suggested by Keppel (1982), involved breaking down the 2 x 3 Two Way ANOVA into three 2 x 2 Two Way ANOVAs. As illustrated in Figure 2, significant interaction effects were found in comparisons of rural and urban youth (1) with no mental health issues and suspected mental health issues ($F(1, 83) = 7.6, p = .007$) and (2) with no mental health issues and youth who sought help for mental health issues ($F(1, 108) = 3.75, p = .004$), but not in contrasts of rural and urban (3) youth with suspected mental health issues and who sought help for mental health issues ($F(1, 87) = .1, ns$).

Figure 2. Post hoc test for determining which interactions between mental health status and rurality/urbanity were significantly associated with community level barriers



In the analysis of influences on system level barriers, there were significant main effects for mental health status and urbanity/rurality, and a marginal mental health status x urbanity/rurality interaction effect ($p=.052$). As shown in Table 12, rural youth reported less important system level barriers than urban youth.

Post hoc pairwise analyses confirmed that youth with no suspected mental health issues reported fewer system level barriers than youth with suspected mental health issues ($p = .002$) and youth who sought help for mental health issues ($p = .007$), but that the perceptions of youth with suspected mental health issues were not different from those of

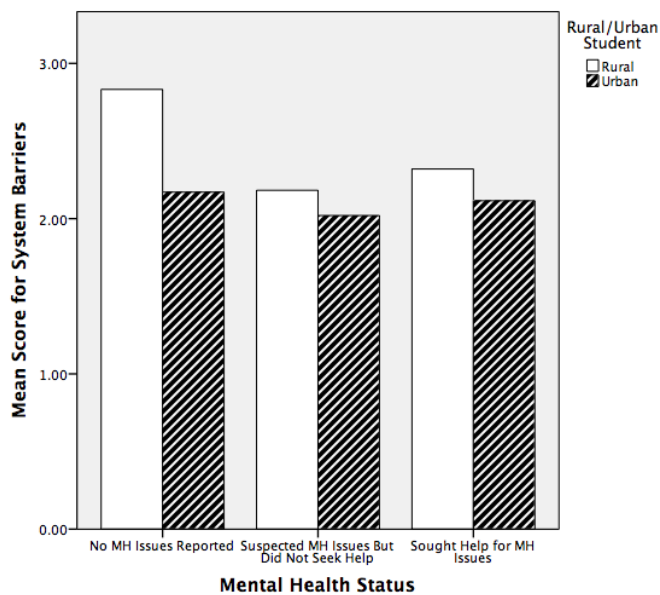
youth who sought help for mental health issues. Although the mental health status x urbanity/rurality interaction effect was not statistically significant, it is worth noting that the pattern of results is identical to that described in the analysis of community level barriers, i.e., youth who are not experiencing mental health issues are less likely to notice system level barriers than all the other categories of youth (see Figure 2 and Table 13).

Table 13: Two-Way ANOVA Contrast of Youth Perceptions of System Level Barriers by Mental Health Status and Rurality/Urbanity

	Sum of Squares	df	Mean Square	<i>F</i>	<i>p</i>
Mental Health Status	3.368	2	1.684	6.083	.003
Rural/Urban	3.516	1	3.516	12.702	.001
Mental Health Status*Rural/Urban	1.667	2	.833	3.011	.052
Error	38.473	139	.277		

R Squared = .25 (Adjusted R Squared = .223)

Fig. 3: Interaction effects of system level barriers, mental health status and rural/urban status.



No significant effects were found for the analysis involving individual level barriers (See Table 14). However a marginal main effect for mental health status was noted. Post hoc pairwise analyses confirmed that youth with no suspected mental health issues reported that fewer individual level barriers than youth with suspected mental health issues ($p = .01$).

Table 14: Two-Way ANOVA Contrast of Youth Perceptions of Individual Level Barriers by Mental Health Status and Rurality/Urbanity

	Sum of Squares	df	Mean Square	F	p
Mental Health Status	2.675	2	1.337	3.248	.042
Rural/Urban	.785	1	.785	1.905	.170
Mental Health Status*Rural/Urban	.611	2	.305	.742	.478
Error	57.241	139	.412		

R Squared = .076 (Adjusted R Squared = .043)

Chapter 6: Discussion & Implications for Practice

Discussion

The results of this study advance our understanding of barriers to mental health services in three areas. First they highlight the major barriers to accessing mental health services from a youth perspective for Cape Breton youth. Second, the results reveal differences between rural and urban perceptions of barriers. Third, they inform as to whether gender, age, and mental health status affect perceptions of barriers of urban and rural youths. In this study, an interesting interaction effect between rurality/urbanity and mental health status was revealed, which suggests that rural youth who do not report mental health issues have a different view of the barriers than rural youth who have mental health issues. This discussion is divided into three sections, according to the areas noted above. In each section, the relevance of the findings in relation to prior research, practice, policy and future research will be presented. This chapter also highlights the limitations and strengths of this study. This chapter will conclude with a reflection on the implications for improving service delivery for youth. In other words, I will consider how these results might guide my activities as Director of Professional Services for Family Service of Eastern Nova Scotia.

Major Barriers to Accessing Mental Health Services

Contrary to existing literature which suggests “preference to confide in peers and family” as one of the most consistent and greatest barriers to youth accessing mental health services (Kuhl, Jarkon-Horlick, Morrissey, 1997; Sheffield, Fiorenza, Sofronoff, 2004; Wilson, Deane, Marshall, Dalley, 2007) the results of this study found that the majority of youth disagreed or strongly disagreed with this statement, as well as the other

individual level barriers. While it is encouraging to note that the large majority of Cape Breton youth express positive and optimistic attitudes and beliefs about accessing mental health services, social desirability bias must also be considered as potentially influencing the accuracy of the results. Given the personal nature of the individual level barriers, it is possible that youth responded in such a way that would be deemed favorable but not necessarily accurate. Furthermore, recognizing community and system level barriers as being more problematic allows youth to remain focused on external barriers without critically reflecting on how their own beliefs and biases may be preventing them from accessing important services.

Lack of awareness regarding available resources and lack of proper education regarding mental health were identified as the greatest system level barriers. These findings are consistent across other studies (Sheffield, Fiorenza, & Sofronoff, 2004; Francis, Boyd, Aisbett, Newnham & Newnham, 2006), and suggest a need for greater promotion regarding existing services and professionals that are available to assist youth with issues relating to their mental health. It also underscores the need for improved education regarding mental health issues.

In terms of education, a study by Esters, Cooker, and Ittenback (1998) supports the idea that instruction in mental health increases a young person's willingness to seek professional help for an emotional problem. Although the educational needs of Cape Breton youth requires further research, the study by Esters et al. (1998) provides interesting insight regarding this particular barrier. This study found that by providing youth with accurate messaging about mental health and illness, emphasizing the roles of different mental health professionals and challenging myths related to mental illness,

their conception of mental health and mental illness was altered. This shift to a more positive understanding of mental illness also resulted in a change in attitude toward mental illness ultimately impacting the youth's willingness to seek mental health services.

Youth responses to the item, "lack of qualified mental health professionals" are noteworthy in that 51.7% viewed this as a significant barrier. This can be explained from two different perspectives. First, this finding suggests that there needs to be improved availability of professionals with specialized training in mental health, ie. psychiatrists, psychologists, social workers. The second perspective is connected to the barrier, "lack of awareness regarding available resources". As opposed to there being an actual lack of mental health professionals, many youth may simply not be aware of the professionals and services that are available. Based on my knowledge of these Cape Breton communities, it seems plausible that the issue may be less related to lack of qualified mental health professionals and more related to the difficulty youth have finding and accessing mental health professionals. Further research will help to clarify which barrier is more pertinent.

It is also important to examine the role of primary care physicians in relation to the barrier, "lack of qualified mental health professionals". Recognizing that GPs are often the first point of contact for many youth presenting with mental health issues, it is important that GPs receive ongoing training regarding assessment and symptom recognition for the effective treatment of mental health issues (Wilson, Deane, Marshall & Dalley, 2007). This recommendation was also highlighted in Nova Scotia's first ever Mental Health Strategy (Government of Nova Scotia, 2012) calling for increased collaboration amongst primary care and mental health services, as well as inter-

professional educational programs for primary care physicians. Transformation of our mental health systems requires a shift from biomedicalism which rations resources (primarily medication) based on diagnosis and severity of symptoms to one that recognizes individuals as part of a larger social system and acknowledges the impact of racism, ageism, classism, sanism, heterosexism and sexism (Morrow & Weisser, 2012).

The theme of “stigma” was prominent amongst community level barriers where a large percentage of youth either agreed or strongly agreed with such variables as: fear of gossip (80.7%), fear of social exclusion (73.1%), fear of shaming my family (50.3%) and fear of stigma from friends (63.5%). These findings are consistent across much of the available literature regarding perceived barriers to mental health services for youth (Esters, Cooker & Ittenbach, 1998; Gulliver, Griffiths, Christensen, 2010; Davidson & Manion, 1996, CIHR, 2010; Wilson, Deane, Marshall & Dalley, 2007). More specifically, data from the Canadian Youth Mental Health and Illness survey suggest variables such as embarrassment, fear, peer pressure and stigma were reported by 63% of youth as reasons for not seeking help (Canadian Institute of Health Research, 2010). Data from this current study also refines our understanding of stigma in the context of community and family acceptance by highlighting heightened concerns regarding shaming family and fear of social exclusion.

Interestingly, while stigma appears to be a significant barrier to accessing services, individual views toward mental health appeared more positive. For example, 73.8% of respondents either disagreed or strongly disagreed with the statement, “I believe accessing mental health services is a sign of weakness”. Similarly, 82.8% of respondents disagreed or strongly disagreed with the statement, “I believe people who access mental

health services are ‘crazy’”. This disparity between positive individual views on mental health and concern about the reaction from others points to the paradoxical nature of mental health: “I will not think less of others if they suffer mental health problems, but others will gossip, shame and exclude me if I develop problems”. This paradox suggests that people tend to harbour false or exaggerated beliefs about how friends and family will react to discovering that a loved one has mental health issues. Given the significant influence this can have on willingness to access services, anti-stigma campaigns must not only focus on delivering positive messaging regarding mental health, but also provide opportunities for sharing positive, likeminded attitudes toward mental illness. This will promote a greater sense that communities and social networks generally respond to those affected by mental health issues with support and compassion, rather than with gossip and alienation.

In addition to those variables that stood out as significant barriers, it is also important to pay attention to the variables where high neutral values were reported. These include: wait times (42.8%), lack of collaboration (48.3%) and a sense of self-reliance on community (45.5%). During a focus group with staff from Family Service of Eastern Nova Scotia, explanations for the significance of high neutral values were discussed. Specifically, it was thought that, for some youth, “neutral” categories are synonymous with “not knowing”. The issue of “not knowing” could be related to one of two possibilities: (1) Lack of knowledge related to that particular variable, ie Lack of collaboration - youth really aren’t aware of processes that occur outside of direct contact with them so they really don’t know if collaboration is occurring (2) Lack of understanding of the variable, ie. youth are unsure of the language or meaning attributed

to a particular variable, and as such, aren't able to provide an opinion in either direction. While the first possibility of "not knowing" presents more of a challenge to overcome, effectively pre-testing the questionnaire with a focus group of youth prior to questionnaire administration would have mitigated the risk of language or comprehension barriers skewing the results. During phase 2, the qualitative study will present an opportunity for greater exploration regarding the meaning behind the high neutral values and an opportunity for youth to acquire knowledge specific to these variables.

Differences Between Urban and Rural Respondents

Interesting differences were noted in rural and urban youth's perceptions of barriers to accessing mental health services. Whereas system level barriers were of greater concern for urban youth, rural youth perceived individual level barriers as greater issues.

Urban youth identified wait times, inability of service providers to relate to youth, lack of collaboration, lack of flexibility and lack of trust as greater barriers. These findings are opposite to the study's hypothesis, which posits that rural adolescents will face greater barriers to accessing mental health services than their urban counterparts. While these results may at first glance appear surprising or contradictory to the existing literature (Boydell et al., 2009; CIHR, 2010), a plausible explanation can be found. A rural public health report in 2007 highlighted that which is unique and positive about working in public health in rural Ontario in the communities of Haldimand and Norfolk (Kilty, 2007). Factors such as the autonomy to make decisions, a sense of community pride, resources and resourcefulness, solid community partnerships and a spirit of

collaboration, as well as close personal connections with community members were viewed as positively contributing to public health in a rural setting.

Again through focus group discussion with Family Service staff, valuable insight was gained to provide possible explanations for the differences between rural and urban youth's perception of barriers. The fact that wait times were seen as less of a barrier for rural youth compared to urban youth was not a surprising finding for participants of the focus group. In rural communities of Cape Breton, hub models established within the schools provide efficient and effective access to mental health service providers. As opposed to waiting months to see a mental health clinician in a hospital setting, youth in rural areas are able to see a clinician within a couple of days. Additionally, the hub-model within the school allows mental health service providers to interact with youth in a more familiar and comfortable environment increasing their ability to relate to youth.

Consistent with the literature (Boydell et al., 2009; CIHR, 2010) focus group participants discussed how the culture of rural communities plays a significant role in minimizing barriers in the eyes of rural adolescents. Services in rural communities were described as more family-centred and community-based, whereas, services in urban areas were viewed as being decentralized. Community-based hub models provide increased opportunities for collaboration and improved flexibility. Distinct from urban communities, members of the focus group felt that there was more of a collective sense of responsibility when a youth is in trouble in a rural setting. For example, principals were described as being much more pro-active in rural communities and were more familiar with each individual student's background. Unfortunately, given the large numbers of

students attending schools in urban settings, this same level of personal connection is not always possible.

The issue of trust being perceived as less of a barrier for rural youth seems inconsistent with existing literature. Because people are more likely to know one another in a rural community, ensuring confidentiality can be a challenge for health professionals (Curtis, Waters & Brindis, 2011; Boydell et al., 2009; Francis, Boyd, Aisbett, Newnham & Newnham, 2006). Although lack of anonymity might act as a barrier to accessing services in rural communities, mutual acquaintances and familiarity between professionals and clients likely helps to foster trust in rural service providers.

Individual barriers were found to be more relevant in rural populations and included such variable as: a belief that accessing mental health services is a sign of weakness, preference to rely on family and a belief that people who access mental health services are “crazy”. Although only a small percentage of youth either agreed or strongly agreed with the belief that accessing mental health services is a sign of weakness (26.2%) and that people who access mental health services are “crazy” (17.2%), the impact that these views can have on those struggling with mental health issues cannot be overstated. Even a small percentage of youth voicing these views could stigmatize a youth thereby preventing them from accessing services. In response, opportunities must be made available to hear and promote the voices of the majority of youth who hold positive and healthy views toward mental health and mental illness. Moreover, if we are to respect the voice of youth as integral to changing negatively held views and stereotypes regarding mental illness, then we must ensure that youth are not used in tokenistic fashion. This can be done through meaningful engagement of youth in discussions regarding effective

support and plans of care. We must also recognize and honor youths' purposeful acts of resistance as a demonstration of agency rather than one of problematic or pathological behavior (LeFrancois, 2014). As social workers, we also have an ethical obligation to challenge the socio-political structures that contribute to the oppression of youth with mental health issues, i.e., overemphasis of biomedicalism (LeFrancois, 2014).

The results of this study indicate that preference to rely on family was a greater barrier to mental health services for those living in rural communities compared to urban youth. The focus group participants who have had direct practice experience working in rural communities of Cape Breton concurred with this finding underscoring the value that is placed on both the immediate and extended family in terms of support. While family support can certainly act as a protective factor against mental health problems (Wille, Bettge & Ravens-Sieberer, 2008) it can also present a risk for those youth who require specialized services but feel family, friends and self are adequate to respond to their emotional and mental health needs (Kuhl, Jarkon-Horlicj & Morrissey, 1997).

Surprisingly, there were no significant differences noted between rural and urban youth at the community level, despite available literature to the contrary. For example, lack of qualified mental health professionals, transportation challenges, and concerns related to anonymity were some of the documented barriers to mental health services for rural youth (Aisbett, Boyd, Francis, Newnham & Newnham, 2007; Boydell, Pong, Volpe, Tilleczeck, Wilson & Lemieux, 2006). It was suggested through focus group discussions that youth in rural communities may not differentiate between professionals who have specialized training in mental health and those who do not, as long as they are receiving some type of support. For example teachers in rural settings may share a more familiar

relationship with their students than youth in urban areas given the small student population making them a key source of support during stressful times. That stated, given the exploratory nature of this study, we are unable to draw conclusive explanations. Therefore, future research is needed to explore these findings in greater depth.

An important limitation should be noted regarding this section. A higher proportion of the urban sample than the rural sample experienced mental health issues. If mental health issues are associated with perceiving greater (or lesser) barriers to services, then differences reported in this section might be a by-product of the unequal distribution of mental health issues across rural and urban youth in this sample. This is addressed in the following section.

Differences in Rural and Urban youths' perceptions of barriers by Gender, Age, and Mental Health Status

In addition to highlighting possible effect of gender, age and mental health status on perceptions, these analyses are also helpful for understanding the differences in perceptions between rural and urban youth in samples where gender, age, and mental health status are unequally distributed across rurality/urbanity categories. Notably, examining means plots and post hoc testing can be particularly useful for extricating overlapping influences on perceptions of barriers, e.g., separating rurality/urbanity effects and mental health status effects. Also, these analyses permit an examination of whether a combination of factors influences perceptions of barriers. For example, differences between urban and rural youth in the perceptions of barriers may be evident for one gender, but not the other.

No main effects or interaction effects were noted for age or gender with respect to barriers to accessing mental health services, other than female youth being marginally more likely to perceive greater community level barriers. This is in contrast to the current literature in which males reported greater barriers to mental health than females (Chandra & Monkovitz, 2005). Additionally, various studies on the topic of help seeking have found that females seek help to a greater degree than do males (Kuhl, Jarkon-Horlick & Morrissey, 1997; Chandra & Minkovitz, 2005; Cheung & Dewa, 2007). In fact, Kuhl et al. (1997) reported, “One of the most long-standing consistent findings in the area of help seeking, including mental health, physical health, counseling and academic work, is that females seek help to a greater degree than do males” (p. 638). Yet, our current study does not align with the existing literature. Possible explanations for this include the sample size being too small to be able to make any meaningful correlations between the impact of gender and perceptions of barriers to mental health services.

Also, it should be noted that I analyzed composite scores for system, community and individual level barriers. While no gender effects were noted using the composite scores for each level, further analysis with the individual items may reveal significant gender effects. For example, social pressures associated with masculinity may contribute to a gender effect for items such as, “I believe accessing mental health services is a sign of weakness”. Therefore, in future research, an item-by-item analysis would be useful. It would be interesting to verify whether the results of such an analysis would converge with recent findings that males are more likely to rely on parents for support (Chandra & Minkovitz, 2005; Kuhl, Jarkon-Horlick & Morrissey, 1997) and females exhibit a more positive response to accessing mental health services (Chandra & Minkovitz, 2006).

Further insight into how gender might affect access to mental health services might also be gained through focus groups discussions.

While the Family Service focus group was not surprised that no significant age effects were found, they were more surprised that there were no main or interaction effects for gender. With that stated, there was a sense among the group that it is becoming more socially acceptable for males to seek professional help for mental health issues today compared to years ago, thus reducing the gap that existed between male and female help seeking patterns. Furthermore, participants from the focus group expressed the idea that boundaries in relation to gender may not be as strong today. For example, social networking is less concerned with gender as more and more peer groups are comprised of both males and females. While this shift towards more androgynous social networks might help explain the lack of gender differences in youth's perceptions of barriers to mental health services, there was no existing literature available to support this theory.

A significant interaction effect between mental health status and urbanity/rurality was found at the community level. More specifically, this interaction effect revealed that rural youth who reported no suspected mental health problems perceived fewer community barriers than all other categories of youth. The reason for this effect is unclear, however, these findings are consistent with those of Meredith (2012) whereby depressed teens were more likely to perceive barriers than non-depressed teens. It could be that rural youth with no mental health issues are less aware of the barriers that exist at the community level, in comparison to youth with mental health problems (who typically have first hand knowledge of these barriers) and urban youth with no mental health issues

(who might have more first hand experience with people suffering from mental health problems and are thus more aware to the community barriers they face). It is possible (though less likely) that community barriers really are less prominent in rural environments, but rural youth with mental health issues are over-sensitive to such barriers. Finally, it is also possible that the sample of urban youth with no mental health problems was too small and provided perceptions that were unrepresentative of the broader population. In the same way that participant with mental health issues were seemingly more motivated to participate in this study, so too might people sensitive to mental health issues (e.g., youth might be motivated to participate because they have a family member who is suffering from mental health problems). The fact that participation rates for urban youth were much lower than that of rural youth (4% and 16% respectively) might have amplified this selection effect in the urban population. In future research, it would be advisable to control for the variable “family members with mental health problems” as this may affect perceptions of mental health barriers.

Regardless of the reason for this interaction effect, the different perceptions that rural youth with and without mental health problems have of community barriers is potentially problematic. It implies some level of misapprehension, such as (1) youth without mental health issues underestimating barriers and overestimating community supportiveness, (2) youth with mental health issues seeing barriers that don't exist and underestimating community supportiveness, or (3) a combination of factors.

The findings of this study lay a strong foundation for continued research and provide practical implications for the Youth Outreach Program which will be discussed at the conclusion of this section.

Limitations

For the purpose of this research study, participants were selected through convenience sampling as it was felt this would provide the easiest access to the greatest number of youth in a time and cost effective manner. Unfortunately, the drawback of this technique is sampling bias, whereby some members of the population are either less likely or more likely to be represented in the study (Creswell, 2014). In this case, convenience sampling occurred at 9 high schools within Cape Breton, thus precluding the participation of youth who were not enrolled in the formal education system, ie. expelled, homeless or home-schooled youth.

Known sampling bias which occurred in this study were the overrepresentation of certain groups, notably: females, youth ages 17-18 years old and youth who reported mental health issues. Females accounted for 69.9% of the total participants which is considerably higher than the breakdown of females (52%) to males (48%) in Nova Scotia (Statistics Canada, 2011). One possible explanation for the overrepresentation of females is a belief that women are more open to discussing mental health issues than men (Rogers & Pilgrim, 2014) and more willing to participate in studies. Youth aged 17-18 represented the largest age category of participating youth. These youth would be considered high school seniors who, by virtue of their senior status, may have been more willing to take a leadership role in terms of their participation. Although these groups were overrepresented there were no significant differences in gender or age perceptions with respect to barriers. In terms of mental health, 62.8% of youth reported experiencing some type of mental health issue. This is significantly higher than the national average which Waddel et al. (2005) predicts to be approximately 20% for children and youth.

This overrepresentation suggests that youth who have experienced some type of mental health issue have a greater interest in sharing their perceptions of barriers to mental health services compared with youth who have not experienced mental health issues. This bias calls into question the external validity of this study or, in other words, the extent to which this study can be generalized to the larger population of youth living in Nova Scotia, particularly youth with no mental health issues.

Of the considerable number of youth who were provided with the opportunity to participate in this study (1916 potential participants), only 145 youth completed the questionnaires. The general demographics of the participating schools were predominantly white, English-speaking students, and although one school served a number of youth with Acadian ancestry, the sample size was too small to permit statistical analyses. School personnel assisting with the research project felt that the informed consent process, which required youth to take a form home for their parents/guardians to sign and bring back to the school, negatively impacted youth participation in the study. The low percentage of respondents also limits generalizability of the results. This study was conducted with youth from rural and small urban areas (Cape Breton Island), therefore, inferences to youth from large urban centres should not be made, as they may face different barriers to mental healthy services.

In terms of the questionnaire design, no information was collected with respect to race, ethnicity or socioeconomic status. Analyses of these factors were beyond the scope of this small preliminary study. Collection of this information in a larger study would provide increased insight into the barriers to mental health services of racialized and Aboriginal populations, as well as uncover potential interaction effects with

socioeconomic status and mental health status. Also, the present research project will be followed by a qualitative study; one objective of this study will be to better understand structural and social inequities within our mental health care system, notably with respect to race, ethnicity and socioeconomic status.

Lastly this new questionnaire was only administered on one occasion. Although some informal pretesting was done, the questionnaire was not formally pre-tested with a large group of youth. Thus, it is possible that some youth experienced difficulties with comprehension or language. Also, there is no way of knowing reliability and validity, i.e., whether this instrument produces stable results, and whether it assesses the underlying construct (perception of barriers) as opposed to some other construct.

Strengths

Despite these limitations the objective of this exploratory study to identify perceived barriers to mental health services for Cape Breton youth was achieved. A detailed measure was created which, provided a richer contrast of perceptions of rural and urban Cape Breton youth, compared to previous research on the topic. Two-way ANOVAs allowed for an exploration of interaction effects of age, gender, and mental health status' in relation to urban and rural youth's perceptions of barriers to mental health services. The response rate was low, but it is fortunate that youth with mental health issues were most likely to complete the questionnaire. Although feedback from all groups is important, the perceptions of those who most require mental health services is particularly valuable information, given the topic of this thesis. Moving forward, this research project lays the foundation for continued research using a mixed methods

approach to gain a deeper and more thorough understanding of the perceived barriers to mental health services for youth living in Cape Breton.

Implications for Practice: The Youth Outreach Program & Family Service

As previously discussed, the original design of this overall research program was a mixed methods approach to understanding the barriers to mental health services for rural and urban Cape Breton youth. Opportunities for future research are clearly laid in a way that builds on our existing findings through qualitative research. The Youth Outreach Program, with a youth-centred approach being one of its core underpinnings, make this program an obvious choice for embedding this next phase of research. Our Youth Outreach workers have established strong and trusting relationships with youth in both rural and urban areas of Cape Breton thus enabling them to carry out focus group discussions in an authentic and uninhibited manner. It is expected that these findings will add depth and context to our initial findings, as well as opportunities for youth to be meaningfully engaged in service transformation. For example, engaging youth in anti-stigma campaigns is effective in reducing perceived barriers to mental health services (e.g. fear of stigma from friends, fear of social exclusion) while also meeting the goal of the YO Program to build self-confidence and improve self-esteem in youth.

Dissemination of research findings will occur at the agency and community levels. A “Fact Sheet” highlighting the major findings will be disseminated amongst Family Service staff, as well as staff and students from schools who actively participated in this research study. The Fact Sheet will also include next steps and how youth can become integral to this process. Staff will be asked to critically reflect on how the results of this

study are applicable to their work with youth, particularly in terms of reducing barriers to service.

Stakeholders and community partners will be informed of study's purpose and findings through community advisory tables consisting of both government and community-based agencies. For example, the Cape Breton Victoria Regional Advisory Committee acts in an advisory capacity for the purpose of improving programs and services for children, youth and families. The Advisory also acts as a vehicle for elevating the priorities and needs of the region to senior government representatives. Recognizing that this research study is closely aligned with the 5 priority areas of the Nova Scotia Mental Health Strategy, it is expected that the results of this study will be relevant and insightful to stakeholders within government.

Finally, I believe it is noteworthy to mention that in addition to highlighting barriers to mental health services for youth, this research project has also validated many of the purposeful efforts Family Service, and the Youth Outreach Program in particular, have made to provide service in a way that is youth-friendly, youth-centred and minimizes barriers to mental health services for youth. As a community-based agency, funding is connected to our ability to demonstrate positive outcomes for the clients we serve. I believe this research project strengthens our reputation as an agency that is committed to ongoing improvements to ensure effective service delivery and meaningful participation of our clients.

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Appendix 1 Illustrations from Youth Outreach Focus Group

Illustration 1

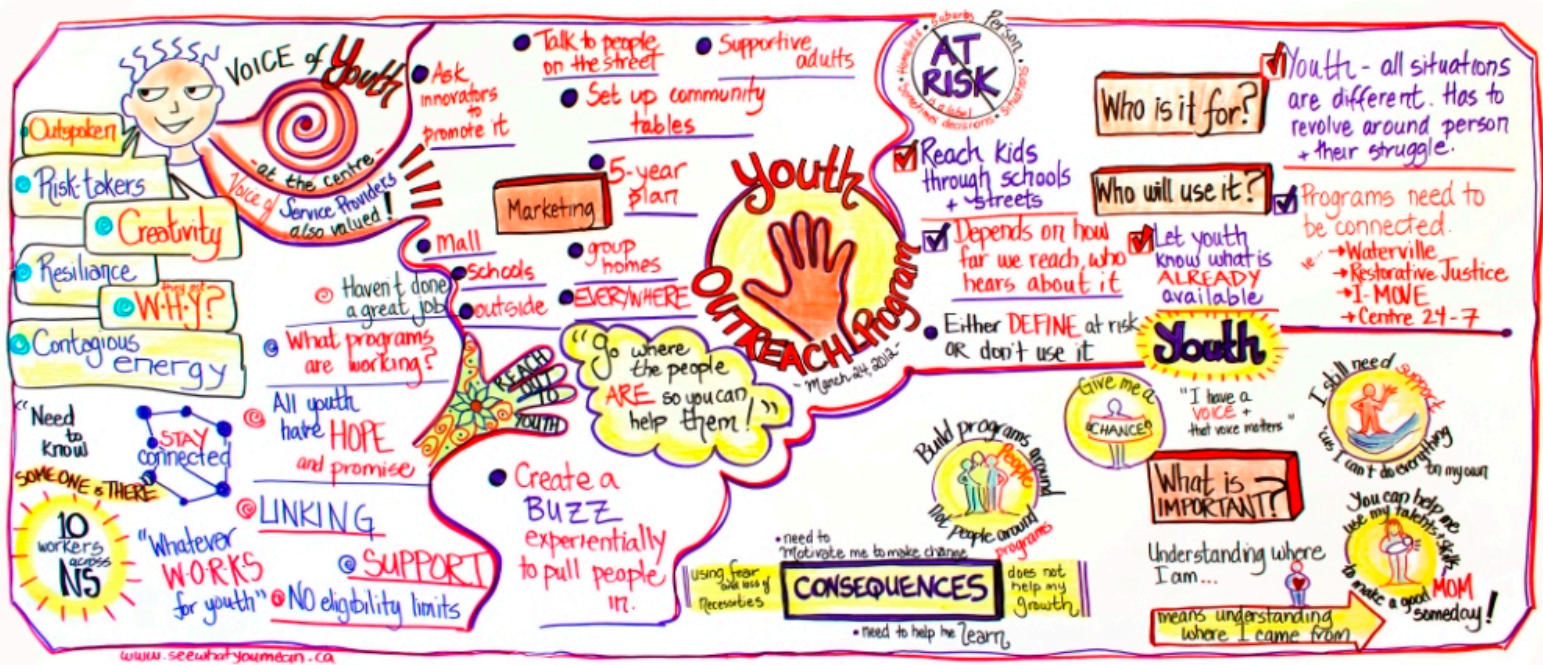


Illustration 2



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St. John's, NL Canada A1C 5S7
Tel: 709 864 2561 Fax: 709 864 4612
www.mun.ca/research

ICEHR Number:	20140791-SW
Approval Period:	November 22, 2013 – November 30, 2014
Funding Source:	
Responsible Faculty:	Dr. Stephen Ellenbogen School of Social Work
Title of Project:	<i>Exploring Barriers to Mental Health Services for Urban & Rural Cape Breton Youth</i>

November 22, 2013

Mrs. Mary-Jo Church
School of Social Work
Memorial University of Newfoundland

Dear Mrs. Church:

Thank you for your email correspondence of November 13 and 19, 2013 addressing the issues raised by the Interdisciplinary Committee on Ethics in Human Research (ICEHR) concerning the above-named research project.

The ICEHR has re-examined the proposal with the clarification and revisions submitted, and is satisfied that the concerns raised by the Committee have been adequately addressed. In accordance with the *Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans (TCPS2)*, the project has been granted *full ethics clearance* to November 30, 2014. Once obtained, please provide copies of the approvals from the Cape Breton-Victoria Regional School Boards and the Strait Regional School Board to the ICEHR for our records.

If you need to make changes during the course of the project which may give rise to ethical concerns, please forward an amendment request with a description of these changes to Theresa Heath at icehr@mun.ca for the Committee's consideration.

The *TCPS2* requires that you submit an annual status report on your project to the ICEHR before November 30, 2014. If you plan to continue the project, you need to request renewal of your ethics clearance, including a brief summary on the progress of your research. When the project no longer requires contact with human participants, is completed and/or terminated, you need to provide the final report with a brief summary, and your file will be closed. The annual update form is on the ICEHR website at <http://www.mun.ca/research/ethics/humans/icehr/applications/>.

We wish you success with your research.

Yours sincerely,

Gail Wideman, Ph.D.
Vice-Chair, Interdisciplinary Committee on
Ethics in Human Research

GW/th

copy: Supervisor – Dr. Stephen Ellenbogen, School of Social Work



CAPE BRETON- VICTORIA

Regional School Board

33 Napoleon St., North
Sydney, NS B2A 3G6
Phone: 902 794-6233 Fax: 902 794-2103

Research Project Approval Form

To: Mary-Jo Church
Email: mjchurch@fsens.ns.ca
Date: November 26, 2013
Re: Exploring barriers to Mental Health Services for Urban & Rural Cape Breton Youth

☒ **YES**, your research project/survey has been approved. You can proceed with your next phase. Upon completion of the study/survey, one copy of the final report of results and discussion shall be forwarded to the Director of Programs and Student Services.

Sincerely,

Name: Rick Simm

Phone: (902) 794-6201

Signature: _____

A handwritten signature in blue ink, appearing to read 'Rick Simm', is written over a horizontal line. The signature is fluid and cursive.

Appendix 5 Letter of Support from Family Service of Eastern Nova Scotia



Serving Families in Eastern Nova Scotia

<i>Branch Offices</i>	<i>Telephone</i>	<i>Toll Free</i>	<i>Fax:</i> <i>Website</i> <i>to:</i>	<i>Reply</i>
Antigonish	902.863.2358	1-866-330-5952	902.863-0457 Main St.	www.FSENS.ns.ca 275
Glace Bay			Antigonish,NS	
New Glasgow			B2G 2C3	
Port Hawkesbury				
Inverness				
Sydney				

To Whom It May Concern,

Please find enclosed a letter of support for the Exploration of Barriers to Mental Health for Urban and Rural Youth of Cape Breton Study. I have reviewed both the ethics application and questionnaire and feel that the purpose of the study is in line with the core values of our Agency, Family Service of Eastern Nova Scotia. If any further information is required please feel free to make contact.

Sincerely,

Nancy MacDonald
Executive Director Family Service of Eastern Nova Scotia

Appendix 6 Research Questionnaire

Exploring Barriers to Mental Health Services for Urban and Rural Cape Breton Youth

About This Questionnaire

A significant number of Canadian youth report having a mental illness, but only one in five actually receive help (Health Canada, 2007). We need your help to learn why. Through this study, we are trying to improve access to mental health services for youth.

This questionnaire is intended for youth between the ages of 15-20. Your participation is completely voluntary and the information gathered will remain confidential. Should you begin the process of completing this questionnaire and decide that you would prefer not to finish, there will be no negative consequences. To withdraw from questionnaire completion, simply draw a line through the questionnaire which will indicate your choice to withdraw. Do not write your name, address or phone number on this questionnaire. Upon completion, please place this questionnaire in the identified envelope. If you have any questions, or if this questionnaire raises any concerns, please feel free to contact Mary-Jo Church by phone/text at (902) 578-7949 or by email at mjc010@mun.ca. If you have any other concerns about this survey, or the people conducting this survey, please email the study's supervisor, Stephen Ellenbogen at sellenbogen@mun.ca.

PART 1 – System Level Barriers

Thinking about large scale barriers (ie. organizational, governmental), please rate on a scale of 1 to 5 how much you agree with each statement.

	Strongly Agree		Neutral		Strongly Disagree
1. Wait times are a significant barrier to accessing mental health services.	1	2	3	4	5
2. Lack of funding is a significant barrier to providing adequate mental health services.	1	2	3	4	5
3. Lack of proper education regarding mental health issues is a significant barrier to accessing mental health services.	1	2	3	4	5
4. Lack of awareness regarding available resources is a significant barrier to accessing mental health services.	1	2	3	4	5
5. Lack of qualified mental health professionals is a significant barrier to accessing mental health services.	1	2	3	4	5
6. Lack of youth-friendly services (ie. texting) is a significant barrier to accessing mental health services.	1	2	3	4	5
7. Lack of collaboration amongst service providers is a significant barrier to accessing mental health services.	1	2	3	4	5
8. Lack of time flexibility is a significant barrier to accessing mental health services.	1	2	3	4	5
9. Lack of trust in “the system” or professionals who work in the system is a significant barrier to accessing mental health services.	1	2	3	4	5
10. Inability of service providers to relate to youth	1	2	3	4	5

PART 2 – Community Level Barriers

Thinking about your own community where you live, please rate on a scale of 1 to 5, how much you agree with each statement.

	Strongly Agree		Neutral		Strongly Disagree
1. Lack of transportation is a significant barrier to accessing mental health services.	1	2	3	4	5
2. Fear of gossip is a significant barrier to accessing mental health services.	1	2	3	4	5
3. Fear of social exclusion is a significant barrier to accessing mental health services.	1	2	3	4	5
4. Fear of shaming my family is a significant barrier to accessing mental health services.	1	2	3	4	5
5. Lack of anonymity is a significant barrier to accessing mental health services.	1	2	3	4	5
6. Same service provider performing multiple roles is a significant barrier to accessing services. (ie. Family physician also acting as mental health counselor)	1	2	3	4	5
7. A sense of self reliance on community is a significant barrier to accessing mental health services.	1	2	3	4	5
8. Fear of stigma from friends is a significant barrier to services.	1	2	3	4	5
9. Lack of consistent mental health services is a barrier to accessing mental health services, ie. service providers keep changing.	1	2	3	4	5
10. Lack of confidential location/space is a barrier to accessing mental health services.	1	2	3	4	5

PART 3 – Individual Level Barriers

On a personal level, please rate on a scale of 1 to 5, how much you agree with each of the following statements.

	Strongly Agree		Neutral		Strongly Disagree
1. I believe accessing mental health services is a sign of weakness.	1	2	3	4	5
2. I prefer to rely on my friends when I have a problem.	1	2	3	4	5
3. I prefer to rely on my family when I have a problem.	1	2	3	4	5
4. I would be to embarrassed to access mental health services.	1	2	3	4	5
5. Due to negative experience(s) with mental health services in the past, I am now less likely to access mental health services.	1	2	3	4	5
6. If I suffered from a mental health issue, I am confident that I could handle this on my own without the need for mental health services.	1	2	3	4	5
7. I would not access mental health services due to the stigma that is attached to mental illness.	1	2	3	4	5
8. I would not access mental health services for fear that I would be put on medication.	1	2	3	4	5
9. I do not trust mental health professionals.	1	2	3	4	5
10. I believe people who access mental health services are "crazy".	1	2	3	4	5

Part 4: About Me...

1. I am currently living with:

- ☐ my mom and/or dad ☐ a family member other than parents ☐ friends
☐ my foster family ☐ no fixed address

2. Current age: ☐ (15-16) ☐ (17-18) ☐ (19-20)

3. Sex: ☐ Male ☐ Female

4. I have met with a doctor, psychologist or other health professional for one of the following mental health issues during the past year:

- ☐ Anxiety
☐ Depression
☐ Eating Disorder
☐ Psychosis or Schizophrenia (ie. hearing voices, hallucinations, seeing things that aren't there)
☐ Substance use problems (Drug and alcohol misuse)
☐ Behavior Problem (ie. aggression problems, delinquency, etc)
☐ Learning problems
☐ Other _____

5. I believe I am experiencing one of the following mental health issues, but have not met with a mental health professional:

- ☐ Anxiety
☐ Depression
☐ Eating Disorder
☐ Psychosis or Schizophrenia (ie. hearing voices, hallucinations, seeing things that aren't there)
☐ Substance use problems (Drug and alcohol misuse)
☐ Behavior Problem (ie. aggression problems, delinquency, etc)
☐ Learning problems
☐ Other _____

Thank you for taking the time to complete this questionnaire!

INFORMATION LETTER

TO: Youth Participant

FROM: Mary-Jo Church
Masters of Social Work Student, Memorial University
Social Worker with Family Service of Eastern Nova Scotia

RE: Research with students to explore the perceived barriers to mental wellness for urban and rural youth of Cape Breton Island.

Date: June 3, 2014

Dear Youth Participant:

As a third year Masters of Social Work student at Memorial University, I am currently conducting a study to better understand the barriers to mental wellness from a youth perspective. In addition to meeting course requirements, this research will provide valuable data which will help inform the Youth Outreach Program which is a service that is offered through Family Service of Eastern Nova Scotia, a not-for-profit organization where I have worked for the past 15 years.

The study invites you to participate in a 35-item questionnaire which will provide information regarding the perceived barriers to mental health services at a systems level, community level and personal level. The questionnaire will be administered during school hours in an agreed upon location within your school, ie. cafeteria/classroom. Please note, your participation in this study is completely voluntary and although your participation will not be anonymous due to the fact that you will be completing the questionnaire in a group setting, the information you provide will be anonymous. All information provided through the questionnaire will be compiled and will result in a report that will highlight the commonalities and differences in barriers to mental health services from the perspective of urban youth versus rural youth in Cape Breton. Should you choose not to participate in this study, there will be no negative consequences now or in the future as a result of this decision.

If you are in agreement with participating in this study, I ask that you review and sign the attached consent forms with your parents/legal guardian. In light of your age, your participation in this study will also require your parents/legal guardian's consent. Both your consent and your parent's consent must be returned to your teacher. The forms will then be placed in a sealed envelope and forwarded to the lead investigator.

Thank you in advance for your consideration of this request.

Sincerely,

Mary-Jo Church
MSW Student, Memorial University

INFORMATION LETTER

TO: Parent/Guardian

FROM: Mary-Jo Church
Masters of Social Work Student, Memorial University
Social Worker with Family Service of Eastern Nova Scotia

RE: Research with students to explore the perceived barriers to mental wellness for urban and rural youth of Cape Breton Island.

Date: June 3, 2014

Dear Parents/Guardians:

As a third year Masters of Social Work student at Memorial University, I am currently conducting a study to better understand the barriers to mental wellness from a youth perspective. In addition to meeting course requirements, this research will provide valuable data which will help inform the Youth Outreach Program which is a service that is offered through Family Service of Eastern Nova Scotia, a not-for-profit organization where I have worked for the past 15 years.

The study invites your child to participate in a 35-item questionnaire which will provide information regarding the perceived barriers to mental health services at a systems level, community level and personal level. The questionnaire will be administered during school hours in an agreed upon location within the school, ie. cafeteria/classroom. Please note, your child's participation in this study is completely voluntary and although his/her participation will not be anonymous due to the fact that he/she will be completing the questionnaire in a group setting, the data they provide will be anonymous. All information provided through the questionnaire will be compiled and will result in a report that will highlight the commonalities and differences in barriers to mental health services from the perspective of urban youth versus rural youth in Cape Breton. Should your child choose not to participate in this study, there will be no negative consequences now or in the future as a result of this decision.

If you are in agreement with your child participating in this study, I ask that you review and sign the "Informed Consent Form for Parents" which will provide you with additional information regarding the study. Both your consent and your child's consent must be returned to your child's teacher. The forms will then be placed in a sealed envelope and forwarded to the lead investigator.

Thank you in advance for your consideration of this request.

Sincerely,

Mary-Jo Church
MSW Student, Memorial University

Informed Consent Form

Title: Exploring Barriers to Mental Health Services for Rural and Urban Cape Breton Youth

Researcher: Mary-Jo Church
Masters of Social Work Student
Memorial University of Newfoundland
Email Address: mjc010@mun.ca
Telephone number: (902) 578-7949

You are invited to take part in a research project entitled, “Exploring Barriers to Mental Health Services for Rural and Urban Cape Breton Youth”.

This form is part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. It also describes your right to withdraw from the study at any time. In order to decide whether you wish to participate in this research study, you should understand enough about its risks and benefits to be able to make an informed decision. This is the informed consent process. Take time to read this carefully and to understand the information given to you. Please contact the researcher, Mary-Jo Church, if you have any questions about the study or for information not included here before you consent.

In light of the fact that you must be a minimum of 19-years of age to provide consent to participate in a research study, both you and your parents/legal guardians must provide consent for you to take part in this research. If you choose not to take part in this research or if you decide to withdraw from the research once it has started, there will be no negative consequences for you, now or in the future.

Once signed, please return the signed consent forms to your teacher. Your teacher will pass the forms on to the lead investigator.

Introduction

My name is Mary-Jo Church and I am currently completing my Masters of Social Work Degree through Memorial University of Newfoundland. As part of my Masters Program, I am conducting research under the supervision of Dr. Stephen Ellenbogen. I also work for Family Service of Eastern Nova Scotia which is a community-based agency that provides counseling services, as well as various programs in our communities. One of these programs is called the “Youth Outreach Program”. The Youth Outreach Program was launched in March 2012 and is designed to assist youth to improve their long-term social, economic and health outcomes. Your participation in this questionnaire will help identify barriers to mental wellness and will provide valuable information which will help shape the future direction of our Youth Outreach Program within Cape Breton Island. It is my hope that your information will lead to improved access to supportive adults and valuable services.

Purpose of Study:

- To gain increased awareness of the perceived barriers to mental wellness from a youth perspective.
- To understand how the perceptions of rural youth differ from those youth living in the more urban areas of Cape Breton.
- To contribute to the existing body of knowledge with respect to barriers to mental health services for youth living in rural areas.
- To help shape the direction of the Youth Outreach Program so that it meets the long-term social economic and health needs of all youth living on Cape Breton.

What will you do in this study:

By agreeing to participate in this study, you will be asked to complete a 35-item questionnaire relating to perceived barriers to mental wellness. Five of the questions will be related to demographic information about yourself, ie. age, gender, current living accommodations and any personal experiences with mental health issues in the past year. The remaining 30 questions will use the likert scale to address perceived barriers to mental health services. This means that you will be required to circle a number between 1 and 5 which indicates the degree to which you agree with each statement. The questionnaire will be completed in an agreed upon location within your school, ie. cafeteria/classroom.

Length of time:

It should not take longer than 20 minutes to complete the questionnaire.

Withdrawal from the study:

Please be advised that you are free to withdraw from this study at any point during the completion of the questionnaire and there will be absolutely no negative consequences as a result of your withdrawal. Once submitted, you will be unable to withdraw your questionnaire which will not contain any identifying information. Participation is completely voluntary.

Possible Benefits:

This study is an opportunity for you to share your own thoughts, ideas and beliefs about the existing mental health services that exist in your communities, lack of services and possible reasons for choosing not to access services. This study is not about adults and professionals deciding what is needed, but recognizes youth as experts in your own lives. The information gathered from this youth-centred approach will assist our Youth Outreach workers in better meeting your individual and community needs. Furthermore, the information gathered from this study will contribute to the existing body of scholarly knowledge that exists with respect to rural and urban youth's perceptions toward mental wellness.

Possible Risks:

Although the risks for participating in this study are minimal, it is important to acknowledge that questions with respect to mental wellness may be potentially distressing for some participants. In the event that this questionnaire should trigger any negative emotional response, the participant is encouraged to contact this researcher who will make a referral to the Youth Outreach Worker. The Youth Outreach worker will connect with you by phone, email, text or in person to help you process your response to the questionnaire and will make appropriate referrals to other service providers should that be required.

Confidentiality and Storage of Data:

a) Although your participation in this study will not be anonymous due to the completion of the questionnaire in a group setting, the information you provide will be anonymous. Identifying information, ie. your name and address will not be required as part of this questionnaire.

b) The only persons who shall have access to the data will be the researcher, Mary-Jo Church and her supervisor, Dr. Stephen Ellenbogen. The data will be retained for a minimum of five years, as required by Memorial University policy on Integrity in Scholarly Research.

Reporting of Results:

The data collected will be used to create a report highlighting the commonalities and differences in perceptions of urban and rural youth with respect to barriers to mental health services. The report will be shared with appropriate faculty at Memorial University, School Board Administration, participating schools, Family Service administration and Youth Outreach Workers. A fact sheet will also be made available to all participants of the study. Participants and/or parents who wish to receive a copy of the full report can do so by contacting the researcher, Mary-Jo Church, and requesting either an electronic or hard copy.

Questions:

You are welcome to ask questions at any time during your participation in this research. If you would like more information about this study, please contact:

Mary-Jo Church, Principal Investigator

295 George Street, Suite 302

Sydney, Nova Scotia

B1P 1J7

Email: mjc010@mun.ca

Phone: (902) 578-7949

Or

Stephen Ellenbogen, Ph.D. – Study Supervisor

Memorial University of Newfoundland

Email: sellenbogen@mun.ca

ICEHR Approval Statement:

The proposal for this research has been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to be in compliance with Memorial University's ethics policy. If you have ethical concerns about the research (such as the way you have been treated or your rights as a participant), you may contact the Chairperson of the ICEHR at icehr@mun.ca or by telephone at (709) 864-2861.

Consent:

Your signature on this form means that:

- You have read the information about the research.
- You have been able to ask questions about this study.
- You are satisfied with the answers to all your questions.
- You understand what the study is about and what you will be doing.

- You understand that you are free to withdraw from the study at any point during the completion of the questionnaire. Once submitted, you will be unable to withdraw your questionnaire which will not contain any identifying information.
- You understand that any data collected from you up to the point of your withdrawal will be destroyed.

If you sign this form, you do not give up your legal rights and do not release the researchers from their professional responsibilities.

Your Signature:

I have read what this study is about and understood the risks and benefits. I have had adequate time to think about this and had the opportunity to ask questions and my questions have been answered.

- ☐ I agree to participate in the research project understanding the risks and contributions of my participation, that my participation is voluntary, and that I may end my participation at any time.

A copy of this Informed Consent Form has been given to me for my records.

Signature of Participant

Date

Researcher's Signature:

I have explained this study to the best of my ability. I invited questions and I gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

Signature of Principal Investigator

Date

Informed Consent Form For Parents

Title: Exploring Barriers to Mental Health Services for Rural and Urban Cape Breton Youth

Researcher: Mary-Jo Church
Masters of Social Work Student
Memorial University of Newfoundland

Email Address: mjc010@mun.ca

Telephone number: (902) 578-7949

Your child is being invited to take part in a research project entitled, “Exploring Barriers to Mental Health Services for Rural and Urban Cape Breton Youth”. In light of the fact that your child is considered a minor and is not able to provide informed consent until he or she reaches the age of 19, I am seeking your informed consent as the child’s parent/legal guardian.

This form is part of the process of informed consent which should give you the basic idea of what the research is about and what your child’s participation will involve. It also describes your child’s right to withdraw from the study at any time. In order to decide whether you wish for your child to participate in this research study, you should understand enough about its risks and benefits to be able to make an informed decision. This is the informed consent process. Take time to read this carefully and to understand the information given to you. Please contact the researcher, Mary-Jo Church, if you have any questions about the study or for information not included here before you consent.

It is up to you and your child whether your child should take part in this research. If your child chooses not to take part in this research or if your child decides to withdraw from the research once it has started, there will be no negative consequences for your child, now or in the future.

Once signed, please have your child return the signed consent forms to his or her teacher. The forms will then be passed on to the lead investigator.

Introduction

My name is Mary-Jo Church and I am currently completing my Masters of Social Work Degree through Memorial University of Newfoundland. As part of my Masters Program, I am conducting research under the supervision of Dr. Stephen Ellenbogen. I also work for Family Service of Eastern Nova Scotia which is a community-based agency that provides counseling services, as well as various programs in our communities. One of these programs is called the “Youth Outreach Program”. The Youth Outreach Program was launched in March 2012 and is designed to assist youth to improve their long-term social, economic and health outcomes. Your child’s participation in this questionnaire will help identify barriers to mental wellness from a youth perspective and will provide valuable information which will help shape the future direction of our Youth Outreach Program within Cape Breton Island. It is my hope that the data gathered from youth participants will lead to improved access to supportive adults and valuable services.

Purpose of Study:

- To gain increased awareness of the perceived barriers to mental wellness from a youth perspective.
- To understand how the perceptions of rural youth differ from those youth living in the more urban areas of Cape Breton.
- To contribute to the existing body of knowledge with respect to barriers to mental health services for youth living in rural areas.
- To help shape the direction of the Youth Outreach Program so that it meets the long-term social economic and health needs of all youth living on Cape Breton.

What will your child be doing in this study:

By providing your consent for your child to participate in this study, he or she will be asked to complete a 35-item questionnaire relating to perceived barriers to mental wellness. Five of the questions will be related to demographic information about himself or herself, ie. age, gender, current living accommodations and any personal experiences with mental health issues in the past year. The remaining 30 questions will use the Likert scale to address perceived barriers to mental health services. This means that your child will be required to circle a number between 1 and 5 which indicates the degree to which he or she agrees with each statement. The questionnaire will be completed in an agreed upon location, ie. cafeteria/classroom.

Length of time:

It should not take longer than 20 minutes to complete the questionnaire.

Withdrawal from the study:

Please be advised that participants are free to withdraw from this study at any point during the completion of their questionnaire with absolutely no negative consequences as a result of their withdrawal. Once submitted, participants will not be able to withdraw their questionnaire as the questionnaires will not contain any identifying information. Participation is completely voluntary.

Possible Benefits:

This study is an opportunity for youth to share their own thoughts, ideas and beliefs about the existing mental health services that exist in their communities, lack of services and possible reasons for choosing not to access services. This study is not about adults and professionals deciding what is needed for youth, but recognizes youth as experts in their own lives. The information gathered from this youth-centred approach will assist our Youth Outreach workers in better meeting the individual and community needs of our youth. Furthermore, the information gathered from this study will contribute to the existing body of scholarly knowledge that exists with respect to rural and urban youth's perceptions toward mental wellness.

Possible Risks:

Although the risks for participating in this study are minimal, it is important to acknowledge that questions with respect to mental wellness may be potentially distressing for some participants. In the event that this questionnaire should trigger any negative emotional response, you or your child is encouraged to contact this researcher and the researcher will make a referral to the Youth Outreach Worker. The Youth Outreach worker will connect with your child by phone, email, text or in person to help him or her process his

or her response to the questionnaire and will make appropriate referrals to other service providers should that be required.

Confidentiality and Storage of Data:

a) Although your child's participation in this study will not be anonymous due to the completion of the questionnaire in a group setting, the information he/she provides will be anonymous. Identifying information, ie. his/her name and address will not be required as part of this questionnaire.

b) The only persons who shall have access to the data will be the researcher, Mary-Jo Church and her supervisor, Dr. Stephen Ellenbogen. The data will be retained for a minimum of five years, as required by Memorial University policy on Integrity in Scholarly Research.

Reporting of Results:

The data collected will be used to create a report highlighting the commonalities and differences in perceptions of urban and rural youth with respect to barriers to mental health services. The report will be shared with appropriate faculty at Memorial University, School Board Administration, participating schools, Family Service administration and Youth Outreach Workers. A fact sheet will also be made available to all participants of the study. Participants and/or parents who wish to receive a copy of the full report can do so by contacting the researcher, Mary-Jo Church, and requesting either an electronic or hard copy.

Questions:

You are welcome to ask questions at any time during your child's participation in this research. If you would like more information about this study, please contact:

Mary-Jo Church
295 George Street, Suite 302
Sydney, Nova Scotia
B1P 1J7
Email: mjc010@mun.ca
Phone: (902) 578-7949

Or

Stephen Ellenbogen, Ph.D. – Study Supervisor
Email: sellenbogen@mun.ca

ICEHR Approval Statement:

The proposal for this research has been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to be in compliance with Memorial University's ethics policy. If you have ethical concerns about the research (such as the way you or your child have been treated or your child's rights as a participant), you may contact the Chairperson of the ICEHR at icehr@mun.ca or by telephone at (709) 864-2861.

Consent:

Your signature on this form means that:

- You have read the information about the research.
- You have been able to ask questions about this study.

- You are satisfied with the answers to all your questions.
- You understand what the study is about and what your child will be doing.
- You understand that your child is free to withdraw from the study at any point during the completion of the questionnaire, without having to give a reason, and that doing so will not affect him or her now or in the future. Once submitted, your child will not be able to withdraw his/her questionnaire as the questionnaires will not contain identifying information.
- You understand that any data collected from your child up to the point of his or her withdrawal will be destroyed.

If you sign this form, you do not give up your legal rights and do not release the researchers from their professional responsibilities.

Parent/Legal Guardian Signature:

I have read what this study is about and understood the risks and benefits. I have had adequate time to think about this and had the opportunity to ask questions and my questions have been answered.

☐ I agree for my child, _____, to participate in the research project understanding the risks and contributions of his or her participation, that his or her participation is voluntary, and that he or she may end his or her participation at any time.

A copy of this Informed Consent Form has been given to me for my records.

Signature of Parent/Legal Guardian

Date

Researcher's Signature:

I have explained this study to the best of my ability. I invited questions and I gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

Signature of Principal Investigator

Date

Prepared Statement/Oral Script

Mary-Jo Church is a Masters of Social Work student at Memorial University of Newfoundland. She is currently conducting research under the supervision of Dr. Stephen Ellenbogen on the perceived barriers to mental health services for rural youth compared to urban youth. As part of her research, she is asking students in grades 10, 11 and 12 from 10 high schools in Cape Breton to consider completing a short questionnaire that will provide her with increased awareness relating to these barriers from a youth perspective. The questionnaire should not take any longer than 20 minutes to complete. It will take place at your school and you will not be required to provide any identifying information about yourself, such as your name, date of birth or address, therefore, the information you provide will be completely anonymous, although your participation will not be anonymous since you will be completing it in a group setting.

Your participation in this research is completely voluntary and there will be absolutely no consequences if you choose not to complete a questionnaire. It is Mary-Jo's hope that the information gained from this research will help improve access to mental health services for youth and will also highlight some of the differences that exist for urban youth compared to rural youth. In the event that your participation in the study creates any feelings of distress for you, you will be provided with a card containing contact information for mental health services. You can also contact Mary-Jo and she will be happy to connect you with the appropriate professional.

At this time Mary-Jo would like me to provide each of you with an information package that provides more details about her research. For those of you under the age of 19, your participation will require permission from your parents, therefore, she is asking you to share this information package with them when you go home and together decide whether you are interested in completing this questionnaire.

Mary-Jo will be at your school in the coming weeks to administer the questionnaire. If you wish to participate, you must have your consent form and your parents consent form signed and returned to the dropbox located in the office. After all the questionnaires are administered to students in all participating schools, Mary-Jo will analyze the data and create a report based on the results. This report will be circulated to each of the participating schools and all students who participate in the study will be provided with a fact sheet summarizing the findings.

Mary-Jo looks forward to meeting you and learning from your personal experiences. Thank you for your consideration of her request to participate in this research.