Access to Mental Health Supports and Services: Perspectives of Young Women Living in Rural Nova Scotia (Canada)

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ABSTRACT

There is limited literature on youths' experiences of accessing mental health supports and services in rural Canada. Through interviews with young women, this research explored barriers and facilitators to accessing mental health services and supports in rural Nova Scotia. Participants shared numerous barriers at the family, school, and community levels, including stigma from family, lack of knowledge of school supports, and limited community service options. Facilitators also existed at these three levels, including supportive parents, school-based service availability, and supportive community members. Increased investment in school-based services may improve access; however, an understanding of young men's experiences is needed first.

Key words: adolescent, mental disorders, school health services, rural population, women's health

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RÉSUMÉ

Peu de documentation existe sur les expériences vécues par les jeunes en matière d'accès aux services de soins et de soutien en santé mentale dans les régions rurales du Canada. Par le biais d'entrevues réalisées auprès de jeunes femmes, la présente étude explore les obstacles et les facteurs faisant entrave ou facilitant l'accès aux services de soins et de soutien en santé mentale dans les régions rurales de la Nouvelle-Écosse. Les participantes à l'étude ont fait part de nombreux obstacles rencontrés au niveau familial, scolaire et communautaire, notamment la stigmatisation de la part de la famille, les connaissances insuffisantes des mesures de soutien offertes en milieu scolaire et les options limitées en matière de services communautaires. L'existence de facilitateurs à chacun de ces niveaux a cependant été soulevée, lesquels se présentent notamment sous la forme de parents aidants, de la disponibilité de services d'aide en milieu scolaire et la présence d'accompagnateurs communautaires. Un investissement accru dans les services offerts en milieu scolaire pourrait en améliorer l'accès. Néanmoins, il convient en premier lieu de bien comprendre les expériences que vivent les jeunes hommes.

Mots clés : adolescentes, troubles mentaux, services de santé en milieu scolaire, population rurale, santé des femmes

Youth mental illness is a public health concern globally, as well as in Canada (Malla et al., 2018; Patton et al., 2016). The World Health Organization (2020) estimates that on a global scale, 10% to 20% of children and youth live with mental illness. It is further argued that mental illness disproportionately affects young people worldwide and is "the leading cause of disability for this age group" (Mei et al., 2020, p. 3). Approximately 1.2 million or about 15% of Canadian children and youth are reported to live with a diagnosed mental illness (e.g., depression) and about 70% of Canadians living with a mental illness report onset of symptoms before the age of 18 (Mental Health Commission of Canada, 2020). Mental illness affects not only youths' mental health but also their physical and socio-emotional development and poses a socioeconomic burden on families and communities due to direct and indirect economic costs such as the cost of missed time from school and/or work (Mental Health Commission of Canada, 2016; Patton et al., 2016; Ungar & McDonald, 2012; World Health Organization, 2018). There is also a gendered aspect to mental illness as young women in Canada are more likely than young males to be diagnosed with depression, to be hospitalized for eating disorders and/or self-harm, and to have experienced a suicide attempt (Bushnik, 2016).

It is important for youth to have access to mental health supports and services. Although prevention is clearly important, it is equally important that those with an existing mental illness have access to supports and services that can support the management and treatment of their illness. Currently, however, less than 20% of Canadian youth with a mental illness have access to specialized treatment (Mental Health Commission of Canada, 2020).

Canada has a mostly rural geography, and approximately 20% of Canadians reside in rural areas (Statistics Canada, 2018). Of the 7 million young people, ages 15–29, in Canada, approximately 15% reside in rural areas and under half are young females (Bushnik, 2016; Statistics Canada, 2019). The province of Nova Scotia (NS) is one of the four Atlantic provinces and one of the most rural provinces in Canada with approximately 40% of its population living in rural areas (Statistics Canada, 2018).

Access to mental health supports and services is thought to be particularly challenging in rural communities in Canada where "geographic, economic and cultural factors [especially] influence access" (Reaume-Zimmer et al., 2019, p. 49), suggesting that there are inequities in access that need to be addressed. The literature, which largely focuses on adult mental health in rural places, indicates that there is often a lack of services and specifically few specialized physicians in rural Canada (Friesen, 2019). In addition, the lack of transportation and stigma can act as barriers to accessing supports and services (Blackstock, Chae, Mauk, & McDonald, 2018; Boydell et al., 2006; Corrigan, 2004; Ghorbanzadeh, Kim, Ozguven, & Horner, 2020; Jensen, Wieling, & Mendenhall, 2020; Knight & Winterbotham, 2018). Yet, Caxaj and Gill (2016) and Statistics Canada (2015) suggest, however, that rural places may create a sense of belonging which can foster supportive social networks and work to facilitate access to mental health services (e.g., help with transportation).

Although access to mental health services is critical, there is relatively little research from the perspective of youth living in rural Canada about their experiences accessing such services. We know even less about the experiences of youth living in rural Nova Scotia. Much of the existing literature on access to mental health supports and services in rural Canada focuses on the western and central provinces (Caxaj, 2016; Roberts, Hu, Axas, & Repetti, 2017). Filling this gap in knowledge is important in order to understand potential barriers to access that need to be addressed, and it is especially pressing given that youth living in Atlantic Canada may experience poorer mental health in comparison to other young Canadians. Findings from a 2019 national survey suggest that more Nova Scotian youth perceived their mental health as being "fair" or "poor" compared to youth in any other Canadian province or territory (9.7% of NS youth versus national average of 6.0%; Statistics Canada, 2020).

In communities where there are gaps in formal services and supports, such as rural communities, schools may fill some of the gaps through the provision of clinical services (e.g., nurse, psychologist; Weist et al., 2017). Unlike community-based mental health supports and services located outside of the physical school and in the greater community, schools can potentially reach a large number of youth, given that many spend an extensive amount of their time in school. This potential reach is particularly important given that many mental illnesses begin during adolescence (World Health Organization, 2018). At the same time, school-based supports may also pose some barriers, which must be identified and addressed to improve access.

Given that little is known about youth and their access to mental health supports and services in rural Nova Scotia, the objective of this qualitative study was to explore how youth in one high school in a rural Nova Scotian community perceive and experience access to mental health supports and services. Although the research sought to understand the experiences of youth of any gender identity, only young women volunteered to participate and, therefore, this paper focuses on the experiences of young women. Young women's interest in the study is perhaps not surprising given that women living in rural Canada are thought to be more prone to developing poor mental health or mental illness due to increased social isolation and vulnerabilities (e.g., violence) in rural areas (Leipert, Regan, & Plunkett, 2015). As a result, they may be especially interested in research centred on access to mental health services in rural places. Further, it is well documented that young men are less likely to participate in mental health research, perhaps due to stigma (Ellis et al., 2014).

METHODS

This study took place between 2017–2018. Ethics approval was obtained from the relevant Canadian university research ethics board and the local school board. One-on-one, semi-structured interviews were conducted with seven female high school students (referred to as young women) who self-reported mental health issues (e.g., depression, stress, eating disorders). Participants were asked about their perceptions of, and experiences with, access to mental health supports and services.

Recruitment and Setting Context

This research took place in a rural Nova Scotia community that has been documented as having the poorest self-reported youth mental health in Nova Scotia (Asbridge & Langille, 2013). Many mental health supports and services in the community have been closed and relocated to urban areas in recent years. There is also no access to public transportation in the community. The high school continues to offer school-based services including counselling and a teen health centre. To recruit participants for this research, posters were placed at the high school in the rural community. To inform students about the study, the school also agreed to regularly announce the study via the morning announcements for a period of three months. Students were eligible to participate if they were in grades 10, 11 or 12, between the ages of 16 and 18, had been a resident of the community for at least one year in order to have an understanding of supports and services in the community, and had accessed, or had tried to access, a mental health service or support. Recruitment was open to all students regardless of gender, but only young females volunteered to be interviewed so the findings are only about the experiences of young women.

Data Collection

Questions for the semi-structured interview guide (see supplemental material) were developed based on the key research question, the existing research literature, and the research team's knowledge of access to health services in rural areas and/or access to mental health services. The guide was reviewed by two high school students from the high school (one male and one female) who suggested prompts and provided feedback about the wording of questions. The students also provided feedback concerning the recruitment materials. They received a small cash honorarium for their assistance. The students were not participants in the study and were not part of data collection, so they were not aware of who participated in the study. Seven female students volunteered to participate in the study, and the interviews took place during the school's lunch hour on a day mutually agreed upon by the participant and the interviewer (Author 1). Interviews took place in a private room in the school. Passive consent from parents (as per school board policy), and written consent from the young women, were collected prior to the interview. All participants received a $20 gift card honorarium. Interviews lasted approximately one hour, and the young women had the option of being either audio-recorded or having the interviewer take notes by hand. Only one of the seven participants opted for handwritten notes. After the interview, the young women were given the option of receiving a pamphlet listing contact information about mental health resources online or in nearby communities. No participants requested this information.

Data Analysis

The audio-recorded interviews were transcribed verbatim and checked for accuracy, and hand-written notes typed into a Microsoft Word document. Information that could personally identify the participant was not transcribed. Transcripts were coded using ATLAS.ti software (Version 8 Mac, 2017) by Author 1 and a sampling of transcripts reviewed by Author 2. Preliminary invivo codes were created by Author 1 and discussed with Author 2 as well as the other authors, and some initial codes were collapsed into higher order codes. For example, initial codes "taxi" and "public transit" were collapsed into a code labelled "transportation." The transcripts were coded by Author 1, and Author 2 reviewed the coding of select transcripts to ensure agreement in coding. The coded data were discussed and further refined. In a few cases, it was decided to rename codes to better represent the data. After coding, all coded data were read and re-read by Authors 1 and 2, and quotes within each code were organized as a barrier or facilitator. For example, within the transportation code, quotes were grouped as either transportation barriers or transportation facilitators. Key themes were inductively developed by Authors 1 and 2 from a process of constant comparison of key concepts from the coded data (Corbin & Strauss, 2015). Although we did not design the study using a model, the socioecological model (Brofenbrenner, 1979), which conceptualizes health as influenced by multiple intersecting factors, was used to organize the themes in terms of three levels: family, school, and community. Collins and Stockton (2018) suggest that using frameworks in qualitative health research can help "organize and connect data" (p. 4) and "provide focus and organization" to the data (p. 5).

Trustworthiness

To ensure the trustworthiness and rigour of the data and analysis, credibility, dependability, and transferability of the research were addressed (Shenton, 2004). Author 1 worked closely with the school principal and the school board superintendent prior to data collection. The school principal and school board superintendent provided feedback on the research question and indicated a need for the research in the community. Author 1 had previously lived in this community for several years, and thus had a good understanding of the community and rural culture. As noted above, Author 1 worked closely with two high school students to develop the interview guide, debriefed with Author 2 after every interview, and worked closely with all authors during data analysis and the writing of the findings. All of the researchers currently live in an urban setting which may have influenced their interpretation of the data; however, three authors have some understanding of rural culture (Author 1, and Author 2 and 3 have conducted research in rural settings). The two high school students who assisted with the interview guide also reviewed the key themes as a form of peer debriefing. The dependability of the study was ensured by clearly outlining the study design so that the process of data collection/analysis was transparent. The transferability of qualitative research is largely dependent on how readers perceive the "fit" of the findings with their own context. We have also outlined the boundaries of the research, including the time period, location of the research, and age and gender of participants in order to provide some context. Given that the study was conducted in a small rural setting, limited sociodemographic information was collected to protect the confidentiality of participants.

FINDINGS

All seven young women who participated in the study disclosed that they had been diagnosed with a mental illness and had previously accessed at least one service or support. Participants' experiences of facilitators and barriers are organized in terms of three levels: family, school, and community.

Family Level

Facilitators to access. Several participants indicated that they believed their parents were supportive overall of their mental health issues, and that their parent(s) acted as facilitators in terms of helping them access mental health supports and services in the community. Most young women who reported that their parents were supportive believed that this was due to their parents' own professional and/or lived experience with mental illness. For example, one young woman explained that her mother's professional experience as a mental health professional made it easier to talk about mental health because: "she does have all the knowledge and the background of like every different mental illness and she understands what everybody is going through" (P5). Another young woman talked about how her father had been an excellent support because of his lived experience with depression: "…[h]e also struggles with mental health, so I feel very connected. I think he struggles with things similar to what I do…" (P3). Some participants reported that their parents not only helped facilitate access to mental health supports and services but were vocal about their child's needs and often quickly helped to connect them to services or supports in the community such as counselling through a parent's employment benefits (P3) or community health services (P1). A few participants reported that their parents were also instrumental in providing transportation to appointments, particularly since this rural community does not have a public transportation system and some young women did not have a driver's licence. In some instances, parents would drive their child up to 30 minutes to the nearest town to access services (P5).

Barriers to access. Although many of the participants spoke about their parents as "facilitators" of access they also discussed family-related barriers to access; sometimes created unknowingly by parents using stigmatizing language or when trying to help their child. For instance, one young woman recounted her father's use of stigmatizing language when talking about her anxiety attacks and how it made it harder for her to talk to him about her mental health. This participant commented that, "He would call them temper tantrums or stuff because he doesn't have like issues like that, so he didn't understand" (P2). In a couple of instances, participants thought that relying on their parents to facilitate access to mental health supports and services was a barrier because they did not personally feel in control of their access and felt unable to continue accessing services without the involvement of their parents. One young woman shared that she did not know the name or location of the service being accessed and, thus, would be unable to access it again in the future (P3). Yet another young woman stated that if she ever wanted to access a service again, she would need to talk with her father because he provided transportation (P6). This was a barrier because it meant the young woman had to disclose her personal health details to her father and could not access these services independently or without the parent knowing about the access.

School Level

Facilitators to access. Discussions with the young women indicated that the school played an important role in facilitating access to mental health supports and services. Some young women reported that they found support for their mental health through the school by relying on particular teachers. Some teachers were trusted, and participants could confide in these teachers about mental health issues. A few of the young women also commented on the positive teaching environments that some teachers created to promote student mental health. One participant stated that, "My [teacher]—she's always like going on about mental health issues and she hates it when people say they have depression and anxiety, even though they don't… you know how they joke about it? And she's like really supportive" (P5).

Most of the young women also spoke about the convenience of having mental health services located within the physical school environment. All seven young women said they would prefer accessing school-based services (SBS) rather than community-based services not part of the school. They cited better privacy in the school than in the community (P6), no need for additional transportation (P1), less reliance on parents (P7), and the focus of SBS on youth (P5) as key reasons for wanting to use SBS. Those who did access SBS were mostly satisfied with their experience at least in part due to the physical location. The in-school location meant that students did not miss as much class time compared to appointments based in the community, did not need to arrange transportation to appointments (P1, P3), and did not need to tell their parents about their visit (P4). Some young women also shared that they believed most students had no knowledge about community-based services, so SBS were the most accessible for them. As one participant commented, "I feel like the only option they would know about is really at our school" (P5).

Barriers to access. Barriers to accessing mental health supports and services at the school level were also reported in the interviews with the young women. Many spoke about mental health stigma in the school and referred to it as "a black wall" (P4). A number shared that stigmatizing language/jokes at school made it challenging for them to talk about their mental health and, as a result, access mental health supports and services. This stigma, as well as reported fears that someone may not want to be friends with a person with a mental health issue, were suggested by one participant who stated that, "Some people will end up being supportive, but it's a fear of 'What if they don't want to be my friend?' I find with a lot of people" (P6). Stigma also was perceived as a barrier to forming peer support relationships with others struggling with mental health issues: "I guess I haven't really… found somebody who was really struggling. I don't know 'cause there's such a stigma—stigma that people hide" (P4).

Barriers to approaching teachers for support were reported by a few young women. One young woman suggested that some teachers did not fully understand the scope of mental health problems at the school (P6), and another commented that occasionally some teachers would bring their own personal issues into the classroom (i.e., stress) which made some students feel uncomfortable approaching the teachers for support. According to one participant:

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

The school offered several SBS including a teen health centre and counselling, but a few of the young women commented that there were a range of barriers to accessing SBS. For example, there were some privacy concerns such as the fear that classmates would know about their mental illness if they were called out of class for an appointment (P5), and fears that the guidance counsellor might share details of their visit with others such as family members or emergency services. One young woman commented on this later fear stating that, "People think they [counsellors] will rat on them [students] if they go" (P1). There was also stigma linked to the teen health centre as it was associated with sexual health and specifically LGBTQ issues rather than a general health centre. One participant stated that, "I think of like the stigma around Teen Health Centre. I think also just like GSA [Gay Straight Alliance]. They think more like Teen Health is more for like people like LGBTQ* and have like that stuff" (P2).

Some participants reported that there was also a lack of understanding about when it was appropriate to use SBS. One young woman commented that they were told to only use SBS in a "crisis" (P5). A few participants who did try to access SBS were sometimes met with operational barriers such as locked health centre doors during operating hours, as well as unfriendly staff (P2).

Community Level

Facilitators. Living in a small community was spoken of by many as a facilitator to mental health supports and services. For example, the small size of the community was reported to create a positive sense of community insofar as it allowed some young women to easily seek out trusted individuals such as members of a local church or community leaders. One participant commented that, "I have lots of nice people in my community and my church community who I have a lot of trust in. And they help me find support and I think that's really great, that you can't really find that in a big city" (P3). A few young women noted that although there were relatively few services, there were some that provided flexible service delivery including counselling or doctor's appointments after school hours or on weekends (P6), short wait times (P5) and "trial" counselling sessions (P1). Some services offered free transportation to appointments which helped facilitate access for one young woman. These facilitators ensured the young women did not miss school when accessing services.

Barriers. Although several benefits to living in a small community were reported, in terms of accessing mental health services and supports, some young women also identified barriers to access related to rural living. A key issue was privacy due to the size of the community. As one young woman noted: "Usually, if someone knows something about you, a lot of other people know about it too" (P5). The perceived lack of privacy meant that some young women were hesitant to access supports or services in case their mental illness was shared in the community.

Several women also noted difficulties accessing services due to few available health services in their community. One young woman explained that her long-time counsellor retired and was not replaced so she stopped accessing mental health services (P1). Another young woman noted that she mainly accessed her family physician, but because there were so few family physicians in the community, it was difficult to get an appointment. She also added that it was challenging for young people to know what services remained in the community given that so many had closed. As she explained, "I know there's not much out there,

but I haven't really like reached out to a service because I'm not really sure what is left out there…" (P4). Another barrier reported by a few participants was the lack of diverse service providers. One young woman identified herself as being a second-generation immigrant, and she shared that it was difficult for her to find people in the community who understood how she felt since there were so few community members and service providers who were part of the immigrant community. The participant stated that,

> The person—the people who I talk to, it's hard for them to understand. If it was someone, for example, someone who was a second generation [immigrant] who I could talk to, that would probably be wonderful. Um, yeah, it's—I've met someone who's good to talk to but sometimes it's hard for them to understand. (P3)

The location of existing services was further noted as a major barrier for many young women. One young woman expressed concerns about the cost of potentially having to travel outside of the community due to the closure of local services stating that,

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

Most of the young women who had access to transportation also expressed concerns about the location of services. Some of the young women talked about how far services were in relation to the location of their rural school, and they believed that they "missed out on a lot of schoolwork" (P6) and other school-related activities due to travel time for appointments.

DISCUSSION

This research with young women living in a small rural community identified several barriers to access to mental health supports and services including stigma, lack of privacy, and lack of service options within the community. Stigma has been reported in numerous other studies as a barrier to access (Brown, Rice, Rickwood, & Parker, 2015; Crumb, Mingo, & Crowe, 2019) and was also highlighted in a recent study of youth in Cape Breton (a small community in Nova Scotia; Church, Ellenbogen, & Hudson, 2020), so this finding is perhaps not surprising. Research by Parr, Philo, and Burns (2004) suggests that concerns about lack of anonymity and privacy are not uncommon in rural areas so findings from our study about these barriers are also consistent with the literature. Our finding that there is a lack of available services in the community and, thus, transportation barriers is also not surprising given that in rural Canada, especially Nova Scotia, there is a significant physician supply shortage (Doctors Nova Scotia, 2018). At the time of data collection for our research there had been several mental health service closures in the study area including the closure of the area's inpatient mental health unit and the retirement of the local psychiatrist (Henderson, 2016; Musick, 2018). A lack of available mental health services in rural communities and transportation-related barriers are also well cited in the literature (Church et al., 2020; Ghorbanzadeh et al., 2020; Jensen et al., 2020; Radez et al., 2020).

The young women in our study spoke quite extensively about key facilitators to service access including how family and community members helped them or aided their access. Although discussion of community members' help to access services is reported in the literature (Caxaj & Gill, 2016), there are contradictory findings about the help of family to access services. Some research indicates that family tensions may prevent

youth who need mental health services from seeking support from their parents (Arora & Khoo, 2020; Ciarrochi, Deane, Wilson, & Rickwood, 2010; Thompson et al., 2007). The lack of formal health services in our study site may help to explain participants' reports of support from family, friends, and community members. Research does indicate that informal supports sometimes fill the void when there is a lack of formal services and supports (Milligan & Power, 2010) and this may be the case in the study community.

There is some indication that parents may facilitate access to mental health professionals (Markoulakis, Chan, & Levitt, 2020), but there is relatively little research on this topic. Based on our findings, a parent may be the only viable option for gaining access to the services one needs (e.g., by providing transportation). Parents' personal or professional experiences with mental health and thus their understanding of mental health issues may also help to explain why some young women in our study relied on parents to facilitate access. Privacy concerns may further explain acceptance of parental support given that disclosing a mental illness to others in the community, such as peers, might result in the spreading of personal information and gossip. The benefits of peer support for mental health are well known, including increased personal well-being, and improved social integration in work and school (Kilpatrick, Keeney, & McCauley, 2017); yet, some of the young women in our study shared that they did not want to rely on friends and classmates due to privacy concerns and stigma.

All young women in our study also indicated that they would prefer to access mental health services and supports through their school rather than through community-based services. Although some barriers were identified with respect to SBS, this type of service was still considered a preferable option to community services because they are familiar spaces and in a location already used by youth so there are no challenges related to transportation. Much of the literature focuses on SBS in relation to sexual and physical health services, but at least one New Zealand study does point to youths' desire to access mental health services through SBS (Gibson, Cartwright, Kerrisk, Campbell, & Seymour, 2015). This research found that youth prefer school-based counselling because it means limited parental involvement and the location is accessible. Kern and colleagues also suggest that SBS "have the highest likelihood of reaching youth in need" (Kern et al., 2020, p. 205). Having SBS that focus on, or at least include, mental health services would clearly address a number of the barriers to access noted by the young women in our study. The implementation of mental health focused SBS would require, however, appropriate resources. For example, there would need to be dedicated and appropriately trained health professionals to staff these services. Currently, many teachers are providing mental health support beyond their role as educators. The reliance on teacher-provided support may lead to "burn out" and not all teachers have the necessary training or skill set to provide the supports needed by some students (El Helou, Nabhani, & Bahous, 2016; McIsaac, Read, Veugelers, & Kirk, 2017; Rodger, Hibbert, Leschied, Masters, & Pandori-Chuckal, 2018).

Limitations

The study findings are based on a small sample of seven women and although the findings may be transferable to some young women living in other rural places, the findings are limited to youth attending public school. Youth who are homeschooled, private schooled, or who are not engaged with the public-school system may have different or additional experiences as they may have limited, or no, access to publicly funded SBS. Another limitation of this study was that systematic sociodemographic information on racial

identity and socioeconomic status were not collected and, therefore, the transferability to young women from diverse backgrounds is unclear. Yet another limitation of the study is that all participants disclosed that they had been formally diagnosed with a mental illness and had accessed a service, which means their experiences accessing mental health supports and services may be different from youth who have not been diagnosed by a health professional or who do not meet the criteria to access specialized mental health services. In addition, the study findings may not include experiences of young women living in rural places where there are significant numbers of mental health services. Finally, it is important to note that only young females volunteered to participate in this study even though recruitment was open to students of all gender identities. Although the research allowed us to understand how young women perceive and experience access to mental health services, more research is needed to better understand other experiences of access, including the experiences of young men.

CONCLUSION

Our research indicates that there are barriers to accessing mental health services and support for young women living in a small rural community in Nova Scotia, but at the same time informal supports, including parents, teachers, and community members, play an important role in supporting access. By speaking directly to young women, this research has uncovered their experiences and highlights how the young women are actively involved in gaining access using key facilitators. It is important to address the barriers identified to improve access for this population, but addressing barriers means working with youth to make the appropriate changes, and it means gaining the provincial government's commitment to appropriate and sustainable investments in mental health supports and services. The experiences of diverse groups of youth, including young men, racialized youth and those who are not engaged with the public-school system also need to be included to ensure that services and supports meet the needs of all youth. Youth are the future of rural communities. It is imperative that they have the mental health services and supports that they need, and that they can easily and readily access these services and supports.

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SUPPLEMENTARY MATERIAL: SEMI-STRUCTURED INTERVIEW GUIDE

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

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

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