Mental Health in Shelburne County:

A Quantitative and Qualitative Research Report

Shelburne County Mental Health and Wellness Association

January – March 2019

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BIRD&BRANCH
consulting

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Executive Summary & Summary of Findings

Shelburne County Mental Health and Wellness Association (SCMHWA) has worked together tirelessly to advocate for, and improve mental health in Shelburne County. During the winter of 2018 SCMHWA sought to better understand the issues, needs and solutions of mental health by engaging the broader community and stakeholders, thus hiring Bird and Branch Consulting to conduct an in-depth quantitative and qualitative research project. This report is the analysis of the data collected and the key findings from the project. The goals of the project included:

1. Engaging new and once-engaged partners and stakeholders in second-voice storytelling initiatives and activities to collect stories and anecdotes.

2. Data review and analysis of quantitative health statistics to include as numbers/statistics to reinforce the stories collected.

3. Complete qualitative and quantitative report with stories and numerical data to paint the complete picture of the issues of mental health and wellness in Shelburne County.

The goal of the report is to paint a comprehensive picture of the issues and solutions for mental health in Shelburne County. The secondary goal of the report was that having this summary of data and in-depth understanding would help with: future funding proposals, ongoing advocacy efforts, and strategic directions and actions for SCMHWA.

The report includes quantitative data on geography and demography, statistics and analysis of: wait times, ER department closures, and self reported mental health status. Qualitative data on the issues, needs and opportunities makes up the second part of the report.

Below is a summary of findings, followed by the comprehensive report. The final summary, including the summary of opportunities and the key research recommendations conclude the report.

SUMMARY OF FINDINGS

AGING POPULATION

- A significantly higher population above 65 years of age (24% versus 19% as provincial average), and a significantly lower population of 0-14-year-olds.

WAITIMES ARE ON THE RISE AND DIFFER ACROSS THE COUNTY

- For urgent cases there have been significant increases in wait times over the last 8 months; from 0-1 days in April-June to 7-13 days in October-December.
- For non-urgent cases Increases in all clinics that residents in Shelburne County (Western Zone) would use took place in the last 8 months. Specifically, in total 90% of non-urgent cases seen wait times increased by 33 days and 50% of cases increased by 22 days.
- A person who was trying to receive mental health supports in Yarmouth would wait at least 25 days longer than a person visiting Bridgewater clinics.

ER DEPARTMENT CLOSURES ARE A MONTHLY REALITY

- In 2017-2018, according to the NSHA, Roseway Hospital in Shelburne saw 789 hours of closure.

SELF REPORTED MENTAL HEALTH STATUS DIFFERS ACROSS THE COUNTY

- The "South Shore" (Bridgewater) area has a higher self-reported mental health status than the provincial average, whereas the "South West" (Yarmouth area) has a lower average.
- This is a significant difference of 6% across the Western Zone, which is important for consideration of mental health programs, services and supports.

YOUTH AND SENIORS ARE AT-RISK OF MENTAL HEALTH ISSUES IN SHELBURNE COUNTY

- *"The young ones are so not motivated. No one is saying you can't drink at 14, all of our parameters for protecting our children are gone. Kids don't have any boundaries."*
- Isolation is a major contributor to a senior's mental well-being and many of the seniors living in their home in the small rural communities are often isolated, can't drive, and have little access to supports or services, unless they are home-based.

DRUGS AND ALCHOLO ABUSE ARE A MAJOR PROBLEM IN OUR COMMUNITIES

- *"There's a great number of people that are drug addicts; we have a huge drug problem. It's mental health issues that have gotten them there."*

SUICIDES ARE A TRAGEDY THAT EFFECTS THE ENTIRE RURAL COMMUNITY

- The unique rural nature of our communities contributes to the fact that suicides are very "visible" and because everyone knows each other, everyone in the community is affected dramatically by suicides.
- Many stakeholders suggested that in recent years the rate, in particular among youth, have risen drastically.

GENERATIONAL ATTITUDES ARE PART OF THE RURAL CULTURE THAT CONTRIBUTES TO STIGMA AND JUDGEMENT

- *"There are still some people that believe 'to just get over it' or to 'snap out of it.'"*

ASKING FOR HELP IS DIFFICULT IN A SMALL COMMUNITY

- Almost all stakeholders discussed people they knew who refused to reach out, stating stigma, judgement and pride as reasons why.

NOT GETTING THE HELP NEEDED IS A REALITY FOR MANY

- *"The people out in the community are not getting the support they need which leads to more serious mental illness and even suicide."*
- *"There has to be a better process than waiting until they harm themselves or others or break the law before they get help."*

SERVICE PROVIDERS ARE STRETCHED THIN

- Ultimately the results from the unmet needs of our community members falls on shoulders of the passionate, hard working and engaged service providers who desperately want to help. Every stakeholder interviewed told stories about the sense of dread and helplessness they have felt when trying to help those with mental health issues in our communities due to lack of training, resources and supports available.
- *"We keep trying to do things but it's not doing anything for the long run; we are caught at a dead end. They can't get the support they need. There is nowhere to turn."*

Context setting and Introduction

DATA ANALYZED, DOCUMENTS AND RESOURCES REVIEWED

Over the course of January-March 2019 various documents, resources and data was reviewed and analyzed. A full list can be found in Appendix A. The quantitative data reviewed included: the Census Profile 2016 for all 5 municipal units in Shelburne County, the 2015 Nova Scotia Health Profile and 2019 Nova Scotia Health Authority (NSHA) wait times.

Further, a variety of research reports and reputable articles were reviewed which included information on: the current state of the mental health system, community success stories, best practices, and mental health public policy.

INTERVIEWS CONDUCTED

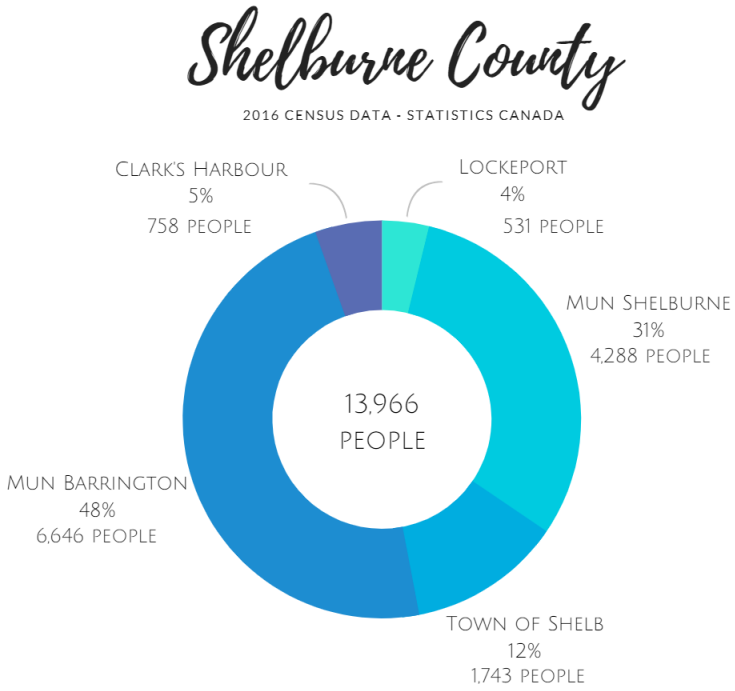
During the month of February 10 key community stakeholders were identified from a list of over 50 community partners and targeted to participate in an in-depth story sharing and interview process. The 10 identified were chosen to take part that best represented the diversity of mental health issues in our community, which included a diversity of age (youth, seniors), gender (women, men, LGBTQ), and income/class level (low, middle, high). Those chosen were so because they could speak for the population they worked closely with as service providers. The list of stakeholders (service providers) interviewed will remain confidential as the interviews were conducted anonymously and all identifying features were removed from the data analysis and final report below.

Quantitative Analysis: The Numbers

GEORGRAPHY AND DEMOGRAPHIC ANALYSIS

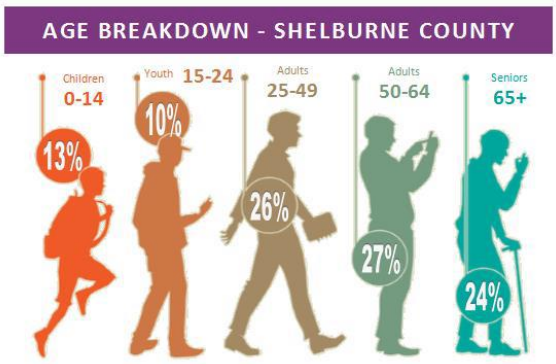
Shelburne County is a distinct geographic area that includes 5 municipal and town governments and numerous small communities in South Western Nova Scotia. For the purpose of health data Shelburne County is included in the Western Zone of the Nova Scotia Health Authority (NSHA), with residents going to Roseway Hospital for most crisis services. For mental health clinics and other non-crisis services typically residents in Eastern Shelburne County would go toward Liverpool or Bridgewater for services and those in Western Shelburne County would travel further west to Yarmouth.

Made up of 13,966 people (Statistics Canada Census 2016) the population is divided by 5 political boundaries: Town of Lockeport (pop. 531), Town of the Shelburne (pop. 1,743) Municipality of the district of Shelburne (pop. 4,288), Municipality of Barrington (pop. 6,646), and the Town of Clark's Harbour (pop. 758).



From Housing: now and into the future: building safe and affordable housing Shelburne county – 2018

According to Statistics Canada Census 2016 data the age distribution in Shelburne County shows a significantly higher population above 65 years of age (24% versus 19% as provincial average), and a significantly lower population of 0-14 year-olds (13% versus 14.5% provincial average) and 15-24 year-olds (10% versus 11.5% provincial average).



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WAIT TIMES

According to Nova Scotia Health Authority (NSHA) In 2018-19 NSHA standardized the way they collect and report wait-times for Community Mental Health and Addictions clinic appointments. Wait time standards have been chosen and waits are reported online by triage level. A person's triage level is determined by their condition as assessed by clinicians working in intake or referral. In providing care and treatment based on clinical assessment, people triaged as urgent receive care before people triaged as non-urgent. Falling into 3 triage categories including:

Triage 1: Emergency, no wait--patients immediate access to care through emergency or crisis services

Triage 2: Urgent, target is within seven days

Triage 3: Non-Urgent, target is within 28 days

Wait time data is public information and posted on the NSHA wait times website: https://waittimes.novascotia.ca/procedure/mental-health-addictions-adult-services.

The wait time data is broken down into geographic area that has a mental health intake department and the data is currently updated every three months and represents data from July-September, October-December, January-March and April-June.

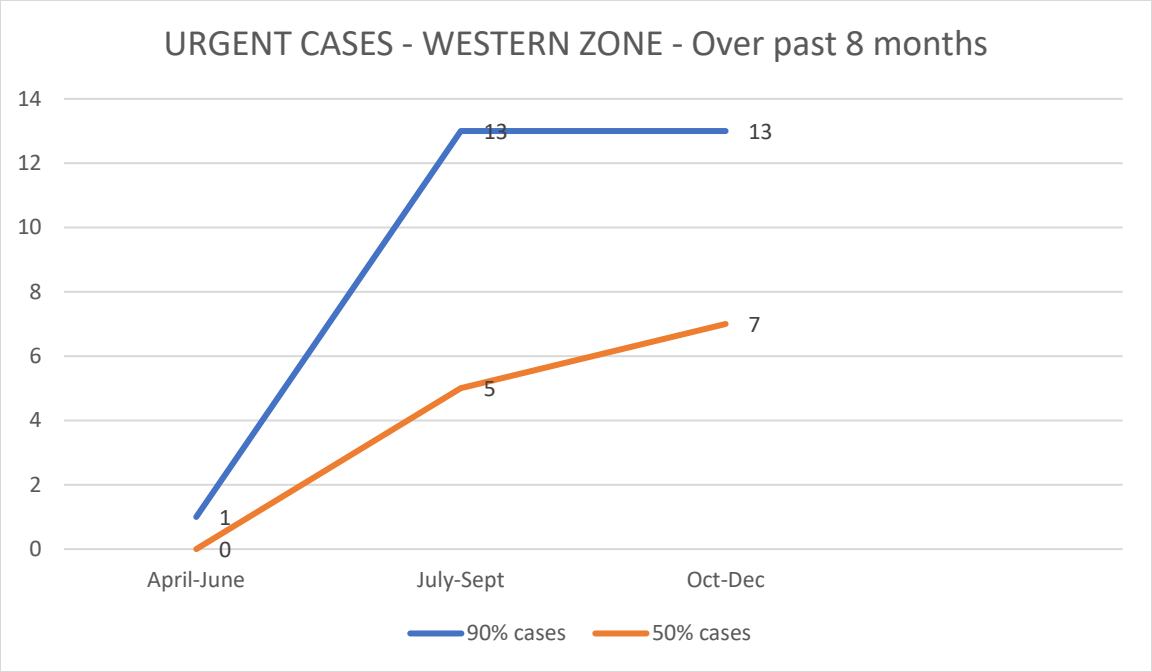
The most recent data currently online represents the wait lists from October 1-December 31, 2018. Below is the data represented in tables and graphs to see the changes in wait times for both urgent and non-urgent cases over the last 8 months.

URGENT CASES

The data is reported only by zone (or geographic area) for urgent cases; Shelburne County is included in the Western Zone, which has seen significant increases in wait times over the last 8 months; from 0-1 days in April-June to 7-13 days in October-December. In total 90% of cases saw an increase of 12 days over the past 8 months and 50% of cases saw an increase of 7 days.

Time Period	90% cases are seen	50% cases are seen
Apr-Jun, 2018	1 day	0 days
Jul-Sep, 2018	13 days (increase 12 days)	5 days (increase 5 days)
Oct-Dec, 2018	13 days (no change)	7 days (increase 2 days)

URGENT CASES WAIT TIMES for WESTERN ZONE– NSHA website



When the data for the entire province is analyzed against the data from the Western Zone, we are approximately in the middle of the pack for wait times. For non-urgent the wait times range from 227 days to the fastest at 29 days; compared to Yarmouth at 95 days and South Shore Regional at 84 days (putting us on par with the provincial average). For urgent cases we are in the third of four rank as the wait times range from 3 days to 18 days, with Western at 13 days for 90% of cases and 7 days for 50% of cases. Although our urgent cases wait times are not as slow as Central zone, we are significantly slower for all urgent cases then the two other zones (Eastern and Northern).

Region	90% cases are seen	50% cases are seen
NSHA Eastern Zone	7 days	3 days
NSHA Northern Zone	7 days	4 days
NSHA Western Zone	**13 days**	**7 days**
NSHA Central Zone	18 days	8 days

URGENT CASES WAIT TIMES ACROSS THE PROVINCE BY ZONE – September 1-December 31, 2018 – NSHA website

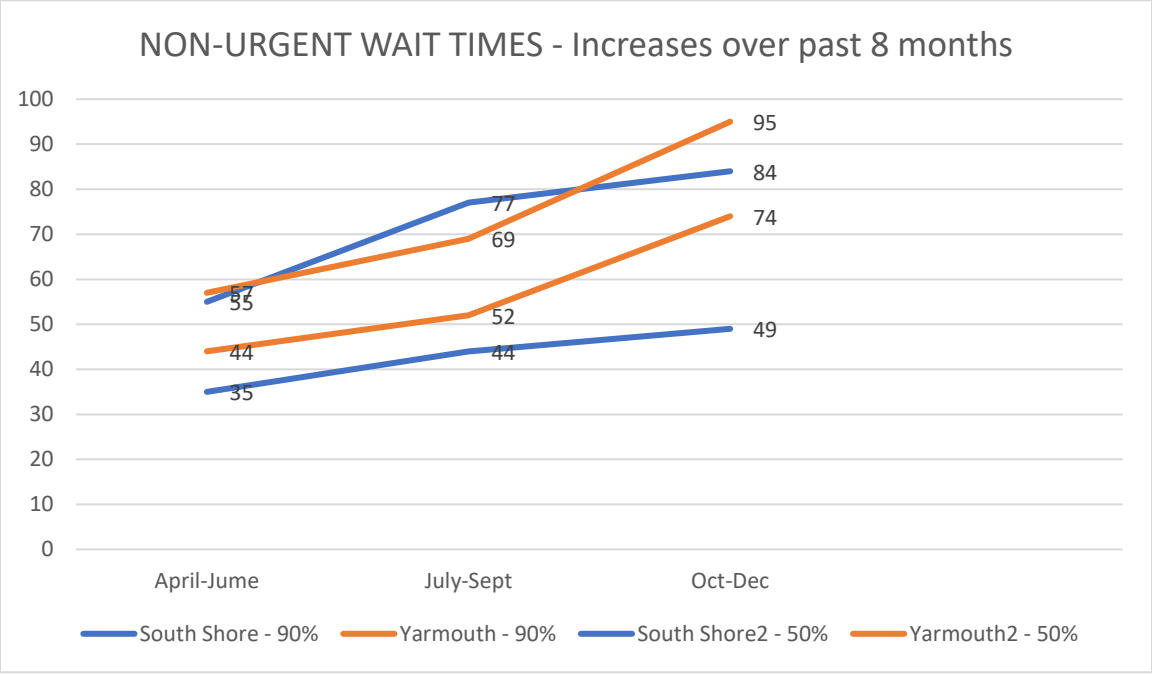
NON-URGENT CASES

Non-urgent cases wait times are broken down more specifically and include the specific clinic wait times; for Shelburne County this includes South Shore Regional clinics (Bridgewater) and Yarmouth clinics.

Time Period	South Shore Regional clinic		Yarmouth clinic		Western Zone AVERAGE	
	90%	50%	90%	50%	90%	50%
Apr-Jun, 2018	55 days	35 days	57 days	44 days	56 days	39.5 days
Jul-Sep, 2018	77 (increase of 22 days)	44 (increase 9 days)	69 (increase 12 days)	52 (increase 8 days)	73 (increase 17 days)	48 (increase 8.5 days)
Oct-Dec, 2018	84 (increase of 7)	49 (increase 5 days)	95 (increase 26 days)	74 (increase 22 days)	89.5 (increase 16.5 days)	61.5 (increase 13.5 days)

Increases in all clinics and with all cases took place in the last 8 months. Specifically, in total 90% of non-urgent cases seen wait times increased by 33 days and 50% of cases increased by 22 days.

In all three-month periods of statistical wait time reporting Yarmouth clinics had longer wait times in both 90% and 50% of cases seen. This was most significant during the most recent period of reporting (October-December, 2018) with a difference of 25 days for 50% of the cases. Meaning, a person who was trying to receive mental health supports in Yarmouth would wait at least 25 days longer than a person visiting Bridgewater clinics.

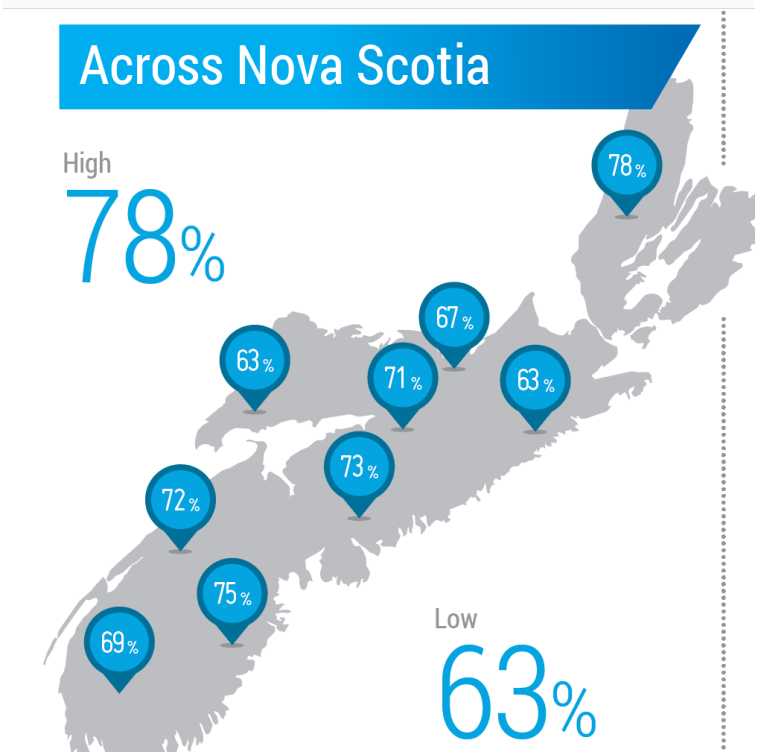


EMERGENCY ROOM CLOSURES

The only health care facility in Shelburne County is Roseway Hospital, located just outside of the Town of Shelburne in Sandy Point. It provides services, including an Emergency Room (ER) department to all residents of Shelburne County. In recent years, due to physician and nurse shortages at Roseway Hospital the ER has been temporary closed on various occasions. In 2017-2018, according to the NSHA, Roseway Hospital in Shelburne saw 789 hours of closure. Smaller hospitals in HRM showed closure rates almost one-third those of Roseway. In 2017-2018 emergency rooms across the province were closed a total of 30,500 hours.

MENTAL HEALTH STATUS

When analyzing the health data on mental health status from the Canadian Community Health Survey (2007-2012) and the recent (2015) Nova Scotia Health Profile the "South Shore" (Bridgewater) area has a higher self-reported mental health status than the provincial average, whereas the "South West" (Yarmouth area) has a lower average. Provincially the average of the population who perceived their own mental health status as being excellent or very good is 72.3%, whereas that percentage is 75% for the Bridgewater area and 69% for the Yarmouth area. This is a significant difference of 6% across the Western Zone, which is important for consideration of mental health programs, services and supports.



Self Reported Mental Health status – NS Health Profile 2015

Qualitative Analysis: The Stories

The stories of mental health in Shelburne County are heard loud and clear from all people in our communities regardless of age, demography, gender, up-bringing, last name, social class, employment, or financial need. People in all of the communities that make up Shelburne County have experiences with mental health. There were many themes that came up numerous times in the interviews. First when understanding the real issues and aspects of mental health in Shelburne County the reoccurring themes that came up were: youth, suicides, drug and alcohol use and addictions, seniors, and judgement and stigma.

Secondly, when discussing the supports, help and needs of our community the themes represented and discussed included: Not being able to ask for help, Asking for help and not getting support, Not being able to help.

Thirdly the interviewees were asked to discuss any strengths and opportunities for mental health in our communities and the themes that emerged were tangible and practical solutions that included: community-based partnerships and supports, peer-supports, mental health support line, education and advocacy, a mental health navigator/support worker in the community.

THE STORIES OF MENTAL HEALTH IN OUR COMMUNITY – THE ISSUES

OUR COMMUNITY

Each person interviewed discussed aspects of our communities that may not seem directly related to mental health, however play a huge role in our environment and the issues that contribute to the mental health of our community members. These issues included the state of housing, employment (or unemployment and lack of jobs), transportation, early childhood development, schools and education, and of course the services and supports available.

"I see mental health as close to 100% environmental; what we see is a lot of anxiety and depression that's situational; their situations are making it worse. Living situation, jobs, lack of supports, all making it worse."

Below are some of the issues and ways in which mental health "shows up" in our communities and as one stakeholder eloquently stated;

"You see mental health issues in our community with drug and alcohol issues, domestic violence, isolation, hoarding, stigma, absenteeism at work; it effects every aspect of your life."

JUDGEMENT, STIGMA, CULTURE AND GENERATIONAL ATTITUDES

The stories heard from our community all had the underlying and reoccurring theme of judgement and stigma and how it contributes to the issues of mental health in our community. For many, this was even more apparent and much more of an issue because of our rural culture and generational attitudes;

"Stigma definitely exists in the older generation. In their generation, a lot of people who had some sort of mental health disorder were shipped away so they were somewhere else. Those people (with mental health issues) were hidden. They were odd and were not conforming. They were not out in the public."

Further, this was reinforced by the lack of support many people suffering from mental health would get "back in the day", however is also still apparent today; "*There are still some people that believe 'to just get over it' or to 'snap out of it'. Some of the people that need the food bank the most would never ever use it because they are too proud. For my parent's generation, it would be snap out of it, you're fine, it would never be the kinder words, of let's talk about it."*

For others, stigma and judgement is ever present in our community in relation to "who you know and who you are related to"; again, being reinforced by the rural nature of our community; *"There's so much prejudices here about who lives where, last name right. There're families in town that don't speak to each other. Those things get in the way. It flares up."*

SUICIDES

An important issue identified and discussed by all stakeholders were the rate and impact of suicides on our communities. Many stakeholders suggested that in recent years the rate, in particular among youth, have risen drastically. Suicides were often linked to poor mental health, lack of supports and drug and alcohol use. Further, many commented on the unique rural nature of our communities that suicides were very "visible" and because everyone knows each other, everyone in the community is affected dramatically by suicides;

"Suicide has really touched our community in the last couple of years. It tears the community apart; it's tragic, the whole community is affected."

"Suicides; really the most severe expression of mental health illness. Broken families; it affects all of us. It's like second-hand smoke; all of our choices effect those around us."

DRUG AND ALCOHOL ABUSE AND ADDICTION

According to the Canadian Mental Health Association *"people with a mental illness are twice as likely to have a substance use issue compared to the general population. At least 20% of people with a mental illness have a co-occurring substance use issue."* Every single stakeholder interviewed brought up the issue of drug and alcohol use and addictions in our community. Many felt the underlying cause of addiction stemmed from untreated and/or undiagnosed mental health issues;

"There's a great number of people that are drug addicts; we have a huge drug problem. It's mental health issues that have gotten them there."

Further to this the stakeholders working closely with youth reinforced that drug and alcohol use was a major issue with our youth.

"I fear for our youth because the drug use is prevalent."

YOUTH

The stakeholders working with youth discussed many of the different issues that youth face in relation to mental health. Some were unique to our youth population, whereas others were reinforced in all of our

population (i.e.: not being able to get support when needed). The unique issues that youth face in our communities include the pressure many feel about "what to do with their life" which in many cases leads to disengaged and unmotivated young people. Stakeholders discussed that often times the environments for our youth (including at school and home) contribute to the feelings of de-motivation, pressure, stress, and engagement. This comment sums up the experiences many youth are facing that contribute to poor mental health;

"The young ones are so not motivated. No one is saying you can't drink at 14, all of our parameters for protecting our children are gone. Kids don't have any boundaries. Kids don't feel safe. They are losing their inspiration to do something with the rest of the life."

SENIORS

The stakeholders working closely with seniors identified many issues in relation to mental health, primarily around lack of support, but also around generational issues (discussed above) and not being able to ask for help (discussed below), and living in isolation;

"How do you cope when you live in isolation and have lost everyone around you and you're the last of your group and you may be living in poverty, there's not a lot of support for that."

THE STORIES OF MENTAL HEALTH IN OUR COMMUNITY – THE NEEDS

Many interviewees told stories that didn't have any ending; meaning they all emphasized the point that the needs of many in our community are ongoing, evolving, and often unsupported (even if diagnosed). Many began their stories of mental health with a person not being able to ask for help (or even not recognizing they had an issue, or being too proud to ask for help), then evolving into a person who finally asked for help but didn't get the support they needed, finally resulting in the service provider struggling with not being able to provide the help needed or meet the needs of their client. The needs in some ways are simple and were clearly reinforced by all those interviewed: better access to support. Even if the needs present as simple, the system, the issues, our communities, and certainly the people themselves are incredibly complex, suggesting complex, multi-faceted, long-term solutions are needed.

NOT BEING ABLE TO ASK FOR HELP

Almost all stakeholders discussed people they knew who refused to reach out, stating stigma, judgement and pride as reasons why;

"As long as there's a stigma attached to mental health, then it's going to impact on people wanting to reach out for help."

Reinforced by the issue of pride and current of judgement felt in the community;

"Changing the whole mindset of the whole community around mental health. Some people are embarrassed and ashamed to talk about it."

Further, many stakeholders suggested that many didn't recognize they needed help, this was particular evident in the senior population;

"Some don't want anything; some people don't know they are mentally ill and don't want help."

Another stakeholder reinforced the difficulty of asking for help and even knowing how or who to ask for help;

"Do they (seniors) realize what they're feeling and would they ever ask for help. Or would they even know how to."

The concept of asking for help and how difficult it is to ask for help no matter who you are amplifies the need to recognize the help one needs and then go the step further and ask for help. Many interviewees recognized the bravery it takes to ask for help and that "putting yourself out there" to ask for help is one of the most challenging things to do;

"Asking for help is really hard."

ASKING FOR HELP

Even though everyone told very different stories about mental health in our communities, the hardest part to tell and the hardest part to hear was when the person finally reached out for help and the pain, anger, frustration and sadness that resulted when inadequate support was found;

"I think when they finally reach out for help and then they don't get anything, then why would they continue to reach out?"

Many stakeholders told stories of people that knew the only way they would get support of any kind was to go to the emergency room, presenting as an emergency, or in crisis;

"I've explained to people that this person is hurting themselves and we need some support here. They keep saying they're not in a big enough crisis here. You have to go in and tear the out-patients apart. There has to be a better process than waiting until they harm themselves or others or break the law before they get help"

Reinforced by this story;

"I've had conversations with people that have told me in order to get the help they needed they told me the system they used which is go to the ER tell them you are going to kill yourself, tell them the pain is a 12 and for the next 8 hours you encounter a lot more people that are going to ask you the same questions and you will tell them the same thing."

Many discussed that they worked with people in the community that might have gotten emergency support when presenting in a crisis to the hospital, but the necessary, ongoing, long-term support was not there;

"You might get the access in that crisis situation, but not after. There's a lot of people who need long-term support."

This point is worsened by the fact that the person who doesn't get long-term, community-based support can often lead back to a crisis situation;

"The people out in the community are not getting the support they need which leads up to more serious mental illness and even suicide."

NOT BEING ABLE TO HELP

Ultimately the results from the unmet needs of our community members falls on shoulders of the passionate, hard working and engaged service providers who desperately want to help. Every stakeholder interviewed told stories about the sense of dread and helplessness they have felt when trying to help those with mental health issues in our communities;

"The analogy for the picture that I get is teeter totter and if you put the people who require something like a mental health service and what we have to offer on the other hand as the service provider we would never be able to budge the community off the ground. It's at the point where I'm thinking it's in crisis."

Specifically, service providers identified that they don't have the qualifications or training to deal with the complex mental health issues they see everyday. They feel they don't have the capacity, education or training;

"The crisis I see is that I am not a trained professional to offer counselling; however, I can recognize when there is no where to make the referral."

"I'm not trained in mental health, I'm a connector, I know the services, but I'm not trained in medications, therapies."

Further, many want to help and are given some training, but not to address the supports and mental health needs;

"A lot of us are taking mental health first aid which is fine; but it's a band-aid; but we're not qualified so how do we give a diagnosis and support to a person and educate around it when we can't access the services. It's like a vicious circle."

This point was reinforced many times, especially when trying to get them the real support they need and finding there is nowhere to get it;

"It's really hard to help people that are mentally ill. We keep trying to do things but it's not doing anything for the long run; we are caught at a dead end. They can't get the support they need. There is nowhere to turn. Constantly spinning, move them from here to there; no wonder they can't get ahead."

THE STORIES OF MENTAL HEALTH IN OUR COMMUNITY –

THE SOLUTIONS and OPPORTUNITIES

Even with all of the issues and challenges we have in our communities around mental health, the key stakeholders and people working "on the ground" still see hope, strengths and opportunity. The stakeholders interviewed all were working on the "front line" and due to the nature of their work and what they see came up with many real, practical and very tangible solutions. Although they all recognized there's no "easy fix" or just

one solution, but a combination of solutions, and most importantly people working together to support those in need.

A uniqueness of our rural nature came up again in relation to our strengths, which was highlighted by many that we will support each other; that when someone is in need the community will rally;

"I would say that one of our biggest assets is the ability for community to rally support."

And that our families are so important to our mental health and support systems;

"There are close knit families and they really care for their people."

COMMUNITY-BASED SUPPORTS AND PARTNERSHIPS

Every stakeholder interviewed discussed the importance of partnerships with each other and continued awareness of the services and supports available to better work together;

"if we could promote our groups amongst each other and collaborate our schedules we could offer so much more. We don't want to overlap, we want more opportunities to get together, to keep each other in mind."

This was reinforced by the fact that supports need to be IN the community and need to be accessible to all. This includes programs and initiatives where many groups, organizations, community members and stakeholders work together to implement solutions (so it's not just up to one organization). This was discussed also in relation to government supports as one stakeholder mentioned;

"The municipal government needs to be an advocate, needs to support this work. We can't do it ourselves, so these types of partnerships are vital."

Further, there are many examples of holistic community-based supports and initiatives that have worked elsewhere that include police, hospitals and community health services across Canada launching innovative partnerships to improve information-sharing and coordination to address gaps in the mental health system. The Crisis Outreach and Support Team (COAST) in Hamilton, Ontario, Assertive Community Treatment teams in BC and the Urgent Response Team in rural Ontario are community-based teams of professionals, organizations and community members that visit people in the community on a routine or emergency basis, reducing mental health hospital visits by 50%. One stakeholder emphasized the importance of programs that are free and accessible;

"Community based support is important. Things like mental health first aid. Make it free and readily and easily available; that would be a huge step in the right direction."

SELF-HELP AND PEER SUPPORT

Every stakeholder interviewed discussed the benefits they have seen with clients and community members who had accessed peer support systems and models. Many identified self-help peer support groups as a very practical and effective part of the solution. Further, it was discussed that people who experience mental health issues want to have this type of support;

"They want to get people who are experiencing the same thing. They want to talk to their peers. It's about connection."

An important aspect discussed by a few interviewees was the point that often "peer support/group support" can be labelled negatively, however something as easy as changing the name can help;

"I have also encountered people that are getting together and DO group therapy, without calling it that, and they are getting lots out of it and now they are bringing their friends. I see all kinds of opportunity, especially in terms if we can start offering support in the ways that are palatable; if I promoted it as a peer support group no one would come. We have a mission that doesn't involved our mental or emotional or spiritual health, but because we are all getting together, we are doing so much for each other."

MENTAL HEALTH HELP LINE

A few of the stakeholders interviewed discussed a potential need for a local mental health support line that could be run by peer-support trained community members;

"A locally-based warm line can fill this before it escalates to crisis, sometimes people just need someone to listen."

Other interviewees discussed the importance of help/support lines and that there is already an existing provincial line that can be used and that we should promote awareness around that support line rather than recreating it;

"There is a 1-800 mental health number already. It's obviously not getting put out there enough. 1-888-429-8167. The service is available 24 hours a day, seven days a week. The crisis line also supports families, friends, community agencies and others to manage mental health crisis through education, outreach and consultation. It obviously needs to get promoted more."

PHYSICAL INFRASTRUCTURE: HOUSING, SAFE SPACES, TRANSPORTATION

Many stakeholders discussed the importance of not just creating programs and supports, but also having physical infrastructure that can help support their work;

"By creating places of safety; and safe people. Schools Plus is a tremendous asset, but we need more safe spaces and safe people. Safe spaces are so important."

The concept that supports for positive mental health go beyond the "traditional" systems and reach out not only into the community, but also take into account all of the aspects of our community that effect one's environment was also emphasized in relation to ensuring good community physical infrastructure. In particular in relation to safe, affordable and accessible housing and transportation systems;

"Finding a way to have a place to have people with issues, safe housing for people in a mixed community. Some place of their own. Housing should be mixed, interspersed, you wouldn't have the stigmatism. AND ensure these places are safe…we need to improve the standards of housing for sure."

EDUCATION AND ADVOCACY

Education and advocacy came up two-fold; in relation to education and awareness for those that have mental health issues, but also in relation to those that support people in their community and in their family. It was identified that not only workshops and programs and education efforts should be made for those with issues, but also for those that really want to help;

"We have a community of people that want to support each other and are eager to, but need the resources to."

Monthly or even weekly workshops were mentioned by many as a possible part of the solution. Ensuring these workshops were about empowerment and advocacy are key aspects for their success;

"Education, advocating for resources, providing resources, workshops, empowerment and education to reduce stigma; it does a whole world of good."

A SUPPORT WORKER/MENTAL HEALTH NAVIGATOR

Although not discussed specifically by every stakeholder a few of those working tirelessly in the community discussed how beneficial and important having someone that was in the community, able to do house visits, and trained in mental health issues would be;

"I need people out in the community. I need someone I can call that can go out and visit this person, is isolated, may not have a phone, has no transportation, has mental illness, needs a visit, want someone to come see them, that person stays with them through the process. This person needs a support worker who is focused on mental health."

This was reinforced by a few that discussed that even if the person had a safe, affordable, clean place to live and meaningful employment, they may still need ongoing mental health support;

"We can set them up with a house, even get them transportation, but they need someone that will check in with them about how they are feeling; someone that is trained in mental health specifically."

Final Summary & Recommendations

In summary, the quantitative and qualitative research conducted begins to paint the picture of mental health in Shelburne County; the issues and the opportunities, the challenges and the strengths, and the needs of the community. The picture painted shows the many small rural communities of Shelburne County in need of mental health services, supports and community attention. Wait times for non-urgent and urgent cases, ER department closures, self reported mental health status, and the experiences we hear regarding lack of help and support all reinforce the need for community-based mental health action. Solutions that came from the data included tangible, practical actions with a focus on providing long-term mental health support. These solutions included everything from a support worker focused on mental health, to more peer support groups, to creating safe spaces and safe people.

Below is a brief listing of key recommendations that came from the analysis of all of the data and that are relevant to the actions, initiatives and movement forward for the SCMHWA. A key factor in the success of any program, initiative or action is that it's not done alone; that stakeholders and the community are engaged in a meaningful way and that it is based in the community and done in collaboration.

RECOMMENDATIONS

COMMUNITY-BASED SUPPORT EFFORTS AND INITIATIVES

- Long term support is necessary for living with mental illness. Crisis support is not enough. SCMHWA should focus efforts on long-term, holistic community-based support systems (i.e.: community-based support worker, peer support groups/workshops, advocacy and education to the community at large, non-crisis support line, etc.).
- Ensure any services, initiatives, programs, and groups are free, or pay what you can.
- Education and awareness efforts should focus on stigma awareness and judgement.
- Change the name! The community, and those who need help, are more likely to support, attend and take the support out there if there isn't a label attached to it; changing the name from peer-support to something more informal, community-friendly is a great way to ensure people don't feel labelled.
- Programs and initiatives where many groups, organizations, community members and stakeholders work together to implement solutions (so it's not just up to one organization) are the most successful and sustainable.
- Think broadly, keeping in mind the determinants of health; there are so many aspects of a person's life that effects their mental health and often it's their environment that needs to be examined and up-stream action on any of the determinants of health like housing, food security, or employment can greatly affect the mental health needs of the community.

COLLABORATION, ENGAGEMENT AND RELATIONSHIP BUILDING

- Collaboration and engagement are key! Collaboration and engagement with ALL community stakeholders, especially with those working "in the field" to ensure they know how the SCMHWA is moving forward and what actions and initiatives the association is taking on.

- Further relationship building with the service providers and stakeholders in the community is needed, which includes awareness of each others programs, services and initiatives.

- Engaging and collaborating with the residents and community members who are experiencing and effected by mental health illness is a key recommendation and next step.

- Collaborating with other service providers on initiatives, actions and programs is a key recommendation; ensuring that it's holistic and an entire team tackling the issues together.

RESEARCH, EVALUATION AND ONGOING COMMUNITY

- Research into why wait times are increasing; what can SCMHWA do to make sure wait times decrease? Advocacy efforts to municipal, provincial and federal governments could be a key action area.

- Differences between the wait times and mental health status between Yarmouth and Bridgewater (Eastern and Western Shelburne County) could be analyzed through community-based research.

- Evaluation of any service, program or initiative the association undertakes is key; ensuring it is helping the community and reaching those that need it is an essential part of evaluating the initiative.

Bird and Branch Consulting commends SCMHWA on their ongoing efforts toward a mentally healthy Shelburne County. Working tirelessly as volunteers we commend the passion, inspiration and commitment the members of the association have and we have greatly appreciated the opportunity to conduct this very important research to help move the SCMHWA mission forward.

APPENDIX A – Bibliography of data and documents reviewed

APPENDIX B – Interview guide and questions

APPENDIX A – Bibliography of data and documents reviewed

- Statistics Canada Census Profile 2016 – Shelburne County
- Canadian Community Health Survey 2007-2012 – Nova Scotia
- Nova Scotia Quality of Life Index 1994-2014 – Engage Nova Scotia & Canadian Index of Wellbeing
- Nova Scotia Health Profile 2015 – Nova Scotia Department of Health and Wellness
- Framework for healthy public policies favouring Mental Health 2014 – National Collaborating Centre for Healthy Public Policy
- Return on Investment: Mental Health Promotion and Mental Illness Prevention 2011 – Canadian Policy Network
- Nova Scotia Health Authority Mental Health wait times July 1 – September 30, 2018- https://waittimes.novascotia.ca/procedure/mental-health-addictions-adult-services#waittimes-tier2
- Housing: now and into the future: building safe and affordable housing Shelburne county – 2018 -
- Peer Support Nova Scotia - http://mhic-cism.com/what_we_do/peer-support-program-development/peer-support-nova-scotia/
- Peer Support success in PEI - https://www.cbc.ca/news/canada/prince-edward-island/pei-mental-health-self-help-1.4604944?fbclid=IwAR3MqOKfzD2loaSzTNPn3FpWMSN3QUdqVSDHrSW5UniPC8YnTnYLAZSVtLM
- The Quiet Crisis of Mental Health Care in Nova Scotia - https://www.thecoast.ca/halifax/the-quiet-crisis-of-mental-health-care-in-nova-scotia/Content?oid=7355675
- Community Partnerships Fill Mental Health Gaps- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3832575/
- A Longitudinal Analysis of the Influence of a Peer Run Warm Line Phone Service on Psychiatric Recovery - https://europepmc.org/abstract/med/28831687

APPENDIX B – Stakeholder engagement: Interview guide and questions

Stakeholder Engagement

PREAMBLE (sent to stakeholder interviewees)

On behalf of Shelburne County Mental Health and Wellness Association (a group of professional and community service stakeholders) we would like to invite you to take part in an informative engagement process to help us build our understanding of the needs of mental health in our communities. We would ask for 30-60 minutes of your time to meet (over the phone or in person) to share your stories, your insights, and your thoughts on mental health in our communities. This information would be completely confidential and anonymous. The data from your interview would be incorporated (with no names or identifying information) into a report (that we would be happy to share with you) that will help provide SCMHWA with a greater understanding of the needs to apply for grants, and to lead our work. This information in the comprehensive report would include both quantitative statistical numbers and the stories behind the numbers (this is where you come in!). We are hoping you would consider taking the time to share your story and insights!

QUESTIONS

1) Tell me a story about mental health in Shelburne?

PROBES:

How does it affect our community?

What are the strengths in our communities around mental health, and how can we build on these strengths?

What are the opportunities?

2) How do you see mental health issues showing up in your community?

PROBES:

What are the real issues here that need to be addressed?

What are the weaknesses and how can we prevent them?

3) How can we support each other to promote mental health in Shelburne?

PROBES:

What can we as SCMWA do for you?

What can you do for us?

How can we collaborate?

4) Are there any other people (clients, community members, other stakeholder) that we should talk to and ask these questions to?