PERCEIVED BARRIERS AND MEANINGS:
THE EXPERIENCES OF PEOPLE ACCESSING NORTHERN MENTAL HEALTH SERVICES

by

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ABSTRACT

Canadians living with mental health conditions, especially those people living in the northern regions, consistently underutilize mainstream mental health services. Most Canadian research aimed at understanding this phenomenon has been quantitative in nature or based on the perspectives of mental health professionals. This research describes the experiences of and explores the barriers facing people living with mental health conditions as they attempt to access and utilize the mental health system in northern B.C. Qualitative descriptive methodology was used to conduct face to face interviews and focus groups with 10 people in a northern B.C. community who were diagnosed with depression. Qualitative content analysis of the transcripts revealed that people experiencing a mental health condition must overcome personal barriers (such as acknowledging their illness, fearing stigmas surrounding mental illness, and the symptoms of their illness) and environmental barriers (such as lack of access to services, limited services, and limited support) to achieve satisfying mental health care in northern B.C. Overall, the most significant finding from this research was how important maintaining good relationships with their mental health care providers (including their family physicians) was to the participants. The participants felt that supportive relationships with their mental health care providers provided satisfactory mental health care. Recommendations to improve the mental health system were also given by the participants. These included improving current support, adding additional services, including people living with mental health conditions and their families in mental health policy making decisions, and improving education on mental illnesses and treatments for the general public and mental health care providers. These recommendations and the findings of this research can inform mental health programs and policies, which better address the concerns and experiences of northern residents.

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CHAPTER ONE

Introduction and Purpose

Mental illness such as depression, anxiety, or addiction affects at least one quarter of the Canadian population with numbers estimated to rise (Nelson, Prilleltensky, Laurendeau, & Powell, 1996; Offord et al., 1996). Even though mental health services in Canada have advanced in the past two decades with improved treatment methods and techniques (Goldner, 2002), research has shown that only a small percentage of those people living with mental health conditions use the mental health system (Cakebread, 2003). This low utilization rate is surprising since a 2001 survey conducted by the Canadian Mental Health Association (CMHA) showed that the majority of Canadians considered maintaining good mental health to be important. It has been documented that barriers to access and use of mental health services exist for people experiencing mental health conditions (Howard et al., 1996). Problems such as service shortages and maldistribution of services, with the majority of services located in urban centres, add to the barriers of access for potential mental health clients. People living in the northern regions of the provinces and territories may encounter even more barriers in their often small and spread out communities (Leipert & Reutter, 1998; Schmidt, 2000).

Despite the well documented barriers and low utilization rates of people experiencing mental health conditions, most research on mental health service usage in Canada has mainly focused on the views of mental health professionals, and not on the views of mental health clients. Largely absent in the mental health literature are the personal experiences of those people living with mental health conditions who are trying to access available services. It is my intention to address this gap as a part of my thesis. Many resources such as the World Health Organization (WHO), Canadian government discussion papers on mental health (Commission on the Future of Health Care in Canada [CFHCC], 2002), and Canadian research (Morrow & Chappell, 1999) have suggested that the views of people living with mental health conditions and their caregivers be taken into consideration when creating mental health policies and programs. It is also my intention to give people experiencing mental health conditions an opportunity to voice their concerns and tell their stories, thus adding to the development of mental health knowledge.

In order to fully understand the mental health system and its effect on people living with mental health conditions, it is necessary to understand the process from the point of view of those people experiencing a mental health condition. Through my own experiences and review of pertinent literature, it has become apparent that people living with mental health conditions in Canada are an untapped resource who could provide valuable information on barriers to accessing and using mental health services.

My Story

I became interested in the barriers to accessing mental health services after developing an anxiety condition and becoming a mental health client. In my experience, accepting my mental illness was a long and hard process. I found that there were very few mental health services available to me in Kamloops where I first developed my anxiety. In Prince George, where I continued to struggle with my condition, there were also limited services. In Kamloops, a family physician put me into contact with government funded psychologists and specialized mental health services, but the wait to access these services was long and disappointing. In Prince George, due to the limited number of physicians, I could not obtain a family physician, and thus I could not obtain a referral to government funded mental health services. Despite this setback, I was able to come in contact with an anxiety support group through the Canadian Mental Health Association (CMHA) in Prince George. In this support group I heard many stories related to limited mental health services and low quality care, especially in northern B.C. It was my experience that my physician had limited knowledge about mental health conditions, and that there was a limited number of mental health services available to me. I experienced long waiting periods accessing many mental health services, felt a lack of support from the mental health system, and found there were many other people with similar experiences.

Research Need and Purpose

After reviewing literature on concerns facing people experiencing mental health conditions, I discovered that there was a shortage of information available in Canada about these people's experiences and their perceived barriers accessing services. The few qualitative studies (e.g. Craven, Cohen, Campbell, Williams, & Kates, 1997) that have been conducted in this area do not reflect the points of view of people living with mental health conditions, but rather those of service providers and "experts" in the field of mental health. The rest of the data is largely quantitative in nature and has focused more on the prevalence of mental health conditions and the utilization rates of mental health services (e.g. Mills, 2003 and Offord et al., 1996). Fuller, Edwards, Procter, and Moss (2000) emphasize that "studying the help-seeking pathways that people use is critical to understanding the link between the onset of symptoms of mental health distress and the use of mental health services" (p. 149).

The purpose of my research is to describe the experiences of people living with mental health conditions. Three research questions guide the study: 1) What are the experiences of people living with mental health conditions in terms of accessing and using mental health services? 2) What reasons do those people experiencing mental health conditions have for not using mental health services, and what perceived barriers to those services exist? 3) What recommendations do people living with mental health conditions have for improving access to and maintaining ongoing mental health services?

The voices of people experiencing mental health conditions have been insufficiently included in the understanding of the mental health recovery process and the barriers to mental health services. This study draws from the experiences and knowledge of people living with mental health conditions. It is my intention that the information gained by this research will aid the Health Authority, government service planners, and government policy makers in understanding the barriers to mental health services that exist for people living with mental health conditions, as well as in reviewing the policies and procedures intended to enhance the well being of this population.

Research Design

I chose to describe the experiences of 10 people living with a mental health condition in northern British Columbia. Using semi-structured interviews, I interviewed each person using 10 questions focused on their journey from discovering their mental health condition to accessing and using mental health services. This research also focused on eliciting the perceived barriers these people encountered with services and their recommendations for, and opinions about, improving accessibility to services. I used a qualitative descriptive research methodology to guide my choice of research methods (semi-structured interviews) and analysis of the transcribed data (Sandelowski, 2000).

Overview of Thesis

Chapter Two contains a review of the literature relating to people experiencing mental health conditions and the mental health services available to this population. It also contains a review of barriers to mental health services, and the added barriers that people living in northern B.C. experience. In Chapter Three the methodology used to guide the study and the methods used for gathering and analyzing the data are described. Chapter Three also includes the ethical considerations that were employed during the study. Chapter Four contains a description of the experiences of the participants in terms of the first research question; their pathway from discovering their mental health condition to using mental health services. Chapter Five contains an interpretation of the findings from Chapter Four by comparing the similarities and differences between each experiential pathway, and includes a description of the perceived barriers to mental health services the participants experienced, and the recommendations they had for improving accessibility to services. Finally, Chapter Six contains an exploration of the key issues revealed by the study pertaining to a successful recovery for people living with a mental health condition in northern B.C. This chapter also contains an exploration of the limitations of the research study, and includes possible suggestions for future research.

CHAPTER TWO

Literature Review

This literature review summarizes published research related to mental health conditions, the Canadian mental health system, mental health service access and usage, barriers to mental health services, and mental health issues specific to a northern geographical context. In the past two decades, there have been several Canadian mental health surveys conducted. The Mental Health Supplement to the Ontario Health Survey (MHSOHS), for example, conducted in the early 1990's provided prevalence percentages of mental health conditions with information about mental health service access in Ontario (Boyle et al., 1996). More recently, the Canadian Community Health Survey (CCHS) conducted in 2002/2003 provided statistics on the prevalence of specific mental health conditions and information about access to mental health services across Canada (Statistics Canada, 2003). In contrast, there has been little research conducted in Canada from the point of view of people who access or attempt to access mental health services.

Setting the Context

To set the context for the study, the population of people who experience mental health conditions is described. This requires exploring the concept of mental health, the prevalence of mental health conditions, and the links between selected risk factors and use of services.

Overview of Mental Health and Mental Health Conditions

The WHO defines balanced mental health and wellness as:

> …more than the absence of a mental condition. Mental health is the ability to think and learn, and the ability to understand and live with one's emotions and the reactions of others. It is the state of balance within a person and between a person and the environment. Physical, psychological, social, cultural, spiritual and other interrelated factors participate in producing this balance (WHO, 2005d, p. 1).

The WHO promotes the realization that wellness is a delicate balance between more than five domains of being. The WHO's current definition of mental health wellness is not a new concept. The Canadian Minister of National Health and Welfare (MNHW) in 1989 recognized that mental health had become understood as the absence of a mental health condition instead of as the external social experience being linked and influential to the internal mental experience. The MNHW defined mental health as "the capacity of the individual, the group, and the environment to interact with one another in ways that promote subjective well-being" (p. 7). This definition of mental health introduced the notion that a person's mental health is not experienced individually, but collectively. In other words, a mental health condition is only one determining factor in a person's mental health status. Mental well-being can be viewed as a continuum between optimal mental health where the person, group and environmental factors are working together effectively and minimal mental health where the person, group and environmental factors conflict (MNHW, 1989). Since then, new developments in the approaches towards influencing optimal mental health have focused on the importance of the external events and social influences that effect mental health.

Mental illnesses vary in severity and chronicity, and the DSM-IV-TR is used as a source of diagnostic categories for mental health professionals in Canada (First & Tasman, 2004). These categories include anxiety and mood disorders, substance abuse and dependence, neurocognitive disorders, and psychotic disorders such as schizophrenia. A mental health imbalance as a recognized disorder is a medically diagnosable illness. A person with a mental illness experiences significant impairment in their cognitive, affective or relational abilities. The treatment and management of mental illnesses are not as clear cut as they are for physical illnesses. In fact, a mental illness can affect a person's overall quality of life in many ways far more severely than physical symptoms (MNHW, 1989). Furthermore, recovery from a mental illness is also subject to the perception of self and others, as well as the recovery process being unique for every person experiencing a mental illness. Recovery from a mental illness is not simply the absence of the condition or a return to a pre-illness level of functioning. Allot, Loganathan, and Fulford (2002), for example, describe recovery as having support and coping mechanisms in place that allows a person experiencing a mental illness to feel they can cope with their symptoms.

Prevalence of Mental Health Conditions

In Canada and the rest of the world, the prevalence rates of mental health conditions are high. For example, the WHO has identified depression as the fourth leading contributor to the global burden of disease (WHO, 2005a). Canadian research has shown that 18% to 25% of Canadians will experience a mental illness at some point in their lives (Nelson et al., 1996; Northern and Rural Health Task Force

[NRHTF], 1995; Offord et al., 1996), and at least 10% of the population is currently experiencing a mental health condition (Mills, 2003). In British Columbia, NRHTF's 1995 report revealed that about 30% of British Columbians experience mental or emotional disorders, a rate above the national average of 20%. More recently, the data from the CCHS has shown that a greater proportion of British Columbians consider themselves to have poor to fair mental health compared to the general Canadian population (Goldner, 2005). Finally, the northern regions of Canada also have a significantly higher prevalence rate of depression (10.1%) than the national average (7.7%) (Mitura & Bollman, 2003), which could mean that northern British Columbians have significantly higher prevalence rates of depression and other mental illnesses than their fellow Canadians.

Links Between Selected Risk Factors and Utilization Rates

Even though each province and territory has different guidelines for approaching mental health conditions and offers different mental health services, risk factors for mental illnesses are the same across the nation. Some people at high risk of mental illness avoid seeking help, which might further compromise their mental health (Mills, 2003; Shields, 2005). There are many risk factors for a mental illness that are linked to utilization of services. The following risk factors are discussed in this section: gender, personal relationships, age, education, poverty, physical disabilities, ethnic background, and geographic location.

Women generally have higher onset and the prevalence rates of mental health conditions than men (Morrow & Chappell, 1999). Women are more likely to have an anxiety or depression illness than men both during their lifetime and at present (Mills, 2003; Shields, 2005; Statistics Canada, 1999). The most common mental illnesses for men are substance abuse and antisocial behavior (Mills, 2003; Offord et al., 1996). Women more frequently experience mental illnesses than men, and women tend to access mental health services more often than men. Men tend to have a more negative attitude towards mental illnesses and mental health services than women (Gift & Zastowny, 1990).

Single, divorced, or separated people have a higher prevalence rate of mental illnesses than people who are married or in common-law relationships (Shields, 2005). Research has shown that people who do not have intimate, sustained relationships, and small social networks tend to be more likely to experience a mental illness (Kent & Yellowlees, 1995). The National Population Health Survey in 1995 indicated that women who lacked emotional support had higher odds of a future depressive episode (Statistics Canada, 1999). Recently, the CCHS revealed that a high percentage of people with social anxiety (Shields, 2005) and people with a bi-polar condition (Wilkins, 2004) reported lacking adequate social support.

Most research has shown that young adults between the ages of 15 to 24 years have the highest rates of mental illness (Mills, 2003; Offord et al., 1996; Statistics Canada, 1999). Furthermore, many of the mental illnesses such as anxiety and bi-polar disorder typically have an early onset between the ages of 13 to 18 years (Sheilds, 2005; Wilkins, 2004). This high prevalence rate of mental illness and early onset of illness for young adults is a concern, since early onset can prevent the development of social skills, the making of a marriage, forming a career, and the planning of a family less likely (Offord et al., 1996; Sheilds, 2005). Also, young people tend to live with a mental illness for three to eight years before receiving mental health treatment (Morrow & Chappell, 1999).

The elderly experience severe loss in their later lives, but are found to have a low prevalence rate of mental illness. Even though the elderly could be considered a low risk group with only 5 to 10% of this population experiencing mental illnesses, there is concern for their low utilization rates of mental health services (National Advisory Council on Aging, 2000). For example, in the U.S., the elderly account for only four percent in psychiatric care, but account for 20% in primary care (Beiser, Gill, & Edwards, 1993). According to Beiser et al., this under-utilization of mental health services by the elderly might be explained by the fact that the elderly tend to rely on one another for support from the distress of aging and loss more so than do adults and children.

Persons with a high level of education are more likely to utilize out-patient specialty mental health services if a mental health condition should develop (Howard et al., 1996). In other words, less educated individuals have a higher prevalence rate of mental illness, but have low mental health service utilization rates. Also, studies have shown that the unemployed and poor have a higher prevalence rate of mental illness and lower rates of mental health service utilization (Kent & Yellowlees, 1995; NRHTF, 1995). What was unclear from these studies was if these poor or unemployed people developed their mental health conditions before or after experiencing their financial or employment challenges.

People who live with chronic physical ailments such as cancer, heart and cardiovascular diseases, diabetes, and HIV/AIDS have been associated with higher prevalence rates of mental illnesses such as bi-polar disorder (WHO, 2005b; Wilkins, 2004). People who live with conditions that cause chronic pain have also been associated with higher prevalence rates (Statistics Canada, 1999).

As previously mentioned, mental health is influenced by many internal and external factors which can be used to predict the groups of the Canadian population that are at higher risk for developing mental illnesses. Considering these high risk groups, it is not surprising that a 1996 study in Ontario found that the strongest demographic predictors for mental health service utilization were low income and uneducated women between the ages of 25 to 44 who were either divorced, separated, or widowed (Lin, Goering, Offord, Campbell, & Boyle, 1996).

Northern and Rural Canada

People who reside in northern and rural communities in Canada are also considered a high risk group because of harsh climate conditions, small communities, and isolation. According to Pitblado (2005), there is no one single definition for a northern or rural community in health research, thus creating disagreements between definitions in many research studies. Regardless of differences in population density, climatic conditions, and definitions, northern and rural Canada share many characteristics that make them distinctive from southern urban cities. The health status of people living in northern, rural Canada has been consistently lower than the rest of the Canadian population (CFHCC, 2002). Therefore, it is also important to set the context for northern, rural communities in Canada by exploring their living environment.

A person's living environment has an effect on their mental health. Northern, rural Canada tends to have a higher rate of unemployment with a lack of viable employment opportunities (Hoyte, Conger, Valde, & Weihs, 1997), and tends to be poorer than southern, urban communities (Cordes, 1985; Feather et al., 1993). Due to high unemployment rates in northern, rural Canada (e.g. northern Saskatchewan's unemployment rate is 30 percent), houses sometimes accommodate more than one family and each family is likely to have more children than the national average. Therefore, the overcrowding in sometimes defective and inadequate housing, with high levels of unemployment in some communities, can add severe stress to those with mental health conditions (Feather et al., 1993). For example, northern, rural Canada tends to have a higher rate of violence than the national average (Leipert & Reutter, 1998).

The social attitudes of northern, rural Canada can be less diverse than those of urban populations because of the isolation, and in some cases, low population density (Leipert & Reutter, 1998). Therefore, some communities have narrower views on morality, religion, political philosophy, and guidelines for normal behavior (Cordes, 1985; Hoyte, et al., 1997). Therefore, seeking mental health services in some northern, rural communities could be viewed as a weakness and looked down upon by other community members (Watts et al., 1999). Urban, southern communities in Canada also have people with the same views as northern, rural communities, but in a larger population density there is more variation of social and political attitudes, allowing for more anonymity and tolerance (Cordes, 1985; Gift & Zastowny, 1990).

Northern, rural Canada has a high percentage of Aboriginal peoples. For example, 13% of northern B.C. residents are of Aboriginal ancestry, which is the highest in B.C. (Northern Health Authority, 2005b). The health status of Aboriginals across Canada is consistently lower than the national average and lower than their fellow Caucasian northern, rural community members (CFHCC, 2002). For example, the suicide rate for some Aboriginal communities is two to three times higher than non-Aboriginal communities (British Columbia. Provincial Health Officer, 1996), and Aboriginals living off of reserves are 80% more likely to report that they experience depression than non-Aboriginals (Mills, 2002).

The stressful environmental conditions, including poverty, high unemployment, conservative community attitudes, and isolation that some communities in northern rural Canada face enhances the need for these communities to utilize mental health services. Barriers unique to some northern, rural communities exist, leading to low utilization rates.

Defining the Problem

As previously mentioned, there are significant numbers of people in Canada experiencing mental illnesses, but a low percentage of these people are accessing and utilizing the mental health system. In this section, the Canadian mental health system and the possible problems existing within this system are explored. This exploration required a review of the Canadian health care system, mental health services, and barriers to service, including those barriers unique to northern and rural communities.

Canadian Health Care System

In Canada there are 10 provincial and three territorial (including Nunavut) health care systems structured around federal guidelines (Health Canada, 2006). In British Columbia, the provincial government allocates funds for public mental health services from a federal block grant to the six Regional Health Authorities that are responsible for ensuring that health services and programs are properly managed and funded within each region (Canadian Centre for Analysis of Regionalization and Health [CCARH], 2005). For British Columbians to access most government funded mental health services, a referral from a general practitioner (GP) is required. For example, to access a psychiatrist, who is considered a medical specialist in B.C., a person must first access a GP who then decides whether a referral to a psychiatrist is warranted. Also, any government funded psychologists, counselors, or programs require a referral from a GP. Private mental health services are also available in B.C. that may not require a GP's referral, and include psychologists, counselors, support groups, and non-profit societies. These services are generally used by employees with third party medical insurance, recipients of insurance settlements, and those people who can afford to pay privately.

Mental Health Services

Mental health services in Canada have changed significantly over the last century. The policies governing the mentally ill in the first part of the century centered on institutionalization within psychiatric hospitals (Goldner, 2002). This policy was seen as more humane than the jail cells the mentally ill were put into before the construction of psychiatric hospitals (Morrow & Chappell, 1999).

Psychiatric hospitals were self-contained institutions supplying residents with basic supports, such as food and shelter, mental health treatment, and rehabilitation services (Durbin, Goering, Streiner, & Pink, 2004). Under institutional policies, the mental health system looked at what was good for mentally ill people in general and as a whole (Bachrach, 1994). While the number of psychiatric hospitals and psychiatric beds were peaking in the 1960s, rumors and accusations about the mistreatment of patients in some psychiatric hospitals were surfacing. During this time, new treatments for mental health conditions were emerging, such as antipsychotic medication and psychosocial interventions (Goldner, 2002). Sociologists and psychiatrists also began to question whether the interests of a person who is mentally ill are best served by institutionalization (Scull, 2004). The combination of these new emerging treatments and concern for mistreated patients prompted a new policy of deinstitutionalization in the 1970s (Goldner, 2002). Politicians and government officials supported deinstitutionalization, and saw it as a way to decrease the large amount of funds spent on institutionalized care (Scull, 2004). Under the new deinstitutionalization policy, the mental health system looked at what was good for a particular mentally ill person (Bachrach, 1994). Unfortunately, the people discharged from these facilities after deinstitutionalization met an unequipped community-based mental health system, which was limited and fragmented (Durbin et al., 2004). It left many of them without proper care, adequate housing, finances, or employment. This new policy also put an extra strain on hospital and out-patient services (Morrow & Chappell, 1999). To date, a system of community-based services and supports needed to replace institutional care for people experiencing mental illnesses has not been fully developed because of competing demands for health budgets and fiscal restraints, as well as many other broad social and environmental factors (Goldner, 2002; Scull, 2004).

According to the Public Health Agency of Canada (2005), the current mental health system and mental health services are:

> .....a mix of health, social, vocational, recreational, volunteer, occupational therapy, and educational services. They include a range of activities and objectives ranging from mental health promotion and the prevention of mental health problems to the treatment of acute psychiatric conditions and the support and rehabilitation of persons with severe and persistent psychiatric conditions and disabilities. (par. 1)

In British Columbia, there are a wide range of services currently available in the mental health system such as institutions like psychiatric hospitals and general hospitals with psychiatric emergency facilities; professionals such as psychiatrists, general practitioners, psychologists, and counselors; and alternative care services such as religious healers, herbalists, massage therapists, and self-help groups. More recently, a new sector of a person's mental health care known as the 'voluntary support network', which consists of friends, family, and self-help groups has been recognized (Howard et al., 1996). Self-help groups are community-based programs usually organized and operated by people living with mental health conditions. Self-help groups have become widespread and popular, with more than 500,000 in North America alone (Beiser et al., 1993). Since the deinstitutionalization of mental health services, the voluntary support group has become important because of inadequacies in the mental health system and its limited services.

Mental Health Service Gaps and Environmental Barriers

Reform of the mental health system in Canada has become a government priority, since major shortcomings have been identified within the system in the past decade. McEwan and Goldner (2002) outline these shortcomings as:

> (a) a failure to give priority to individuals with the most disabling mental health disorders (Canada, 1997a, 1997b, 1997c), (b) a move to deinstitutionalization without sufficient expansion of community-based services and supports (Bachrach, 1996), (c) a gap between research evidence and practice (Wasylenki & Goering, 1995), and (d) minimal or no involvement of consumers and families in the planning and delivery of care (Trainor, Pomeroy, & Pape, 1993). (p. 5)

The deinstitutionalization of mental health services has benefited many patients by providing community-based services, thus allowing patients to recover at home instead of in an institution. Unfortunately, this benefit does not out-weigh the many problems people face accessing and utilizing mental health services. Many mental health professionals and advocates for community-based services recognize that it was much easier to access mental health services in a hospital-based system (Bachrach, 1994; Durbin et al., 2004). In the 1960s and 1970s, the population of psychiatric hospitals was reduced by 78%. Unfortunately, the savings for these bed closures were not reinvested into community-based services. Now, provinces and territories are struggling to improve the community-based mental health system

(Freeman, 1994). After deinstitutionalization, the community-based services were not prepared for the effects the exposure to street drugs and the lack of a social support system would have on clients. They did not anticipate the confusion and hardship that the service fragmentations would cause some clients (Bachrach, 1994). The inadequacy and inequity of mental health services has led to many access and utilization barriers, thus leading to low utilization rates. For example, the CCHS revealed that only 32% of those people living with a mental health condition sought professional help (Cakebread, 2003). The WHO recognizes that fewer than 25% of those people experiencing depression will ever receive treatment for their illness (WHO, 2005a). Finally, the regionalization of the B.C. health care system in 1997 created confusion for some people struggling to understand and use the services that were implemented under new policies. Even though regionalization was designed to organize and create a more efficient and accountable health care system (CCARH, 2005), this restructuring led to a loss of some important services and to difficulties accessing others (Morrow & Chappell, 1999).

In the wake of regionalization, the B.C. government released a new mental health plan in 1998 called "Revitalizing and Rebalancing British Columbia's Mental Health System" (Ministry of Health, 1998). Some of the focus of this new plan was to decentralize tertiary care centers, increase community supports, improve access, increase crisis intervention services, increase consumer and family involvement, increase mental health education initiatives, and create a more accountable mental health system. Unfortunately, there is some evidence that this plan has not improved accessibility and treatment availability. For example, the recent CCHS has shown that patients reporting unmet care needs from the health care system, including the treatment of mental or emotional conditions, are dramatically increasing in the new century (Martin, 2002). The CCHS has also shown that only a low percentage of mental health sufferers received mental health services, but a high percentage of those who did receive services were very satisfied with the quality of care (Statistics Canada, 2003). There might be factors contributing to inequities in the mental health system that are leading to barriers of access and utilization of mental health services. These factors might include limited services, lack of access, discontinuity of services, and lack of support, as well as factors related to economical, pharmaceutical, cultural, and professional barriers.

Even after regionalization there is still a lack of coordination among the three major treatment sectors of the mental health system. These sectors are the provincial psychiatric hospitals, the psychiatric units in general hospitals, and community mental health programs. Their lack of coordination has led to fragmentation of services, a lack of continuity between services, and an absence of accountability for the provision of comprehensive mental health care (Durbin et al., 2004; Wasylenki, Goering, & Macnaughton, 1994). One of the largest problems facing the mental health system is the limited services and numbers of mental health professionals available in many communities. For example, in some communities where the local hospital does not have a psychiatric unit, jail cells are often used to hold people in mental health crisis until they can be transported to the nearest psychiatric equipped hospital (Morrow & Chappell, 1999). Consequently, when most mental health professionals reside in large urban cities, matters of inequity of services are even more extreme. Limited available mental health services and professionals also lead to discontinuity problems within and between mental health services. For example, if a community has difficulty recruiting and keeping mental health professionals, a continuous turnover of primary mental health providers can occur, leading to a decrease in use by people experiencing mental health conditions (Durbin et al., 2004). The problem of limited mental health services and professionals also leads to a lack of access. For example, access to mental health services is quite commonly gained through a general practitioner, and 14% of Canadians do not have a family physician (Gagnon, 2004). This leads to accessibility issues when diagnosis and treatment is required.

Even after a referral has been made to a mental health professional, there is a high failure rate for a person living with a mental health condition to keep their initial appointment. Most people still receive help in the year following the missed appointment, but unfortunately it is because the problem has worsened (Nicholson, 1994). Another problem plaguing the mental health system is the long waiting periods for appointments with specialized mental health services. These long waiting periods have been shown to promote unmet care needs for people living with mental health conditions (Goldner, 2002; Martin, 2002). The high failure rate for initial mental health appointment attendance could be influenced by these long waiting periods (Nicholson, 1994).

To help alleviate some of the problems associated with limited mental health professionals, the WHO believes that depression can be reliably diagnosed and treated with a 60-80% success rate in primary care using antidepressant medications and psychotherapy (WHO, 2005a). About 20% of visits to GPs in Canada are mental health related (Beiser et al., 1993; Howard et al., 1996), and about 30% of patients of a GP's practice require psychotherapeutic and counseling interventions (Swanson, 1994). Watson, Heppner, Roos, Reid, and Katz (2005) looked at the changes between the years of 1992 to 2001in family physician usage for the detection and treatment of minor to moderate mental health conditions in Winnipeg, Manitoba. They found that family physicians had a significant increase in their treatment prevalence rates since 1992. They found that family physician encounters with mental illnesses increased by 20%, making it one of the more common conditions seen in the family practice. They recognized that these increased rates could have been due to either increased incidences of mental illness, or increased likelihood of people seeking mental health care, or increased family physician proficiency in detecting and diagnosing mental illnesses. Regardless of the reasons, Watson et al. point out how import the family physician, and access to primary care has become in mental health care. Therefore, any efforts to improve the effectiveness of mental health care should include the family physician.

Diagnosis rates of mental health conditions are sometimes low for GPs, resulting in major misdiagnosis problems for people experiencing mental health conditions. For example, an Ontario survey revealed that only 20.8% of individuals with diagnosable mental health conditions were actually receiving mental health services, even though 82.9 % of the diagnosable population was utilizing general practitioners for health problems (Parikh, Lin, & Lesage, 1997). Unfortunately, people who do not receive the appropriate treatment can go on to develop more serious problems (Beiser et al., 1993). When a patient does not respond adequately to treatment by a primary care physician, appropriate referral to a specialist does not always occur, thus compounding the problem. This could be because specialist support is unavailable (Goldner, Bilsker et al., 2002).

Even though medications for mental health conditions have helped many people, there are still problems associated with medications leading to barriers to mental health recovery. Many people experiencing a mental health condition complain that the side effects of these drugs are sometimes dangerous and more severe than the mental health condition (Boydell, Gladstone, & Crawford, 2002; Morrow & Chappell, 1999). These side effects can lead to people failing to continue their medication or discontinuing their medication prematurely. Also, some people can be prescribed ineffective medications because of low doses and not being prescribed medication for long enough periods (Goldner, Bilsker et al., 2002). Another problem with medications is the rising costs. If a person with a mental health condition does not have extended medical coverage, they must pay the full cost, which can be a significant financial burden on lower income families.

Poverty is a significant barrier to preferred mental health services (Goldner, Bilsker et al., 2002). A person living in poverty can only access publicly funded mental health services, thus making it impossible for the poor to access private psychologists, counselors, or alternative treatments (Morrow & Chappell, 1999).

Alternative therapies for mental health conditions are often not taken seriously or dismissed by physicians and mental health professionals. This dismissal of alternative therapies can be a barrier to proper mental health services for the many people who do not accept the therapies of the mainstream mental health system. This problem is also important because of the multicultural population of Canada. Many other cultures have healing methods that may be useful in the recovery from a mental health condition (Morrow & Chappell, 2002).

Another problematic area within mental health services is the language barrier faced by immigrants and minorities (Leipert & Reutter, 1998; Li & Browne, 2000). The language of the immigrant or minority member might attribute different meaning to the words than the English interpretation reveals to the therapist. Also, the therapies are based on Euro-North American values, which may contradict the beliefs and values of the immigrant or minority. This combination of miscommunication and differing value systems quite often prevents immigrants and minorities from receiving adequate service (Beiser et al., 1993, Goldner, Bilsker et al., 2002; Li & Browne, 2000). Also, many minorities and immigrants do not understand how to access the Canadian mental health system, and this leads to underutilization (Morrow & Chappell, 1999).

Even if there was an overabundance of mental health services and professionals available, utilization of mental health services by people experiencing a mental health condition is not guaranteed. For example, universal health care in Canada has not been found to promote higher mental health service utilization rates compared to the United States (Lin et al., 1996). Other studies have also found that the majority of those needing mental health care did not receive it in places with generous mental health service coverage. Therefore, other factors such as emotional barriers must play a major role in perpetuating the gap between service need and utilization (Howard et al., 1996).

Emotional Barriers to Mental Health Services

Service gaps are not the only barriers leading to low utilizations rates of mental health services. Several other barriers exist because of a person's preconceptions of mental health conditions and services. The first and most significant barrier is a person's ability to recognize that they might be experiencing a mental health condition. For example, one survey examining depression and problem recognition revealed that 2/3 of people with high depressive scores denied feeling depressed (Howard et al., 1996). Another survey conducted in the United States found that people who screened positive for mental health conditions did not seek help, even after an educational intervention about mental health conditions and services took place. Furthermore, some of the people in that study refused to take part in the educational intervention after learning of their screen-positive result (Fox, Blank, Rovnyak, & Barnett, 2001). This denial was linked to the stigma surrounding mental health treatment and mental health conditions. This stigma still pervades the general population, creating a substantial fear of what others will think of them. Stigma can lead to rejection by friends, relatives, neighbours, and employers for people living with mental health conditions. Stigma can also have a detrimental effect on a person's recovery and ability to find acceptable services (Goldner et al., 2002; WHO, 2005c). For example, a study conducted by the CMHA (2001) revealed that Canadians are increasingly secretive about receiving treatment or counseling for stress and depression.

Howard et al. (1996) stated that a person's social network could also be a barrier to mental health services in two ways. First, if a person lacks a social network, they may lack the support to recognize and define the problem and as well as decide on what actions to take. Second, if a person's social network holds certain negative opinions of mental health conditions and the mental health system, the person could choose to ignore the problem and not seek professional help.

Relying on such a social network can have an even larger impact on help-seeking problems for women. Men with mental health conditions tend to seek help from the mental health care sector directly, usually late in the illness episode. Women rely more heavily on family, friends and social contacts and are less direct in seeking professional help (Beiser et al., 1993). Since women have a higher prevalence rate of mental health conditions, the gap between mental health service need and utilization widens and the barrier to service is strengthened.

The environmental and emotional barriers identified above exist in northern, rural communities, and are compounded by other barriers unique to these areas.

Barriers to Mental Health Services in Northern, Rural Communities

Northern, rural communities have added barriers, which are not always taken into consideration when implementing new mental health initiatives. Schmidt (2000) reports that most psychiatric rehabilitation programs originate in urban centers, and therefore lead to certain assumptions or beliefs based on urban residents. He outlines these assumptions:

> (a) that communities have a range of housing options available for consumers (Carling, 1995; Trainor, Morrell-Bellai, Ballan-tyne, & Boydell, 1993); (b)

> that the employment market is diverse and reflects multiple opportunities for work (Chandler, Levin, & Barry, 1999); and (c) that various services-such as psychiatry, hospitals, social work, and nursing-are readily available within the community, or at least are available within close proximity (Anthony, Cohen, & Farkas, 1990). (p.77)

As previously discussed, these assumptions do not reflect the reality for northern, rural communities.

Northern, rural communities are sometimes small and spread out across large distances and usually across harsh terrain (Leipert & Reutter, 1998: Underwood, 2004). For example, northern British Columbia is 2/3 of the province and includes more than 300,000 people (Northern Health Authority, 2005a) of the 4.2 million living in B.C. (Statistics Canada, 2005). Consequently, assessment and treatment of mental health conditions is a problem in northern, rural communities because of limited access to mental health services and professionals such as psychiatrists, psychologists, nurses, social workers, mental health counselors and addictions specialists (Pong, 2002; Provincial Co-ordinating Committee for Remote and Rural Health Services [PCCHRRHS], 2002), and health care facilities such as independent living spaces and residential care facilities (Morrow & Chappell, 1999). Services available in these communities are usually secondary with most tertiary services only available in urban communities. Some northern, rural communities are too small to support a GP and do not have easy access to other communities with secondary services (PCCHRRHS, 2002; CFHCC, 2002). Finally, recruiting and maintaining mental health professionals in northern, rural communities is difficult, and leads to gaps in service and discontinuity of care (CFHCC, 2002; Morrow & Chappell, 1999). These service gaps create large obstacles to recovery for people living with mental health conditions residing in northern, rural communities (Schmidt, 2000). For example, a northern Ontario survey revealed that northern communities had less mental health service utilization than their urban counterparts because of unmet needs for services (Parikh, Wasylenki, Goering, & Wong, 1996).

An update on the recommendations made by a report issued in 1999 called, "Enhancing Health Services in Remote and Rural Communities of British Columbia", was released in 2002 (B.C. Ministry of Health, 1998). This updated report indicated that rural and remote areas had become more self-sufficient because of decentralized decision-making and new mental health care funding. They also reported that psychiatric outreach services had been expanded, including "Tele-mental health", which provides linkages to local physicians, counselors, consumers and specialists in Vancouver. Reflecting these recommendations is the Iris House in Prince George, which opened in 2002. It provides space for mental health patients who would have previously received treatment at Riverview Hospital located in the Lower Mainland. The expansion of Iris House in 2003 doubled its bed capacity (Northern Health Authority, 2003). This facility and others like it provide patients with private rooms and a more normalized lifestyle, including opportunities for cooking, cleaning, and other activities of daily living (B.C. Mental Health Society, 2002). The CFHCC (2002) acknowledges that some approaches have been implemented to improve access with outreach programs and financial assistance for people who need to travel, but cautions that the problems facing northern, rural communities are far from solved.

Northern, rural communities are at a greater disadvantage for specialized mental health services, and for this reason people living with mental health conditions must travel to urban centers to access specialized services (Cordes, 1985). These communities can be small and spread over long distances, thus creating transportation difficulties between communities. Winter can exacerbate these conditions making traveling between communities hazardous, time-consuming, and impossible. People forced to travel to other communities for specialized mental health services creates a significant barrier for several reasons. First, people living with mental health conditions and their families in northern, rural communities frequently cannot afford the travel costs to urban centers (Northern Alberta Development Council [NADC], 1991; Schmidt, 2000). Not only do these people have to bear the burden of paying the high cost of travel, but they also have to endure the cost of accommodations and meals (CFHCC, 2002; Pong, 2002). For example, a study conducted by Fortney, Rost, Zhang, and Warren (1999) revealed that long travel times were highly correlated with less frequent visits to mental health professionals for people experiencing depression. Also, northern, rural communities do not have the same transportation alternatives available as the southern, urban communities (Cordes, 1985; Leipert & Reutter, 1998). Second, if a person receives specialized mental health services in an urban center there are few, if any, follow-up services available in most northern, rural communities. This two-tiered system of mental health services leaves northern, rural community members feeling disconnected from preferred mental health care when they are at home and disconnected from their communities when they are receiving preferred care in an urban center (Schmidt, 2000). Finally, when a person must travel long distances to receive mental health services, they lose the social supports that might be present in their own communities (CFHCC, 2002; Pong, 2002). For example, a study of northern Alberta conducted by the NADC (1991) revealed that clients reported successful outcomes from mental health services more twice as often than when local services were used instead of out of commuinty services only.

Finally, in smaller, isolated northern, rural communities, it is hard for a person to maintain anonymity. This creates another barrier to service utilization (Gift & Zastowny, 1990; Leipert & Reutter, 1998; Morrow & Chappell, 1999). This loss of anonymity can be a significant barrier for accessing services in those communities with strong conservative attitudes and a low tolerance for abnormal behavior (NRHTF, 1995; Hoyte, et al., 1997; Leipert & Reutter, 1998). Schmidt (2000) noted, "the problem for residents in small northern communities is that their activities are highly visible to friends and neighbors, and accessing a service in a way which is discrete and confidential may present challenges" (p. 78).

Integration

To date, most of the research on mental health service utilization in Canada has been previously undertaken using quantitative surveys. These surveys are an excellent way to reveal problems existing in the mental health system. For example, the most recent CCHS conducted by Statistics Canada in 2002 reports the prevalence rates of mental health conditions and the low utilization rates of people experiencing mental health conditions. Unlike other surveys conducted in the past, this survey asked questions relating to the reasons people give for having unmet mental health care needs (Statistics Canada, 2002). Unfortunately, the answers chosen by the participants are from a pre-selected answer key. Although the CCHS has begun to try and understand the barriers to mental health service utilization, a quantitative survey cannot elicit the perceptions of people who have attempted to use the system, especially in the north. The CCHS does not give an accurate picture of the problems facing northern communities, since the study sample did not include people residing on reserves and some remote areas. For these reasons, it is important that research studies designed to explore the experiences and perceptions of people attempting to access and utilize services be conducted, especially in the north. These studies could create a broader picture of the problems facing people experiencing mental health conditions when accessing the mental health system. These studies could also provide policy makers and program designers with valuable knowledge needed to improve the accessibility of the mental health system and its programs.

Craven et al (1997) designed a qualitative research study to understand the low diagnosis rates for mental health conditions by family physicians. The study used five focus groups of family physicians in the small communities of northern and southern Ontario. The study described the experiences that family physicians had with the range of mental health conditions encountered, the special problems associated with mental illness detection, and the barriers to optimal mental health care. This study was an excellent starting point for understanding the phenomena of low diagnosis rates of mental health conditions by family physicians. It was also a beneficial step towards understanding the potential barriers people living with mental health conditions face in the mental health system. This study could have been taken one step further by interviewing the clients of these family physicians in order to gain their perspectives and knowledge about their perceived barriers to mental health services. A U.S. study was conducted in 2004 reflecting this idea by interviewing mental health care providers as well as consumers. The study focused on the perceptions of service quality in community mental health care. Interviewing both providers and consumers revealed different points of view about service satisfaction, and provided a broader picture about the difficulties in maintaining service satisfaction (Mason et al., 2004).

'Psychiatric survivor' literature has been emerging in the last decade focusing on the experiences of people who have spent time in psychiatric hospitals. Unfortunately, the majority of this research has not been conducted in Canada. It is apparent that there is little known about the perceived barriers that mental health clients face in Canada. What is known is mostly based on mental health professional opinions and quantitative surveys, which are not designed to elicit the opinions and perceptions of people living with mental health conditions.

There is a definite need for research regarding service satisfaction of the British Columbia mental health system. Since northern communities are in greater need of service equity, client-based research exploring the perceptions of mental health service performance and the potential barriers to service is needed in the northern region of British Columbia. The perspectives of people living with a mental health condition and their use of mental health services is untapped knowledge that has the potential for contributing insight into the efficacy of mental health services offered by Canadian provinces and territories.

Chapter Summary

Research indicates that there is a significant proportion of Canadians living with mental health conditions, but low numbers of these people are accessing and utilizing the mental health system. The mental health system has been through many changes since the beginning of the 20th century. The mentally ill were moved from jail cells to psychiatric hospitals until the 1970s. Under public pressure and accusations of abuse, deinstitutionalization took place in the 1970s, and the majority of psychiatric hospitals closed. Now, the community-based mental health system that has been implemented to replace institutionalization has been unable to provide equal service-delivery to all people accessing the system.

Research shows that barriers to mental health services prevent people from accessing the system. These barriers range from service level problems such as limited mental health services, leading to discontinuity of services and misdistribution of specialists, to emotional issues such as acknowledging the existence of mental health conditions and facing the stigmas associated with accessing services.

Northern, rural communities face even more challenges when overcoming barriers to mental health services. These communities deal with harsher climates and the difficulties associated with living in smaller communities. Misdistribution of specialized mental health services forces people living in northern, rural communities to travel to large urban centers for these services. If some mental health services are available in a northern, rural community, people living with mental health conditions are often faced with the loss of anonymity when accessing these services.

Most of the published research in past years has used quantitative surveys designed to report ratios and percentages. Qualitative research is needed to examine the perspectives of people living with mental health conditions. A qualitative study on the experiences of people accessing and utilizing the mental health system in northern B.C. could assist toward researchers narrowing down the common barriers to mental health services and assist toward understanding the low utilization rates of people living with mental health conditions.

CHAPTER THREE

Methods

I specifically chose to conduct qualitative descriptive research because of Sandelowski's (2000) explanation of how this research methodology is less interpretive and more dependent on "the facts of the case in everyday language" (p. 336). Other qualitative methodologies such as phenomenological, ethnographical, or narrative descriptions, re-present the facts of a person's experiences in various forms. For example, descriptive phenomenology is based on a philosophy, looks at the essence of meaning, and is not guided by a theoretical formula (Creswell, 1998). Even though qualitative descriptive research is less interpretive then other qualitative methodologies, it is more interpretive and in-depth than quantitative descriptive research, which uses mainly statistics and predetermined variables (Miles & Huberman, 1994; Sandelowski, 2000). Since I approached this research looking for a particular pathway with possible barriers (Appendix 1), I felt that a research project using qualitative descriptive methods, such as individual interviews and focus groups, was needed to describe the experiences of people living with mental health conditions.

In this chapter I discuss the people who participated in the research, my methods of data collection, ethical considerations before and during the research, preliminary biases, and my choice of data analysis techniques.

Research Participants

In this study, I chose to focus on people who were currently or previously living with depression. The person agreeing to participate needed to have been diagnosed with depression by a mental health professional at least one year prior to the study, giving the person a chance to access the different programs and professionals available within the mental health system. I chose to focus on people living with depression because mental health illnesses are very diverse with varying symptoms found with each mental health condition. I also chose to focus on depression because I, as the researcher, live with anxiety disorder, and I wanted to minimize the influence my personal experiences might have during data collection and analysis.

My plans were to interview 10 people individually, and then conduct two focus groups of five people each. I did not anticipate the problems I would have in recruiting people to participate in the research. After mentioning my research topic during a passing conversation, two acquaintances came to me separately and asked if they could participate in my research. One acquaintance was a colleague from UNBC and the other was a friend. I informed each of them what would be expected if they decided to participate. I also made it clear they were not expected to participate because they were acquainted with me. They assured me that they wanted to participate because they were interested in my research topic, and not because they felt obligated. Thus, with the approval of my previous thesis supervisor, those two people agreed to be my first two participants. I then sought the help of the Canadian Mental Health Association (CMHA) to find more participants. Because of the sensitive nature of the topic to be discussed with potential participants and the privacy issues of those people in therapy, counseling, and support groups, I could not just look at attendance lists and call potential participants. I had to let the participants come to me. After the CMHA approved my research project, I worked with the consumer advocacy coordinator to construct posters and to place my research on the CMHA web site. Posters were located all over Prince George, including doctor's offices, drug stores, and community centers. I also faxed research packages to counselors in the Prince George area. The consumer advocacy coordinator at the CMHA even agreed to talk about my research to people living with depression whom she was in contact with. Through this process, I was able to obtain one more research participant. Fortunately, during these months of trying to recruit participants, the consumer advocacy coordinator at the CMHA was also trying to get me an interview with one of the Prince George newspapers. After six months of correspondence with the paper, the Prince George Citizen finally agreed to interview me and write an article on my research project. Immediately after it appeared in the Prince George Citizen, I received a few calls from prospective participants. In a few days, and to my relief, I was able to confirm the final seven participants. Unfortunately, there were still not enough people willing to participate to be able to eliminate the first two participants, who were acquaintances, from my research. I decided it was necessary to include them, since they matched the research participant profile and because their inclusion gave me the 10 participants I needed in order to complete the research.

Data Collection Procedures

I chose two different types of data collection methods for this research project, face to face interviews and focus groups. According to Rothe (1993), there are advantages and challenges to using interviews as a tool to collect research data. One advantage of interviewing is the opportunity it provides for people to speak their minds about issues that a structured questionnaire cannot provide. An interview gives the researcher an opportunity to verify answers either immediately or by altering future interviews to verify the answer with future respondents. One potential challenge is the high degree of rapport and trust that must be developed between the researcher and the person being interviewed in order to attain honest and in-depth answers. As well, it can be difficult for the researcher to reach respondents and interview certain groups because of the sensitive nature of their experiences, and of the trustworthiness that needs to be established in the relationship between participant and researcher.

I chose to conduct semi-structured, face to face interviews because I wanted to elicit specific experiences from the participants that relate to their mental health service knowledge (Rothe, 1993). I had ten predetermined questions that were each followed up with a few probing questions designed to focus on the participants' experiences accessing and using the mental health system. I recorded their answers on a specialized interviewing tape recorder that would shut off during long pauses in conversation. Since I chose to use qualitative descriptive research methods, I felt that recording the interview rather than taking notes would allow me to stay closer to the data with less interpretation during the analysis process.

Each of the participants were given a copy of the questions in advance to give them time to prepare, and to give them a chance to let me know if they were uncomfortable with any of the questions. They were also given my letter of intent containing information that outlined the research, and sought their consent to participate. I met each of the ten participants at their houses for the face to face interview to provide the comfort of familiar surroundings. I talked to them for about fifteen minutes before starting the interview so that I could develop some rapport and trust, since this was the first time the participants were meeting me in person. I also took this time to explain again what was meant by informed consent and asked them to sign the informed consent form. In order to ease the interview into the more sensitive questions, I asked the participants several questions that did not relate to the research study, but did provide some background information.

During the interview I did not take notes because I did not want to distract the participant, nor disrupt the flow of responses. I did, however, make notes after the interview about the participant's place of residence for future research analysis of their living conditions and economic status. I also made note of the overall success of the interview. Even though I had the participants answer 10 set questions about their experiences with the mental health system, the last two questions asked for their personal opinions, which I hoped would give them a further sense of empowerment as a result of participating in the interview. Most of the interviews were approximately 45 minutes in length, but I did have one interview that was 20 minutes and one interview that was 90 minutes.

I also chose to conduct focus groups with the same10 research participants after the completion of the face to face interviews. Focus groups provide the participants with an opportunity to get a group perspective on the discussed topics by encouraging each other to speak frankly and honestly (Rothe, 1993). My goal was to conduct two focus groups consisting of five people each. I found, after conferring with the participants during the face to face interview, that they would agree to participate in the focus groups if the last two questions about barriers and recommendations were the only topics to be discussed. The majority of the participants did not feel comfortable discussing their personal experiences in a one-time focus group with strangers. I agreed. Due to the sensitive nature of their experiences, the participants were informed in my letter of intent that a mental health facilitator would be present as an observer during the focus group sessions. I discussed with the participants after the face to face interview my difficulty locating a trained mental health facilitator. Because the participants would not be discussing their personal experiences, and they were now familiar and confident with my interviewing skills, they felt that a trained facilitator would not be necessary for the focus group, and agreed to proceed without one. Due to technical problems with my recording equipment and a short time frame to achieve my interviews, I decided to put the barriers and recommendations the people in the focus group discussed on a white board and then transfer the contents to paper for my records. At the beginning of the focus group, I again discussed the concept of informed consent, and I asked the participants to sign informed consent forms. I also asked the participants in the focus group to sign a contract with me and the other people agreeing that they would not reveal each others identity, and that they would not discuss the proceedings of the focus groups with anyone (Appendix 2). Even though all 10 of the people I interviewed face to face agreed to participate in the focus groups, I experienced problems with a lack of attendance, and eventually I had to cancel the second focus group. Consequently, only one focus group of five participants was conducted.

Challenges

One possible explanation for some of the challenges I faced with finding people to participate and then securing their attendance was my choice to talk to vulnerable people. People living with depression commonly experience feelings of worthlessness and hopelessness, and eventually withdraw from society. They can also experience a significant loss of energy and motivation along with difficulty concentrating and memory loss (Depression Canada, 2005; Goldner, Bilsker, et al., 2002). These symptoms can range in degree from day to day, week to week, or month to month, depending on a person's ability to cope with symptoms and the effectiveness of medications. Consequently, it was challenging for me to encourage people with depression to participate in face to face interviews and then focus groups because of how disabling depression symptoms can be for some people. When I did locate participants, it was also challenging to conduct the face to face interviews. Some people cancelled interview appointments because they were experiencing increased symptoms that day, and other people continued with the interview despite experiencing increased symptoms. A few of the people had difficulty with memory loss and experienced a lack of concentration during the interview. One person had significant memory loss during her experiences with depression. At her request, I interviewed both her and her husband, who was present during most of her experiences with the mental health system. Despite these challenges, I was able to successfully interview all 10 people individually. At the same time, because of these challenges, I was only able to interview five in the focus groups.

Ethical Considerations

Ethical considerations were taken into account during the planning and implementing of this research project in order to protect the participants in my study. First, my research proposal was approved by the Research Ethics Committee at the University of Northern British Columbia. The CMHA also gave their support for my research after reviewing my proposal (Appendix 3).

Second, the participants were given a participant package (Appendix 4), which included my letter of intent containing information on the purpose of my research and what would be expected of them if they agreed to participate, an informed consent letter for both the face to face interview and the focus group, and a copy of the questions that would be asked during the interview. The participant package contained information on the goals of the research, what was meant by informed consent, and that the participants could withdraw from the research project at any time without prejudice. The participant package also noted that their names would be protected by using pseudonyms, that their privacy would be protected by my keeping all tapes, transcripts and documents in a locked cabinet, and that the data collected during this research would be destroyed at the completion of the research project. Since we would be discussing a potentially sensitive topic, it also contained information on how they could access a counselor from CMHA, who would be available for them to talk to after the interview. To my knowledge, no participant required use of these services.

Third, before conducting the face to face interview, I reviewed the purpose of my research, the procedures involved in participating, and the risks and benefits of participating. Then I asked for their consent to participate. During this discussion I let the participants decide the pseudonym that would be used in my research report, which I felt would give them some feeling of control as a participant in this study. At this time, I also explained to the participants that they were free to use their pseudonym name during the focus group interview to protect their identity from the rest of the people in the focus group. Surprisingly, I found that none of the people found it necessary to hide their identity during the focus group, and thus no pseudonyms were used during the focus group session.

Fourth, since personal and sensitive information was being shared with me in the interviews, I further protected the participants' identities by changing other names used in the interviews, as well as some other sensitive details. I also transcribed the interview tapes myself, and only my thesis supervisor and I saw the transcriptions before the participants' names were changed.

Finally, because two of the interviews were with acquaintances, I had further discussions with them before conducting the interview. I informed each of them that if they participated, I would be gaining knowledge of their personal lives and potentially sensitive information. I also assured each person that they had the freedom to discontinue participating without it affecting our relationship. Since each of their interviews were different from each other and both interviews were similar to other participants, I felt that the information they provided was not affected by our relationship. I also did not experience a change in my relationship with either participant after their participation in this study.

Researcher Bias

While conducting my research, I kept myself aware of the biases that are inherent in my research design. First, there is experimenter or researcher bias (Isacc & Micheal, 1995; Padgett, 1998). Since I was also living with a mental health condition, I was aware of the views and biases that I had due to my experiences in the field of mental health. It was my duty as a researcher to consult with others familiar with my research to minimize these views and biases so that they could not unduly influence the research and create invalid results. I conferred with my thesis supervisor during interviewing to ensure that others validated my data analysis and conclusions.

As the researcher, I was aware of the bias that was created simply by talking to research participants (Padgett, 1998). My potentially dominating presence as the researcher asking participants to talk about experiences that may be sensitive could have influenced these people to alter their recollection of events. In order to try and remedy this potential bias, I attempted to develop a rapport with the participants that reflected my concern for their well-being. In order to be sincere, I also asked more in-depth, follow-up questions about particular issues that the participants felt strongly about. I felt that the participants described their experiences to the best of their abilities because as Padgett (1998) points out, "once a respondent has given informed consent to participate in the study, it seems unlikely that he or she would cooperate just to trick the researcher" (p. 96). Also, during the interviews, I did not feel that any of the participants hesitated or held back information.

A bias of sampling was inherent in this research design. In qualitative research designs, the sample size tends to be smaller and purposive to prevent the researcher from becoming overwhelmed with too much data, because the data gathered tends to be information rich (Miles & Huberman, 1994).

In order to lessen the bias in the analysis of the data, several measures were taken. I believe that people living with mental health conditions are not being provided the proper treatment from the mental health system. Therefore, I had to lessen this bias as much as possible. First, the participants were sent their transcribed interviews, and were encouraged to contact me if they wanted to clarify or add more comments to their transcript. None of the participants contacted me to make any changes or add information. Second, I chose to use exact quotations from the participants in order to preserve their thoughts and ideas. This helped to lessen the bias inherent in the study because I did not paraphrase their wording. Finally, I tested out my analytic framework and my interpretations on my thesis supervisor during analysis to keep my findings in question.

Data Analysis

I chose to use qualitative content analysis, which, according to Sandelowski (2000), is the preferred choice of analysis when conducting qualitative descriptive research. I also felt this type of analysis fit my research, because qualitative content analysis keeps a researcher close to the data whereby analysis is "data-derived" (p. 338). In other words, the codes used in qualitative content analysis are generated from the data themselves, as opposed to quantitative analysis where the researcher applies a pre-existing set of codes to the data (Berg, 1995; Marshall & Rossman, 1995). In this study I used the 10 questions generated for the interviews as the first initial set of major categories and analyzed each person's transcripts for words, sentences, or paragraphs that fit these categories. I then looked for common and uncommon themes in each of the original 10 sets of categories and derived more specific codes for each major category (Morse, 1995). To gain more perspective on common themes and frequencies I looked at the more specific codes for each major category as it pertained to each person separately. Consequently, I found that some of the participants had consistently similar specific codes for each major category, and therefore I decided to group these participants together when presenting the data.

Since only one focus group was conducted and I could only ask questions pertaining to barriers and recommendations already focused on in the face to face interviews, I found that no new information was gained from the focus group data on barriers and recommendations. What I did gain from the one focus group was some measure of validity and reliability to my findings. Rigor in a research study refers to the degree to which a study's findings are authentic and credible (Padgett, 1998). Triangulation is one strategy for enhancing rigor by using multiple methods of study on a single topic such as interviews and focus groups (Miles & Huberman, 1994; Padgett, 1998; Tuckett, 2005). Since my face to face data were consistent with my focus group data, I felt this was indicative of some trustworthiness. Morse (1995) described four aspects of trustworthiness that she felt was relevant to qualitative research. They were, "(a) truth value, (b) applicability, (c) consistency, and (d) neutrality" (p. 143).

Morse (1995) describes truth value as the researcher's obligation to report the perspectives of the participants as clearly as possible. I felt that I achieved some truth value by using exact quotations from the transcribed interviews and by not paraphrasing. Applicability was described as, "The criterion used to determine whether the findings can be applied in other contexts or settings or with other groups" (p. 143). I felt that this study could be successfully applied to other groups of people experiencing depression with similar success. Consistency of the findings, if the study was replicated with the same participants or in a similar context, was outlined as a criterion of trustworthiness. Since the data from the focus group was the same as the individual interviews in terms of no new information, I felt that all the data was in my analysis, and replication of the research would produce similar information. Finally, Morse described neutrality as freedom from bias in the research procedures, analysis, and findings. I felt that I achieved a sufficient level of safeguards against potential bias by the procedures I followed outlined in the Researcher Bias section of this chapter.

Since qualitative research is concerned with the wide range of life experiences and emphasizes the uniqueness of the human situation (Morse, 1995; Padgett, 1998), I felt that another level of rigor was achieved by the range of experiences my participants described. These experiences were on a continuum from satisfying to poor.

Chapter Summary

In this research study I chose to be guided by qualitative descriptive research methodology to interview people living with depression with 10 questions designed to elicit their experiences accessing and using the mental health system. I conducted face to face interviews with 10 people and one focus group with five of the participants. I followed ethical guidelines when conducting the research and while interacting with the participants to ensure that they did not feel pressured or manipulated. During data collection I was aware of the preliminary biases inherent in my research design and took steps to avoid or minimize the biases that could influence my collection of data, as well as data analysis. I chose qualitative content analysis to analyze the transcripts. Finally, I decided to present the data based on groups of people who were experiencing particular similarities between them.

CHAPTER FOUR

Analysis

Through the analysis of semi-structured interviews with 10 participants, I was able to discern four possible pathways a person might take when they experience a mental health condition and decide to access the mental health system in northern British Columbia. The participants interviewed were located in a northern mid-sized city and two smaller northern communities. This chapter provides a rationale for presenting the 10 participants' experiences as four pathways, and then describes the experiences of the participants in terms of seeking help, accessing services, using services, and maintaining services.

Rationale for Four Pathways

The participants in this research were similar in many ways. After interviewing each of them, I found all of the participants had a fair amount of support from family, friends and colleagues before accessing the mental health system. Also, most of the participants felt they had little or no support from the mental health system even after many years of accessing its services. The exceptions were two participants whose contact with mental health providers was relatively short and satisfactory. Finally, based on information obtained from the interviews and observations of the participants' homes, it was determined that all of the participants were of working or middle socioeconomic status.

Even though the participants were somewhat similar, the experiences they had accessing the mental health system were not. The most significant differences were the pathways of their mental health journeys from realizing they had a mental health condition through accessing services and maintaining a mental health recovery program. Jane and Sue both felt that their experience was an overall satisfying mental health journey. Sufficient ongoing mental health services were in place for Sue, and Jane required no further ongoing services. These two participants were “feeling well supported”. The participants who were “feeling somewhat supported” were Darryl, Alex, and Jeff whose pathway took them on a lengthy mental health journey. These participants had some ongoing mental health services in place, but felt that those services were not providing adequate care. Dana and Carol were the two participants who were “feeling more supported in the south”. This pathway was long, but eventually led to what they felt were adequate ongoing mental health services, many of which were located in southern British Columbia. Finally, the participants who were “feeling unsupported” were Stacy, Tom, and Doloris (who was interviewed with her husband Fred). These participants’ mental health journeys were also long. Despite accessing mental health services for many years, these three participants felt that they had still not found adequate ongoing services in or outside the community of their northern community.

These four pathways emerged when analyzing the experiences of the participants and are used to present the data in this chapter in terms of the first research question. The four experiential pathways are revisited in Chapter Five in order to compare the differences and similarities between the pathways. These pathways are analyzed further in relation to why most of the participants did not feel well supported.

Feeling Well Supported

The two participants who were feeling well supported had a relatively short encounter with the mental health system and either did not require further mental health services, or had ongoing and satisfying mental health services in place at the time of our interview. Jane and Sue developed their depression later in life and lived with this condition for less than a year before seeking help. Overall, the participants who were feeling well supported expressed satisfaction with their encounters with the mental health system.

The pathway of the participants who were feeling well supported was consistent (Appendix 1). They experienced a period of denial about their mental health condition, and eventually sought help. Becoming aware that they could feel better and wanting to feel better led them to seek help. They had support from family and friends when seeking this help. They were able to access services quickly and the services they accessed were received efficiently. For the most part, Jane and Sue felt that they had received good support from family, friends, and the mental health system.

Seeking Help

The participants who were feeling well supported voiced concern about other people's perceptions of mental illnesses. They indicated a lack of awareness of mental illnesses when asked what had influenced their recognition of and action on their need for help. Sue noted that she delayed seeking help, and was in denial "because that sort of thing [seeking help] was considered weak willed". Her reluctance to admit her need for help reflected a worry about what other people would think.

Sometimes it is difficult to recognize the need for help. Neither Jane nor her family and friends recognized her mental health issues. She stated, “I was really in crisis before I recognized or anybody recognized that I needed help”. Even though their delay was a relatively short period of time compared to other participants, the delay in seeking assistance was months long. “It probably had been going on for about six months” (Sue).

The role of the participants’ families in their decision to seek help was notable. Both Jane’s and Sue’s husbands helped them to instigate action. “My husband said we’ve gotta do something” (Jane).

These two participants had some prior knowledge about the mental health system before they sought help. Sue expressed that she had felt knowledgeable about the mental health system. She stated, “I was well informed [about mental health services] and I read books and things”. Jane noted that her knowledge about certain mental health services was gained through her work “because I worked in the Ministry of Social Services, I was aware of a lot of counseling services”.

These two participants found it reasonably easy to seek help and they were feeling desperate to feel better. They had a strong sense of preservation for their own lives. Sue simply expressed, “I wasn’t embarrassed to talk to the doctor”. Jane described her situation as being desperate and beyond worrying about talking to someone:

> I didn't have a problem with it [talking to a doctor]. I didn't find it difficult because by the time we went and saw the doctor, I knew that I couldn't cope anymore. I knew that it wasn't right to have thoughts of killing yourself. So that frightened me more than having to talk about it with someone.

Jane's worry about hurting herself overcame any doubts she might have had about confiding her serious mental health condition to an outside person.

Overall, the two participants who were feeling well supported had a short time of denial and misunderstanding about their mental health condition, but eventually sought professional help with the support of their families. These two participants admitted that asking for help was easier than continuing to deal with their depression. This aided their decision to access services sooner than other participants in this research.

Accessing Services

Both of the participants who were feeling well supported sought the advice and help of a family physician and were recommended to specialized mental health services immediately or within one to two visits. These services were psychiatrists, psychologists, counselors, and the psychiatric ward of the hospital. Since Jane and Sue both had extended medical plans provided by their workplace, both public and private services were available to them, but they did not always specify which kind of service they were receiving. These participants also started taking prescribed anti-depressant medication as evidenced in Jane's statement, "[the doctor] put me on medication and it went from there".

When the participants were asked to describe their experiences accessing these recommended mental health services, Jane noted, “I don’t recall there being a great deal of delay from the time I talked to my doctor to when I started seeing counselors and got started on medication”. Sue mentioned that she did not access these services immediately, but this delay did not negatively influence her mental health recovery. Sue stated, “I think that’s one thing the [military] teaches you is that is just how life is. That you wait. It really does. It sort of teaches patience and how a big system works slowly”. Sue’s ability to be patient helped her cope with the wait for services. Overall, Jane and Sue were able to access the recommended mental health services with few problems, allowing them to utilize these services efficiently.

Using Services

The participants’ lack of problems accessing mental health services was consistent with their initial utilization of these services. For example, Sue stated, “The services were certainly there.”, and she was satisfied with the amount of mental health services she was provided. Jane was also pleased with the quality of mental health services she received and stated,” I found it [group therapy] really helpful”. Satisfaction with the treatment they received from some of the individual health care providers was significant, and one participant stated, “They [counselors] certainly listened. They never put their own views on how things should be, and whatever was said was accepted that that was your reality” (Sue). Sue felt that the health care providers listened to her, which was important to her recovery.

The participants who were feeling well supported also had a lack of problems with their prescribed anti-depressant medication. Jane describes her experience with the medication as being helpful:

> I didn't like the idea of taking medication, but one of the problems was that I couldn't sleep and that was making my depression worse. So, the medication helped me sleep. I was never on a strong enough dose of anything to feel like I was drugged or zombeeish. They talk about people being on anti-depressants and not being themselves and being angry. I never had problems like that.

Jane made it clear that her doubts about taking prescription medication were put to rest when she found that the medication did help her recovery.

Overall, the only problems the participants who were feeling well supported had with utilizing the recommended mental health services were personal. For example, Sue had a personality conflict with one of the nurses during her stay in the hospital and stated, "I found her [nurse] very almost like giving orders and that just kind of rubbed me the wrong way". Jane felt uncomfortable telling her story at her group therapy sessions and expressed, "Talking about these incidences from my childhood was very painful and this was a group of strangers that I didn't know".

Jane and Sue's experiences with the mental health services, such as psychiatrists, support groups, and prescribed anti-depressant medications, were generally satisfactory, with the exception of a few personality conflicts and personal concerns. This supportive environment allowed these two participants to continue to successfully use mental health services.

Maintaining Services

When participants who were feeling well supported were asked about their ongoing mental health care, they either expressed satisfaction in the care they were receiving or stated that they no longer required continual care. They were generally satisfied with the support they received from mental health services, which was reflected in Jane's statement, "I went to the [support] group for about a year and a half and it was just a very positive experience". This mental health support also included their family physicians. When Sue was asked about ongoing support from her doctor, she immediately stated, "He [family physician] is good. He has me in probably once a month just to see how things are going". Jane also noted the good relationship she had with her family physician throughout her entire recovery process. Jane found it important to express how much her relationship with her family physician aided her recovery:

> I have a really good relationship with my family physician and I have a lot of faith and trust in him. I think that he did everything that he could. He recognized the problems I was having and he dealt with them the best way he could.

Jane and Sue continued to talk about the amount of support they had received during their ongoing care. Not only did they feel they received adequate support from the mental health system, but they also felt that they had good support from friends, family and their employment community. For example, Sue mentioned, "At the school they have a good rehab program and I have had nothing but support from the school district and the principal". Sue was impressed with how much support she had received from her employer and her colleagues.

The only statement of dissatisfaction that I found from these two participants regarding ongoing care was centered on the discontinuity of mental heath services:

> One of the hardest things with my going into rehab and the rehab counselor is when they change. I am on my third one and hopefully she is going to stay for a long time. Because they always want to go back to the beginning and I say I don't want to do this anymore (Sue).

Despite this discontinuity, the participants who were feeling well supported experienced a satisfying conclusion or were receiving satisfying and ongoing services for their mental health problems.

Feeling Somewhat Supported

The three participants who were feeling somewhat supported had developed their mental health conditions quite early in life and expressed a general lack of knowledge of mental illnesses and mental health services for many of these early years. Their lack of mental health awareness led Jeff, Alex and Darryl to not seek help for their mental health conditions for many years. When they finally did seek help, their recovery pathway was filled with many successes and failures. Overall, the participants who were feeling somewhat supported did not feel completely satisfied with the outcome of their recovery, but were satisfied with parts of the recovery process.

The pathway to mental health recovery for the participants who were feeling somewhat supported was not consistent (Appendix 1). All three of these participants claimed to have gone through a long period of denial about their mental health condition and said they eventually sought help out of desperation. They had many friends and family supporting their struggle to seek help, but felt that they alone made their final decision to seek professional help. These participants had a few problems accessing services and said that they did not respond well to some of the services they had begun to utilize. These participants did note that they had successfully responded to a few services, which kept their recovery process continuing. For the most part, Jeff, Alex, and Darryl said they felt that they had adequate, but not satisfactory amounts of, support from the mental health system.

Seeking Help

The participants who were feeling somewhat supported expressed that they did not have adequate knowledge about the mental health services available in their northern community before deciding to seek help. Alex further acknowledged that he was not aware he had a mental illness for most of the years he was living with his depression, because he developed his condition as a teenager. For example, Alex stated that he didn't know that his depression was something that could be identified:

> I think in the beginning I didn't think of it as depressed. I just thought of it as different. And it was just my unique personality and I didn't realize that it was something that was actually a problem.

Because Alex developed his condition as a teenager, he thought that depression was just a part of his normal personality. When the three participants finally realized they could be experiencing a mental health condition, they went into a long period of denial. For Darryl and Jeff, this denial was so strong that it overcame knowledge they had about mental illnesses from their family histories. This denial was evidenced when Darryl stated, “Well I did [know] just because the history of my family....So, even when I thought that maybe there was something wrong, I was in denial for years”. Alex acknowledged that it took “a long time to realize that I needed help, and then a long time after that to think that I actually needed it”. It took Alex a long time to convince himself that he was experiencing a mental health condition and that he was worthy enough to receive help for this concern.

These participants did not have adequate knowledge about the mental health system and its services during their decision to seek help. Jeff stated:

> I didn’t know about POPS [Psychiatric Out-Patient Services]. I didn’t know about Northern Interior [Health Unit], you know, I had no idea about any of that stuff. I didn’t know anything about mental health with the exception of the Mental Health Association, which isn’t even a part of mental health.

Jeff had knowledge that there were other people who lived with mental health conditions, but he did not have enough knowledge about possible mental health services to support his decision to seek help. If these participants did have any knowledge about mental health conditions and services, it was due to a family history of mental health illness, which was based on 20 to 30 year old mental health policies and treatments.

Although the participants who were feeling somewhat supported did make several statements regarding the adequate support of their friends and family, when asked who specifically influenced their seeking professional help, they all noted that they alone made the final decision. This was evidenced when Alex stated, “I guess no one really pushed me to get help. I just sort of over a period of time decided that something is wrong and I should try to get help". These participants felt that they came to the realization on their own that if they did not seek help, their lives might be in jeopardy. This realization and their instinct to stay alive did not ease the difficulty they had asking an outside person for help. Jeff found it to be "extremely hard. It was probably one of the toughest things I've had to do".

The participants' lack of knowledge about mental illnesses and available services made the transition difficult between acknowledging that they were experiencing a mental health condition and deciding to seek professional help. These participants eventually overcame this difficulty and started to access services.

Accessing Services

The participants who were feeling somewhat supported first contacted their family physicians to discuss their depression, and were recommended prescription medication. These participants expressed that medication was the only course of action recommended by their family physicians, and as Darryl stated, "That was pretty well the only treatment. It was just pills". These participants were eventually recommended other mental health services such as psychiatrists and counselors, but not all of these recommendations came from their family physicians. Some of these recommendations came from friends and contacts they had made while trying to access different mental health facilities on their own such, as POPS, Adult Mental Health Services, and "the director of the [halfway] house, she told me about Dr. [psychiatrist]" (Jeff). Jeff admitted that the recommendation for him to see the mental health care provider from whom he now receives sufficient care did not come from his physician or family, but from the director of the halfway house where he was living.

These participants did use some privately funded mental health services, but only two out of three of these participants had extended medical service plans offered by their workplace. When the participants tried to access their recommended public mental health services, they experienced long waiting periods, limited amounts of service, miscommunication with service providers, and feelings of dissatisfaction. The long waiting periods to access services hindered their achievement of satisfying care, and was evidenced when Alex stated, "I did go back to mental health a second time and it [waiting period] was considerably worse then the first time. It was a whole month before my first appointment. I didn't even go". Alex said he would contact mental health services when he felt really ill, but the wait to see the mental health professional was so long that he felt better when it was time for his appointment. Consequently, Alex would cancel his appointment believing he didn't need it anymore.

These participants felt at times they were denied service due to either a limited amount of services available or a miscommunication between them and the service provider. For example, a lack of services and miscommunication about how serious his situation was led to a denial of much needed service for Alex:

> A couple times I just went to [the hospital] emergency cause I was scared for my life again and all they ever did was say, "Well, did you really think that you are going to commit suicide?". I mean, I don't want to. That's why I am

> here. I want to try and stop it and they say, "Well, the psych ward is full", or something, "so go home".

Alex, in his state of mental health crisis, may have chosen to go to the only place that he knew of and may not have had the ability to communicate how serious his condition was. Alex went on to express that the emergency ward at the hospital was not the best place to go with a mental health crisis.

Jeff experienced poor reactions to his anti-depressant medication, and he indicated that the medication made him feel stoned, listless, and with the inability to concentrate. This poor reaction to his medication caused a miscommunication with his service provider, which, according to Jeff, led to the provider denying access to the service:

> The guy at POPS told me, "Okay, we will get you in to see a psychiatrist and he can try and do an assessment on you". They phoned me about a week and a half later when I was all mucked up on my new medication, and that and I had no idea at the time that I was even talking to anybody. It took a week before I remembered that I had some kind of conversation with somebody on the phone about an appointment. Because I missed my new appointment they felt that I wasn't willing to take an active part in my treatment in seeking help and what not. So they decided that I didn't need to see a psychiatrist after that.

Jeff's adverse reaction to his prescribed medication may have hindered his ability to properly communicate with his service provider's office, leading the service provider to withhold services until Jeff could properly communicate.

These participants also had poor encounters with several mental health services and providers, such as physicians, psychiatrists, counselors, and organizations (Teen Crisis Line). They said that these poor encounters made the continuation of their mental health care difficult, because they no longer wanted to access these services.

Although the participants who were feeling somewhat supported did experience quite a few problems trying to access mental health services, such as long waiting periods and miscommunications with service providers, there were some instances of quick access and satisfying experiences. These good encounters helped them to continue their mental health care.

Using Services

The participants who were feeling somewhat supported did eventually secure some satisfying mental health services that they felt provided good quality care and an adequate amount of service. These included some services in southern B.C. Before these participants could secure these services, they accessed and used many different mental health services, such as counselors, psychologists, and psychiatrists, and ran into some difficulties with misdiagnosing, medication, and discontinuity. For example, Jeff talked about the struggle he had obtaining a proper diagnosis for his depression:

> I didn't enjoy and have a very good experience with them [mental health services] because of my diagnosis being bipolar. It takes an awful lot to get properly diagnosed. You usually have to see a lot of people. I'd seen three doctors, a counselor guy from POPS, and I'd seen a psychiatrist in town. And

> none of them were able to really give me a proper diagnosis....There was no support for me as far as support groups or anything like that until I had a diagnosis. I knew about the bipolar group in town, but I wasn't allowed to go until I had an official thing from my doctor.

Without a proper diagnosis, Jeff said that he found it difficult to access proper services since quite a few of the mental health services available were diagnosis dependant. Furthering their frustration and contributing to a misdiagnosis was the perception that these participants were not listened to by their service providers. For example, Alex stated, "They were really concentrating on the fact of my mom leaving and I kept trying to tell them that I was depressed for so long before that happened, that's actually a minor event". Jeff felt that service providers would also do too much listening, and not engage in enough conversation and provide enough information. Jeff expressed, "When I would go and talk to him [counselor], you know, he would say maybe ten words and expect me to fill up the hour with conversation. He wasn't helping". Jeff preferred to have a conversation and brainstorm with his service providers rather than spend his time with unstructured rambling.

A misdiagnosis can also lead to problems with prescription medication, and these participants were no exception:

> I started to realize that I wasn't just severely depressed and I knew there was something more to it then that. Because it wasn't the right medication for me, it didn't do the job that it should have done. (Jeff)

Jeff felt that his misdiagnosis led to the wrong medication, and consequently the medication did not adequately help his depression. These participants found that a proper diagnosis did not always ensure the right medication, since the exact cause of mental illness is still unclear and medications are so variable in their effectiveness. According to Darryl, finding the right medication for him was purely trial and error, which created frustration and mistrust between him and his family physician:

> So my doctor told me that, you know, it's like fishing. You know you gotta try different lures until you get the right one and then you're gonna catch the fish. We tried all of them [anti-depressant medications] and what he said wasn't coming true, you know, and then that makes you distrust, you know, what he said to begin with. Because, you know, he was pretty confident that, you know, they could cure me of this.

Darryl felt that his physician had told him that if they kept trying different medications, the right medication could be found, and Darryl would be relieved of his depression symptoms. When the medications did not relieve Darryl of his symptoms, he became upset with his physician and began not to trust his advice.

Finally, these participants were disappointed with the discontinuity in some of the services they received. For example, Alex talked about how the Adult Mental Health Center continually changed his care provider:

> I still went [to mental health] for a few times. I think I went four times actually, and the first time I had one psychologist, and then the next two times I had a different one, and then the last time I had a third one. I really wasn't getting anywhere. All three of them wouldn't get off of it [mother leaving] and you can't get into a groove when you keep switching

> psychologists. So, I was very disappointed and I didn't think that it was helping me at all.

Alex could not maintain a sense of continuity and familiarity with his given care provider because of turnover in staff. This discontinuity made Alex feel that he was not receiving helpful mental health care, and this consequently led to Alex discontinuing his access to this service.

Because the participants who were feeling somewhat supported accessed so many different services, they not only discussed experiences referring to the hindrance of their recovery process, but also discussed some experiences referring to the progression of their recovery. These positive experiences mainly focused on them receiving a sufficient number of services, good quality service, a proper diagnosis, proper medications, and satisfying private services in a large southern centre that were provided by their companies. For example, Alex talked about how supported he felt by his family physician during his initial trial of anti-depressant medication and, "after the first week of using them [pills], after the first three weeks, after a month and a half, she [family physician] totally kept checking up on me". Alex felt that his family physician checking up on him showed that he was supported and cared for. These participants felt that a proper diagnosis was important to their recovery process and praised the mental health professional that provided them with one. For example, Jeff expressed, "...having interviews with him [southern psychiatrist], and then he was interviewing my wife as well and getting a good history about what was going on. And he did make that determination that this [bipolar disorder] is what I had". These participants felt that a proper diagnosis was important because it helped determine the proper medication, and therefore led to satisfying anti-depressant medication experiences:

> I think I got sick in late summer early fall and then by the following June or July [being on the right medication] I was back to work and I felt, you know, I felt somewhat better. I wouldn't say that I was cured or anything like that, but I was well enough to work and to cope with going to work again (Darryl).

Finally, the participants felt they had received satisfactory private mental health services in a large, southern, urban centre, which helped the progress of their recovery in their northern community. Darryl stated, "So they sent me down there [large southern centre], and the psychiatrist down there (of course you know he's the company's psychiatrist) he recommended massive treatments [of medication to commence in northern community]". According to Darryl and the other participants in this research, the mental health professionals they saw in a large, southern centre were more aggressive with their diagnoses and treatments, which eventually led to better care in their northern community.

Maintaining Services

Despite their path through the mental health system being plagued with disappointments and dissatisfaction, the participants who were feeling somewhat supported were able to obtain stable and continual mental health care. Unfortunately, they felt that they were not completely satisfied with this care for several reasons.

First, these participants felt a lack of real support from the mental health system as seen when one participant stated, "I still don't think that I have it [support] now. All I have now is the pill that I take every morning" (Alex). The participants also felt unsupported when they had to demand services which they knew were available to them, but were not being offered. Darryl reflected this point when he expressed, “Like right now I’m seeing a counselor who I can talk to, and I had to ask for that as well, you know, half a dozen times before I finally got it”. This perception of a lack of support translated into a lack of quality mental health services for these participants. Alex discussed how just taking a pill everyday without the support of counselors or support groups was not enough to promote a satisfying recovery for him:

> I mean, if I had a problem I could go talk to my doctor, but she is not a psychologist and she has tons of patients. So she is not someone I can sit down with for two hours and work things out. I just don’t feel like there is anybody good in town to talk to, so I am just going on my own.

Alex felt that he had support from his physician for his medication needs, but did not feel that he had any support for his emotional needs. The participants also felt that they were not supported by the mental health system when they had to endure long waiting periods when trying to access their mental health services. For example, Jeff stated, “Like I made an appointment to see my doctor, my psychiatrist. It takes a month, month and a half to get in. You know there are no services”. Jeff felt frustration with the long waiting periods between visits when seeing his care provider, and therefore, did not feel adequate support from his care provider and the mental health system.

Second, the participants discussed their disappointment in the effectiveness of their prescription anti-depressant medication. For example, in Alex’s situation the medication seemed to work in the beginning of his recovery, but the effectiveness soon wore off. Alex expressed, “They [anti-depressants] definitely helped a lot in the beginning and not so much later”. In Darryl’s experience, the medication never seemed to help him throughout his recovery:

> It’s an ongoing struggle. All these whiz drugs they got out there that work so great on some people, they don’t work on me. And so I’ve taken, you know, just about everything that they’ve got out there. And some of them….you just can’t take them because of the side effects. They just screw up your whole life physically and mentally. They screw you up, you know, worse.

Darryl did not have any success with any of the anti-depressant medications that he tried and complained how the side effects of these drugs made him feel worse then his depression symptoms.

Finally, the prior disappointing experiences the participants had limited the amount of future mental health services available to them for continual care in their northern community. Since the participants were disappointed in these services, they chose not to access them again, thus narrowing the choice of mental health services. This point was supported when Alex stated, “I have been so dissatisfied with mental health I wouldn’t go back there”. Jeff talked about his disappointment in mental health services, which led him to only see a few professionals for his depression:

> And ever since then I have stayed away from POPS. I stayed away from Dr. [northern psychiatrist] and what not. And I was just going to see my doctor and I had a private counselor through work and I was seeing them. Because, I didn’t have any faith in mental health at all.

Overall, the participants who were feeling somewhat supported struggled with many of the mental health services offered in their northern community, such as counselors, psychologists, psychiatrists, POPS, Adult Mental Health, and depression medications. Despite their struggles, these participants did claim to obtain adequate amounts of ongoing mental health services, but indicated that these services did not make them feel satisfactorily supported by the mental health system.

Feeling More Supported in the South

Dana and Carol experienced a pathway that was inconsistent in their northern community, and felt more supported in the south (Appendix 1). These participants expressed that it was their lack of knowledge about mental illnesses and mental health services that led them to live with their depression for years before deciding to seek professional help. With the support of their families, they eventually sought help out of desperation. Their disappointing encounters with the mental health system in their northern community left them wanting to seek help elsewhere. Eventually, Dana and Carol felt that they had obtained solid and continuing care from mental health services in southern British Columbia.

Seeking Help

A lack of knowledge about mental health problems and embarrassment in asking for help led the participants who were feeling more supported in the south to live with their depression for years before receiving care. Carol admitted that she “didn’t really know what was wrong”, and therefore did not realize that she could seek help for the way she was feeling. During this time of bewilderment, these participants also indicated that they had no knowledge of any mental health services, except for a psychiatrist, whom they assumed was for other people who were sicker than they were. According to Carol, she eventually learned of mental health through talking to colleagues "…and then I talked to the office nurse and she said, 'Oh it sounds like depression'". Dana indicated that she learned about mental illnesses and services through advertisements:

> You know they would start to have commercials on TV. You know are you this and this and you go to the doctor's office and there is a little poster. So that's when I finally realized ok well, I am chronically depressed.

Most significantly, though, these participants sought help because of "complete exhaustion and not being able to cope" (Dana).

Even after these participants realized they were experiencing a mental health condition, the embarrassment of asking someone for help kept them even longer from seeking help. Dana expressed that asking for help was one of the hardest moments in her life and said, "I was embarrassed to admit that I was faulty. That I was a faulty human being. I felt ashamed to admit that I was all these things. It was embarrassing. Like it was hard". Dana felt that if she asked for help she was admitting that there was something wrong with her. The participants' lack of understanding also indirectly helped them to seek help. Carol indicated that it was her lack of knowledge about mental health services and procedures that allowed her to ask her doctor for help with reasonable confidence. Carol stated, "It [asking for help] wasn't that bad because I didn't know he [physician] was going to send me to a psychiatrist. But, if I'd known that, maybe I wouldn't have gone". Carol expressed that if she had known that she would be sent to a psychiatrist by her physician, she might not have asked her doctor for help, because of her preconceptions about only "crazy people" needing to see psychiatrists.

Accessing Services

The participants who were feeling more supported in the south were given recommendations for very few mental health services after they asked their family physicians in their northern community for help. They were given prescriptions for depression medication with no further recommendations. When Carol was asked if any other mental health services were recommended to her by her family physician, she stated, "No. [The family physician said], 'here are the pills". Along with the medication, Dana was also sent to a mental health organization by her physician for further assessment. Dana stated, "He [physician] sent me to psychiatric out-patients at the hospital". She further expressed that the assessment performed at this mental health organization did not advance her mental health care and left her with only her family physician and prescription medication for years. The participants eventually insisted on other mental health services as evidenced when Dana stated:

> I wanted to see a psychiatrist because I was aware that option was open to me. I insisted actually. Never ever did he [family physician] say, you know, "Here this is". I actually had to insist. My doctor has never been one to say, "Here, this is available", until just in the last little while.

It was not until Carol and Dana pressured their physicians for specialized mental health services that they finally received a referral to them.

Even though one of the participants may have had extended medical services available to them through her employment, these two participants did not indicate whether private mental health services were used. They did indicate, however, that they experienced long waiting periods and poor service when they tried to access some of the mental health services to which they were referred. Dana had to wait a significant amount of time before her first appointment with her care provider. She stated, “I wanted to see a psychiatrist. Then I got put on a six month waiting list”. For Dana, six months seemed like a lifetime. Carol also had to wait several months for her first appointment with her psychiatrist, and also expressed how hard it was to wait that long.

Poor service was mentioned by these participants when accessibility was discussed. Emergency services at the hospital were the most notable of this poor service and Dana’s experience the most extreme:

> If I wasn’t suicidal when I went in there [Emergency Department], I was when I left because of the treatment. The [act of] shuffle her off into a corner and then surround her by all this pain and suffering. Well it was just another instance at Emergency where they completely treated me like crap. They never called my family doctor. They never called my psychiatrist. They never ever did speak to anyone in those two particular instances and both of them are not on record that I was ever there.

Dana felt that the staff at the emergency ward and the process for admission were not sympathetic to her situation and she felt unsupported.

Since most of the participants’ experiences with accessing the mental health services in their northern community were unsatisfactory, these participants pressured their physicians to give them referrals to mental health services in the south. It was in large southern centres that these participants felt that they had found satisfaction in accessing several of these mental health services. For example, Carol was very pleased with the accessibility of a disorders clinic in one large southern centre she was referred to and stated, "I went to the seasonal affective disorder clinic at UBC and was diagnosed with seasonal affective disorder, but then I also had depression the rest of the year". Carol was pleased with the quick access and the quick diagnosis. Since most of the participants' experiences of satisfactory access occurred in the south, they continued to access services in large southern centres.

Using Services

When the participants who were feeling more supported in the south discussed use of mental health services, their experiences were cluttered with many disappointing situations mixed with a few pleasing moments in their northern community.

These participants started the discussion by noting appreciation for particular mental health care providers in their northern community who they felt provided satisfactory treatment. Dana felt it necessary to state that her family physician "was fairly good. He gave me his pager number and answered my calls if I was desperate". Carol also wanted to say that her experience with one northern community care provider was rewarding:

> I liked him [psychiatrist] and I thought, you know, when he asked me questions, I thought, oh wow, here is somebody who recognizes that this is a valid problem. So, that made me feel better.

The participants then moved their discussion towards the many disappointing experiences they had with the mental health system in their northern community, such as problems with misdiagnosis, long delays, poor services, and anti-depressant medication. The participants talked about the trouble they had obtaining a proper diagnosis, which they felt could have directed them toward the proper services:

> I blamed it on my Dad being an alcoholic, but I've been this way [depressed] forever. It was not just this. This was just aggravating it. You know the nurse [at Psychiatric out-patients] never picked up on that. She told me to go to ACOA (Adult Children of Alcoholics) and said that was pretty much all she could do with me. So that left me feeling pretty empty (Dana).

Dana felt that the professional assessing her should have discovered her long history with depression and then put her in contact with mental health care providers to help with her mental health condition, not her alcoholic father. Unfortunately, this misdiagnosis led Dana to follow ACOA's advice and quit using illegal drugs with no mental health professional present to assist with her depression:

> So that sort of led into quitting the pot and then feeling worse when it was supposed to be helping me. ACOA was supposed to be, you know, helping me understand and accept everything right. Well no. It really wasn't the issue. It was just surface stuff, right.

Carol and Dana complained that there were not enough mental health professionals available and this caused long delays between appointments. Carol supported this point when she stated, "Well I guess I went to the psychiatrist again maybe two months later and then the next time it was three months later". The limited services in their northern community also meant that these participants felt that they had no choice between mental health professionals. They had to see whoever was available at the time. The participants noted that this lack of choice caused major problems with patient to professional bonding and trust:

> I think I would have liked to have had a choice because I really had a hard time hearing him [psychiatrist] or understanding him through his accent. It was a real strain rather than, you know, sitting and relaxing and being comfortable and being able to say what's on your mind (Carol).

The participants were clearly unhappy with the mental health care providers they were referred to, but did not feel they had the opportunity to change to a different person.

Finally, the anti-depressant medication these participants were prescribed was not providing the results they desired. The participants discussed the terrible side effects that they experienced. For example, Carol complained of gaining excessive weight while taking anti-depressants, and "in the end I gained a hundred pounds, which certainly didn't help the depression". Dana complained that the anti-depressant medication made her so spaced out that she could not function normally, and stated, "I would miss my appointments because I couldn't get out of the house".

The participants then discussed their experiences with mental health services in the south after they were referred to them by their northern community physicians. Carol and Dana discussed satisfactory experiences, such as seeing mental health care providers with much shorter waiting periods then in their northern community, and being satisfied with the services they received from these providers. For example, Carol talked about a care provider located at a southern university to whom she asked for a referral "and got in fairly quickly". Also, Dana discussed her success with a care provider she was referred to in a large, southern, urban centre who, "asked me eight questions and diagnosed me, and everything he has said has come true".

Maintaining Services

When I discussed the topic of continuing mental health care with Dana and Carol, I found they were satisfied with their care, but that this care was being given solely in southern British Columbia. As Carol stated, "I still just go to the specialist and the GP in [a large southern centre]. And that's a lot more satisfactory". When I asked Dana if she was receiving any mental health care in her northern community, she quickly expressed that, "they [northern mental health care providers] just treated me like crap and I couldn't honestly tell you, unless I absolutely have to, I will not go to the doctor [in northern community] anymore". Dana went on to discuss her satisfaction with the psychiatrist she continually sees in a large southern centre, which further supported the reasons these participants continued their satisfying mental health care in the south.

Feeling Unsupported

Stacy, Tom, and Doloris, who was interviewed with her husband Fred, were feeling unsupported, and had not obtained satisfying and continuous mental health care at the time of our interview. They developed their depression many years ago, and were accessing mental health services for most of those years. Consequently, they accessed services in other places before encountering the northern mental health system. Overall, these participants were dissatisfied with the northern mental health system, and still desired adequate continuing care.

The pathway of the participants who were feeling unsupported was consistently filled with failures and disappointing experiences (Appendix 1). They experienced a short period of denial, and with the influence of their families sought help out of desperation. They consistently failed to obtain continuous mental health services. Unfortunately, the few successes that Stacy, Tom, and Doloris, along with Fred, did experience were not enough to ensure adequate care, and for the most part they felt that they had not received good support from the mental health system.

Seeking Help

For the participants who were feeling unsupported, family played a significant role in influencing them to seek help. These participants expressed that they knew little about mental health services as evidenced when Tom stated, "I mean I knew that there was a psychiatric community, but I didn't know anything about it". Consequently, these participants indicated that they were unaware of what was happening to them. For example, Stacy stated, "I didn't know what was wrong with me and I never heard of depression before". These participants expressed that a strong family influence helped shorten the time they lived with their depression before deciding to seek professional help. Doloris's husband, Fred, expressed, "My sister is a qualified nurse and she said, 'She [Doloris] is very sick. Get her to the hospital.', and that's what we did". Although these participants felt that they were in a desperate state by the time they asked for help, it was still difficult and embarrassing for them to ask someone outside of their families for help. As one participant mentioned, "We just knew that I needed help, but I felt very, very embarrassed going to the doctor. Extremely humiliated because it wasn't something physical" (Stacy). Stacy found it difficult to speak to her family physician about her depression, because she did not view her concerns as a physical ailment.

Accessing Services

After several years of accessing mental health services in other locations, the participants who were feeling unsupported moved to northern British Columbia. All of these participants had moved to the north one to three years before the interview. All indicated difficulty accessing mental health services in their northern community. First, these participants had a hard time obtaining a family physician and in some cases it took "over a month to find a family doctor" (Tom). Next, the participants experienced long waiting periods before initially accessing some of the mental health services, as evidenced when Stacy stated, "I went on a waiting list to get into the hospital". In some instances, these participants were even denied service:

> The most disgusting thing that has ever happened in any episode was that I took Doloris to the mental heath unit…and they threw us out. My wife was in the middle of an episode and they threw us out. They said you can't come here without an appointment. Well I said I have come to make an appointment, you can see my wife is ill and they said we're not bothered. You haven't got an appointment. Get out. (Fred & Doloris)

Fred and Doloris were unaware that the mental health unit did not accept emergency cases and felt denied of a much needed service. This confusion over the procedures involved in accessing mental health services also caused problems with Tom, who had moved to northern B.C. from Ontario:

> It's difficult. First of all I've never lived in a jurisdiction where you have to go through two or three people before you get to see a psychiatrist. I got a family doctor before the appointment [with the psychiatrist] and then went to the appointment. They wouldn't see me because they said no, no. You have to go and see the doctor and the doctor has to report to us. All you [psychiatrist office] said was I had to have a family doctor. I got one.

Coming from a different medical system and with no one to guide him, Tom found it difficult to understand the steps needed to access certain mental health care providers.

Using Services

Despite the participants' number of dissatisfying experiences accessing mental health services in northern British Columbia, they did start using many different mental health services. Consistent with the difficult experiences the participants had accessing services were the difficult and poor experiences they had using most of these services. Fortunately, they did experience a few instances of adequate care, which these participants said "fueled" their determination to find supportive and continuous care. These participants faced a limited amount of services and expressed their experience of this lack of service in terms of no support, discontinuity, and dissatisfying service.

The participants expressed a poor sense of support from their service providers when they talked about the limited services. For example, one person stated, "I saw no counselors [in the hospital]. I saw a psychiatrist, but it was very brief. She spent five minutes with me, if that. It was so short, and I saw her twice and I was in there two weeks" (Stacy). Doloris and Fred also experienced a lack of service:

> I went to our family doctor in [a small northern community] and [that community] really wasn't prepared for mental health cases. So Doloris was on a medical ward taking psychiatric medication and they [small community hospital] had nobody there trained to look after her. And this went on for...I think she had three bouts of being hospitalized. The last one reaching the stage where our family physician said enough is enough and had Doloris admitted to [another community hospital] where there was psychiatric help.

Doloris and Fred experienced a lack of specialized psychiatric care in a northern, rural town and they felt that this lack of care was detrimental to Doloris's recovery, eventually causing her physician to decide to send Doloris elsewhere for proper treatment.

These limited services also led to experiences of discontinuity for these participants. For example, Doloris could not get in to see her original mental health care provider because "she is a [specialized] psychiatrist now. So, when Doloris became ill, we couldn't get back to see her". Doloris and Fred felt that their inability to see the same care provider they had previously seen hindered the progress of Doloris's mental health recovery.

Adding to their experiences of limited services was the number of instances of poor service these participants felt they had received when they did manage to use services. For example, Stacy felt the facility that she was in failed to provide her with comfortable surroundings and enough mental health support:

> Well it was actually a terrible, terrible experience. It was when the [northern community] psychiatric ward was not yet renovated and the rooms were terrible. The doors were falling off their hinges. The bathroom door didn't close all the way. The nurses were unavailable at that time. I didn't see them much, so I basically spent all of my time in my room. So that was the worst experience I have ever had in a hospital.

Poor communication between these participants and the service providers, and poor communication between fellow service providers, also was perceived to prompt a significant set back to these participants' recovery process:

> Our family physician…discontinued Doloris's psychiatric medication without any consultation with her psychiatrist. And he [family physician] discontinued it because he said that the medication that she was on was not within the normal therapeutic range. He didn't do it in consultation with me. He just told Doloris he was stopping it. (Fred & Doloris)

After the break down in communication between Doloris's family and the service providers, Doloris stopped taking her much needed anti-depressant medication and experienced a severe relapse of her illness.

Further disruptions to these participants' recovery were the many problems they were having with their prescribed anti-depressant medication. Stacy stated:

> In fact, that particular one [anti-depressant] would leave me extremely sleepy. In fact, I got worse and lost all sorts of weight. I mean I am 5'7", and I went to about 110. I couldn't eat. I couldn't even do the dishes.

Stacy felt that the side effects from her medication were making her feel worse and she stopped taking them. Doloris found that her medication was not helping relieve any of her depression symptoms, even though she tried many different types of medication, with the advice of her physician. She experienced many months of no relief from her depression symptoms, which Doloris felt impeded her recovery.

Even though the participants who were feeling unsupported experienced many set backs, these participants also experienced a few instances of adequate service. The participants expressed gratitude towards the service providers they felt provided them with good support. One participant stated, "I saw my GP everyday. He was the one that actually gave me most of my help" (Stacy). They also expressed gratitude to those service providers they felt were experts in their field:

> She [Doloris] went to [the second small community] and she was put in the charge of a Dr. [psychiatrist]. Now Dr. [psychiatrist] is by his own admission a lousy clinical psychiatrist, but he is an expert in psychiatric medication. And within three weeks again Doloris was out of the hospital and we were required to see him every week, but only to fine tune meds and she picked up very, very quickly again. (Fred & Doloris)

Fred was impressed that the care provider could be honest about where his expertise did not reside, even though he could be strong and effective in other areas.

Maintaining Services

The participants who were feeling unsupported responded with significant dissatisfaction when asked about their current continuing mental health care. At the time the interview was conducted, these participants said that they had not been able to secure satisfying, continuing mental health care despite their many years of accessing mental health services. For example, Tom stated, "I haven't gotten into a regular situation here [northern community]. I haven't gotten a regular course of treatment here". These participants also indicated that the few services they did obtain had to be fought for or demanded by them:

> We called an external, a friend of mine from town here who was a social worker and he has a private practice. I said, "I want you to become my wife's case worker" and he said, "OK, the case manager". (Fred & Doloris)

These participants felt disappointed that they had not been able to obtain ongoing and satisfying mental health support and services.

Stacy, Tom, and Doloris, along with Fred, gave many reasons why they felt that they had not been successful in securing ongoing care. One reason Stacy expressed was the long waiting periods and how "the waiting list is getting longer and longer. I have a counselor there [Adult Mental Health], but it has been a month and a half between the last time that I saw her and my next appointment". Along with the long waiting periods, Stacy also felt that the discontinuity of services hindered her chances of obtaining continuous care and said, "I had an awesome psychologist who I had for about two years and then he moved away. That was devastating because he helped me a lot". Fred also felt that there was a lack of support from the mental health system and stated, "I had a lot of experience dealing with that kind of thing [mental illnesses]. So, I mean because of my competence we have been hung out to dry by the medical and psychiatric services". Fred felt that since the mental health service providers knew he was a service worker, and had experience working with the mentally ill, the providers did not give them as much support and service as they did to other clients. Finally, these participants felt that it was too expensive to seek out private care to supplement the failing government funded mental health services:

> I have found a counselor that I think that I might look into, but I don't know what meets the criteria of what my husband's company will pay. So, I may have to just bite the bullet and spend the money. But, it's still a lot of money. (Stacy)

The participants who were feeling unsupported expressed that after years of accessing mental health services in northern B.C. and other locations, they had experienced the most problems with services in northern B.C. and had not yet secured satisfactory, ongoing mental health care.

Chapter Summary

Following the completion of the interviews, the data were analyzed for themes and categories relating to the first research question. I identified four potential pathways a person may follow upon entrance to the mental health system. These pathways are based on the relative degree of success in obtaining continuous, satisfying mental health care: *feeling well supported, feeling somewhat supported, feeling more supported in the south, and feeling unsupported.*

The participants who were feeling well supported consistently had good experiences with the mental health system, despite their initial denials about their depression. These participants responded well to the services and treatments they were provided, and had either satisfactory ongoing mental health services or no longer required services within two years.

The participants who were feeling somewhat supported were not as consistent. They also went through a lengthy period of denial about their depression, but they did not respond well to many of the services and treatments provided to them. It was clear that many times during their recovery process there were not enough services and supports provided. After many successes and failures over a period of a couple of years, these participants managed to secure ongoing care, but were still not entirely satisfied with the quality and type of care they were receiving.

The participants who were feeling more supported in the south were similar to the participants who were feeling somewhat supported in that they both went through a long period of denial before seeking help, and that they did not respond well to many of the services and treatments. They also felt that they did not receive enough services and support from their northern community mental health system. But, instead of continuing to seek help in the north, they sought help in the south. After a few years of struggling unsuccessfully with the mental health services in their northern community, it was in larger, southern centres that they found the needed supports and services to secure satisfactory, ongoing mental health care.

Finally, the participants who were feeling unsupported consistently had poor experiences with the northern mental health system, even though their length of denial was less than the other participants in this research. Lack of care and quality of services plagued them through the many years they had accessed services, and at the time of the interview, these participants had not secured ongoing mental health services despite their many attempts.

CHAPTER FIVE

Interpretation and Analysis

This chapter centers on exploring the experiences of the participants in relation to the three research questions: 1) What are the experiences of people living with mental health conditions in terms of accessing and using mental health services? 2) What reasons do those people experiencing mental health conditions have for not using mental health services, and what perceived barriers to those services exist? 3) What recommendations do people living with mental health conditions have for improving access to and maintaining ongoing mental health services? Since the data for the first research question have already been presented in Chapter Four, this chapter first includes an interpretation the findings from the first research question, and then presents a description of the findings for the second and third research questions.

Experiencing Access and Use of Mental Health Services

This section of the chapter explores the four experiential pathways of the participants by comparing the support received in seeking help, accessing services, and using services. The most obvious distinction between the four pathways was how the pathway of the participants who were feeling well supported consistently differed from those participants who experienced the three other pathways. For example, the participants who felt well supported had a quick and satisfying recovery from their depression as a result of accessing and using mental health services in their northern community, unlike the participants experiencing the other three pathways.

Seeking Help

All of the participants experienced their depression at different points in their lives ranging from childhood to young adulthood. The majority of the participants who were feeling well supported and who were feeling unsupported began their mental health journey similarly in that they lived with their depression for less than a year before seeking assistance. These two pathways diverged immediately, reflecting the participants' decisions to seek help. Unlike the participants who were feeling well supported, those who were feeling unsupported expressed that they had experienced no continuing and satisfying mental health services in northern or southern B.C., despite their many years of accessing services. Seeking assistance after living with depression for less than a year was contrary to the majority of the participants who were feeling somewhat supported and those who were feeling more supported in the south, who expressed living with their depression for years before deciding to seek help. These two pathways did not diverge until the participants who were feeling more supported in the south expressed that they were only going to continue their mental health care with the services they were introduced to in southern B.C. The participants who were feeling somewhat supported, on the other hand, expressed that despite contact with southern mental health services, they continued to seek assistance in their northern community.

Unlike those on other experiential pathways, the participants who were feeling well supported revealed a significant amount of knowledge about mental illnesses and mental health services before deciding to seek professional help, which they indicated made it easier to ask for specific types of support. The majority of the participants experiencing the other three pathways expressed having minimal or no prior knowledge about the mental illnesses and the mental health system before deciding to seek help, which they acknowledged added to their difficulties when asking for professional help.

Accessing Services

Unlike the participants experiencing the other three pathways, the participants who were feeling well supported expressed experiencing a good relationship with their family physician. This family physician was the first professional they contacted regarding their depression. This physician also continued to serve as their primary care physician throughout their entire mental health journey. The participants experiencing the other three pathways, however, expressed feeling dissatisfied with the relationships they had with the first family physicians they contacted regarding their depression. In fact, most of the participants experiencing the other three pathways had several different family physicians during their mental health journey.

All of the participants were prescribed anti-depressant medication after making contact with their family physicians about their depression. With the exception of the participants who were feeling well supported, most of the participants indicated that they were not referred to specialized mental health services, such as counselors, psychologists, psychiatrists, or support groups after visiting their family physician about their depression. These participants described finally receiving referrals to specialized mental health services after persistently asking their physicians for these services. This experience was unlike the participants who were feeling well supported, who received referrals to specialized mental health services within one or two visits after contacting their family physician.

Finally, most of the participants first started accessing mental health services in northern B.C., with the exception of the participants who were feeling unsupported. Those participants first started accessing mental health services in other places, such as Ontario, southern B.C. and Britain, before moving to northern communities in B.C. These participants also noted that many of their problems of accessing mental health services started after they moved to northern B.C.

Using Services

Most of the participants felt that they were denied service at least once during their mental health journey, and felt that the waiting periods for services were too long. Also, most of the participants expressed dissatisfaction with some of the care they received, and the amount of services available to them. Contradicting this experience was how well the participants who were feeling well supported responded to the services that were recommended; the waiting periods for these services were also felt to be satisfactory. As well, the care they received and the amount of service provided was perceived to be adequate.

Most of the participants, with the exception of those who were feeling unsupported, managed to secure some ongoing and satisfactory mental health care, but some of those participants found this care in southern British Columbia instead of in their northern community. The participants who were feeling more supported in the south indicated that they had many contact opportunities with mental health services in southern B.C. For example, one participant had family in Vancouver and traveled there on a regular basis. Another participant explained that she saw a documentary on a psychiatrist in Victoria and insisted her northern physician give her a referral to the Victoria doctor. Notably, many of the participants did have contact with different mental health services in the south, but only the two participants who were feeling supported in the south continued an ongoing service plan there. The remaining participants either expressed dissatisfaction with the treatment they received in the south and discontinued service there, or discontinued service in the south, because they felt that their contact with services in the south helped their care in their northern community.

In summary, the four experiential pathways were different in significant ways. First, the participants who were feeling well supported had quick and satisfying recovery success along with a good relationship with their family physician. Those participants described responding well to the mental health services recommended and provided to them. That experience was unlike those participants experiencing the other three pathways. They described having poor relationships with their family physicians, and they had to persistently ask their family physicians for a referral to specialized mental health services. When they eventually received specialized services, they did not respond well to many of these services.

Perceiving Barriers to Mental Health Services

As previously mentioned in Chapter Two, the WHO (2005d) defined mental health as a state of balance between a person and the environment in terms of at least five domains of being; physical, psychological, social, cultural, spiritual, and other interrelated factors. The Canadian Minister of National Health and Welfare (1989) also described mental wellness as the person, group, and environmental factors working together effectively.

This section of the chapter presents the barriers to mental health services described by the participants in terms of those definitions of mental health and wellness. The participants were asked to express their most significant barriers to accessing and maintaining adequate mental health care. A barrier to mental health services was defined as any experience that the participants felt hindered their ability to access, use, or continually use a mental health service. This section does not compare the differences between the four experiential pathways because all of the participants expressed similar barriers.

The participants described overcoming personal barriers, such as being stigmatized, in denial, and unmotivated, and overcoming environmental barriers, such as arguing their case, finding their way, being disappointed with their care, experiencing problems with their drugs, having the right to know and decide, and paying for their care.

Overcoming Personal Barriers

Being stigmatized. According to Webster's New World Dictionary, stigma is defined as, "a mark of disgrace or reproach" (Neufledt & Sparks, p. 580). The participants said they felt the general public viewed the subject of mental illness as a stigma, stating that they had to overcome their own personal embarrassment about possibly having a mental illness before they could ask for help. For example, Dana said, "First of all, there are my own personal prejudices against the stigma of it. You know you don't want to be labeled a nut or whatever. So, I had to overcome that in order to even ask for the help". According to Fred, the fear of being judged by the public keeps people living with mental health conditions from participating in social activities such as working, and influences them to stay away from mental health services. Fred stated:

> Try getting a job working in Kmart if you have a history of mental illness and find out just how much stigmatization there is out there. It is even on some of the damn forms, although it is not meant to be. But if you don't fill it in, you are stigmatized and if you do fill it in and you lie, you are stigmatized. If you fill it in and you don't lie, you are stigmatized. So you can't win and that's why a lot of people won't work. That's why they want to avoid any way possible to come into contact with any mental health services.

Dana felt that once a person is known to be living with a mental health condition, the medical community treated you differently, which made her feel unsupported and stigmatized. Dana said:

> Nobody took anything I said seriously. They all started treating me like an infant. As soon as you are labeled, then you are treated like a freak, literally by the pharmacist you get your drugs from, by the nurses that take your information down whenever you need help, and by the doctor who pooh pooh's your desperateness.

The participants felt that the stigma surrounding mental illness in society was a significant barrier to asking for professional help and accessing mental health services.

Being in denial. Compounding the influence of stigma was the strong personal barrier of denial. The participants expressed that they refused to believe or accept that a mental illness could be the source of their problems. For example, Sue stated, "I would say that it was a personal [barrier] and that I had to get myself to accept what this [mental illness] was". The participants noted that this denial lasted for many years and prevented most of them from accessing much needed services.

Being unmotivated. Some of the participants mentioned that motivation to seek help was also a personal barrier. Alex expressed that when a person experiences a mental illness like depression, they are probably battling low self-esteem and a low desire to help themselves. Alex stated, "When you are extremely depressed and have no self esteem, you have no desire to help yourself. I mean you don't think you are worth it". Most participants said that it was only when they feared harming themselves or acting upon their suicidal thoughts that they overcame this motivation problem, which meant that they lived with their depression for years before the condition became severe enough to elicit such fears.

Overcoming Environmental Barriers

Arguing my case. Most of the participants expressed disappointment in their lack of access to services, and one of the participants stated, "The biggest external barrier was access" (Alex). Access was perceived by the participants as any entry point into the mental health system and how easy or difficult it was to use that entry point. Most of the participants felt that the main entry point into the system was through a physician. When the participants discussed barriers to accessing the mental health system, they mostly focused on experiences of trying to convince their family physicians or the emergency ward doctors of the seriousness of their depression. For example, Jeff noted that at the hospital "if you are suicidal, they will jump all over the band wagon to help you out. Other than that, they won't". Fred also echoed this view when describing his experience. He further stressed how he felt that people living with mental health conditions deciding to access services needed to play an active role in order to access those services successfully. Fred pointed this out as a barrier when he said:

> With general practitioners and emergency care people there is this expectation that you in fact argue your case to get into the hospital when in fact you are mentally ill. They think that you should have more self awareness and self confidence in dealing with the problem when you first encounter a medical practitioner.

Jeff's experience was similar to Fred's. He noted that the support system currently available requires the person living with a mental health condition to aggressively pursue services, instead of the system offering services that are more people friendly. Jeff stated, "The support system that's out there for me, it's a passive system. You know, I have to be the active one". Jeff felt that the client needed to be active in his northern community, which was a barrier to services, especially since his depression made him feel passive.

The participants experienced needing a referral from a physician before they could access most specialized mental health services. As a consequence, Jane felt that the limited number of general practitioners available in northern B.C. also resulted in a lack of access. This was seen when she stated that, "If we had more doctors here, people would be able to get into see them to get more quick referrals. So that's probably the biggest barrier [to access] now". Compounding this problem was the poor relationships some of the participants had with their family physicians regarding mental health care. With the limited number of physicians available, the participants felt unable to change family physicians and experienced a lack of access. For example, Alex stated:

> You can get referral from your doctor, but your doctor has to feel that you are sick enough to require a psychiatrist. So if you feel that you cannot talk to your doctor....I mean, just a total lack of accessibility to services that generally you require now.

Alex felt that he did not have a good relationship with his family physician, and therefore did not feel comfortable asking him for help with his depression. This heavy reliance on general practitioners providing access to specialized mental health services frustrated some of the participants, and saw this pathway to mental health services as a significant access barrier. For example, Tom stated:

> And I don't want my [mental health] care resting on a nonspecialist's [family physician's] opinion. That shouldn't govern whether or not I get care. The intake system is seriously flawed. I mean would you want your family doctor to decide whether or not you receive cancer treatment? Why is he or she deciding whether or not you get mental health treatment?

Tom felt that people experiencing mental health conditions should be allowed to directly access specialized mental health services, such as psychiatrist services, instead of requiring a referral from a family physician, who may not have adequate mental health knowledge.

Clearly, the participants felt that the requirement of gaining access to services via a family physician, and a limited number of family physicians available, were strong barriers to accessing mental health services.

Finding my way. After gaining access to mental health services, the most significant barrier that all of the participants noted was the limited services available in northern B.C. For example, Dana expressed that when a person is living with a mental health condition in her northern community, "you have to overcome the lack of services and be well enough to find your own [services]". Stacy said, "There is just not enough counselors. There is just not enough [services]". When Tom talked of the lack of services he discussed specific service shortages and stated, "The problem is the lack of qualified psychiatrists". Some of the participants were so disappointed with the number of services available that they said they have often considered paying for private mental health care to supplement the lack of government services. This problem of limited services also contributed to concerns that pertained to speed of access, adequate time with a service, discontinuity, as well as a general feeling of being unsupported.

The long waiting periods experienced when accessing new services and wait times between appointments were mentioned by several of the participants as a notable barrier. Carol found the long waiting periods to be unbearable and unacceptable when suffering from a mental health condition and stated, "Waiting time is just, it's awful. If you have another two months to wait for your appointment, you know, that isn't good enough". Jeff also talked about the difficulties he had waiting to see his psychiatrist and stated:

> I waited a long time. Wait, wait, wait. Like, I am starting to have a lot of problems. I have been having problems since December, but I can't see my psychiatrist. Got to wait to the middle of February. Yah, you still have to wait.

These limited services resulted in some of the participants feeling rushed through their long awaited appointments. Alex specifically referred to these shortened appointments and the possible implications this situation may have had for him when he stated:

> They really were seemingly trying to get people in and out, in and out, like they were running it like a McDonalds. They are very quick at judging each person very quickly. Like, poof, category A and poof, category B and not spending enough time to see exactly what's wrong, which is what they need to do right at the beginning.

Alex expressed that he was afraid of being rushed through appointments and of being quickly assessed, because it would lead to a misdiagnosis and future difficulties. Stacy also felt that her rushed appointments were hindering her mental health recovery, which was a barrier to satisfying service. She stated:

> I just sometimes feel so rushed when I am at, say, mental health or at the psychiatrist. Like, I don't want to bother them. I don't want to take too much of their time and that also frustrates me a little bit. I find that I am watching the clock and they keep sure that I don't go over time.

A few of the participants noted that the discontinuity of services was also a strong barrier against obtaining continuous and satisfying care. Alex, for example, expressed that his experiences with discontinuous service negatively affected his progress during his mental health recovery. Alex stated:

> When they are constantly switching or, even just that once, when I was doing so well and then I got a new one [counselor], you feel like poof, back to the beginning. So you feel like that last two months were wasted. So, it is very discouraging.

The participants expressed their frustration with mental health professionals, such as psychiatrists, psychologists, and counselors, changing during their attempts to secure ongoing mental health services. They agreed that this change impeded the continuation of satisfying services, and made them feel that they were starting again from the beginning, rather then continuing forward with their recovery.

Finally, the limited services available contributed to most of the participants feeling unsupported by the mental health community. Dana agreed with this point of view when she expressed, "Literally on so many occasions I desperately needed some help or even just to talk to somebody". Dana and the other participants felt that there was an insufficient amount of services in place to support them, especially in times of crisis when they said they needed support the most.

Being disappointed with my care. When the participants were discussing the topic of barriers, the low quality of mental health care available was expressed by most of the participants. For example, Darryl was very disappointed when he stated, "Once you do get into treatment then there's the quality of the treatment. And so you don't get the quality, you don't get very quality health care".

Low quality care was experienced by the participants quite often when dealing with general physicians for mental health issues. For example, Doloris stated that:

> A GP can usually decipher symptoms if its depression, right. So, he just prescribes an anti-depressant pill. But if it goes into the realms of deeper mental illness, then I don't think he initially has the expertise to recognize all the symptoms. The problem we encountered with our own GP was if he'd known more about mental illness, then he would have never ever taken me off my mood stabilizer. He didn't know enough, and he didn't think of conferring with a fellow psychiatrist before he took me off.

Doloris felt that general physicians are not trained enough in mental health care to adequately treat serious mental health cases. Tom also made this point and asked, "Why are you going to a family doctor? Why is a family doctor judging whether or not you need mental health care? It's not a slight against family doctors, but how many things are they supposed to specialize in?" Tom, Doloris, and the other participants felt that most of the family physicians they encountered were not sufficiently educated in mental illnesses and treatments, and that this lack of education was a barrier to receiving satisfying mental health care.

Some of the participants felt that a few of the support programs and mental health professionals involved with these programs provided poor quality services. For example, Carol's experience with a support group was disappointing when she felt that it wasn't meeting her needs. Carol stated:

> I know that they do have those programs in psychiatric out reach. But I wasn't very satisfied with the program. I didn't think that it was run very well. You know it was kind of like looking in the mirror and saying I am OK. You don't believe it. And there's more to it [mental health recovery] then just telling yourself that.

Jeff had a similar experience of poor quality care with some mental health care programs, but specifically felt that the mental health care providers were not helping him and eventually decided to discontinue using those services. Jeff complained, "There is POPS and I am sure that there are good counselors there you know. The ones that I had weren't very good".

A few of the participants also spoke of the disappointing experiences they had with their psychiatrists, which also eventually led them to discontinue seeing them. For example, Jeff felt that his psychiatrist was not thorough enough with his initial assessment, and felt that his psychiatrist consequently made the wrong diagnosis. Jeff stated:

> Like how can he [psychiatrist] make an assessment on me without discussing any of my issues with my family. You know, I mean, I read a lot about mental health now, and one of the most important things in therapy and getting the proper assessment, especially for my situation, which is to have extra input.

Jeff and the other participants felt that their experiences with poor service quality were a barrier to continuing mental health care, because it led to them discontinuing those services.

Experiencing problems with my drugs. The participants described many problems with their prescribed anti-depressant medications. They felt that the side effects and their family physicians' limited knowledge about anti-depressant medication were barriers to a satisfying recovery. Dana described her experience as "being drugged to the hilt and then being left to sort it out on my own". Darryl also noted that the results of the medication are so unpredictable that physicians are over and under medicating people. He mentioned, "The doctors will admit themselves that they are shooting in the dark with this medication".

Having the right to know and decide. Several participants mentioned that a lack of education and information about mental illnesses was a significant barrier to accessing care, and as Tom stated, "Education is really critical and it is a big barrier". Jeff mentioned several times that, "There is no information". The participants expressed two types of absent education: public education about mental health problems and services by the government, and consumer education about consumer rights and available services by the mental health system.

Some of the participants felt that a lack of public education about mental illnesses was a barrier to their own understanding of what they were experiencing. This lack of education also hindered their knowledge about how to receive help. For example, Carol admitted that if she had received education about depression, she would have sought help sooner. She stated:

> That was the thing. I think if I had read in the paper or in a magazine or if they had pamphlets at the doctor's office. If I'd read the symptoms of

> depression and the signs of depression, then maybe I would have said, ‘Hey, that’s what I’ve got. I need to see somebody about it’.

The participants also felt that once they had entered the mental health system and became consumers, there was no education on how the system worked, what services were available, and what their rights were. Tom said that there was no education for him about the system, which was reflected in his statement:

> Once you get into the system, the barrier to getting help is that you really don’t know how the system works. You enter the system blind because there’s nothing that tells you. You don’t know until you are well into the system and usually you’ve been in the system a long time and that’s when you learn the ins and outs in the system.

Jeff also mentioned that a lack of education was a significant barrier to a consumer’s understanding of their rights and expressed:

> When I went there I had no knowledge. I had no idea of my rights as a patient. And you know that is one thing they don’t tell you. They don’t tell you it is your right as a patient to refuse treatment or to have input in your treatment period. They just tell you what you are going to do and what you’re not going to do.

The participants mentioned on several occasions during their interviews that their lack of knowledge about mental illnesses, and then their lack of knowledge about mental health services and consumer rights, impeded their mental health recovery.

Paying for my care. Finally, some of the participants mentioned that the financial burden incurred to supplement the lack of public services with private services and the cost of anti-depressant medication was just too high. Alex noted that this financial burden was a significant barrier to accessing and maintaining satisfying care and stated, "I feel there is a great shortage of psychiatrists and I actually looked into [private] psychologists, but it is mega expensive and being poor...". Alex felt that it was too expensive to seek private mental health services and this limitation further restricted his access to mental health services.

Darryl also talked about how high the cost of prescription anti-depressant medication was for him and he said:

> Well, you know still they keep giving me medication and medication and I mean I've spent thousands of dollars a year on medication. I went down to pick it up for two weeks and it was like 270 dollars for two weeks. So you know, I mean all these new antidepressants that are coming out they're just getting more and more expensive all the time.

Darryl expressed that the expensive anti-depressant medications he was taking were a financial burden for him even though he had an insurance company covering some of the costs. Darryl went on to say that he felt sorry for those people who could not afford to pay for these medications and did not have any insurance coverage.

Most of the participants mentioned that private mental health care and anti-depressant medication were expensive and a barrier for participants living with mental health conditions in relation to continuing their mental health care.

Overall, all of the participants expressed barriers to mental health services that referred to personal barriers such as overcoming feelings of stigma and denial, and environmental barriers such as overcoming a lack of services, and a lack of education about mental illnesses. The participants also felt that they experienced a lack of access to and disappointment with the mental health services available.

Improving Access and Maintaining Support

All of the participants had recommendations and suggestions for improving the mental health system in northern B.C. The participants who were feeling well supported also made recommendations, because they could see the problems other people in the system were having, and acknowledged that their experiences were not the norm. For example, Jane stated that:

> My experiences were positive, but they were 15 years ago and things have changed dramatically with the health care field here.... Someone coming into the community in the past five years probably doesn't have a personal physician or probably doesn't have a physician who has that sort of experience, who's got that kind of caring because they are so overworked. And I suspect that they [person living with a mental health condition] wouldn't be able to get into the [mental health] system as quickly.

This section is presented as a whole and not as a comparison between experiential pathways, because of the commonalities among the participants' recommendations. The participants made recommendations and talked about improving current support, needing additional support, improving education, increasing government funding, and facilitating consumer participation.

Improving Current Support

The most significant recommendations the participants had for refining the mental health system were improving patient treatment, improving assessment and diagnosis procedures, considering alternative treatments, and increasing current services.

The participants spoke of improving the treatment of patients by mental health care providers and recommended that nurses, physicians, counselors, psychologists, and psychiatrists receive ongoing sensitivity training and mental health updating. For example, Tom found that his treatment from some mental health care providers was poor and desired a way to prevent this same treatment occurring in the future. Tom stated:

> The treatment I was receiving was worse than the illness. There has to be a way and I just don't know enough of how doctors and nurses and the whole system works to know what they can do on their side of the fence to prevent that sort of thing happening. To improve the way patients are treated.

The participants recommended that the procedures used to assess and diagnose patients become more thorough and accurate. Dana expressed that the procedures used to assess a patient were lacking when she stated, "The test that they give you is pretty lame. It's pretty general. They could improve that". Dana also noted that in order to make the assessment of a patient more accurate, the mental health care providers needed to talk to family members, especially those living with the person experiencing a mental health condition. Dana stated, "I think it is extremely important to have some communication with a family member who actually lives with the person who is mentally ill. To actually get the full picture. How can you get the full picture [without doing that]? It's impossible". Tom also expressed that the diagnosing of patients needs to be greatly improved, because the consequences of a misdiagnosis can last for years. Tom made the point, "The earlier the intervention the better. The longer it is before you are treated, the worse it gets. The more chronic it becomes. That pretty much says that early intervention is critical".

A few of the participants noted that mental health care providers need to become more open to and educated about alternative treatments. Dana felt that this could be achieved through updated and alternative mental health training for mental health care providers and could prevent her experience from occurring again. She stated, "I had every symptom of a milk allergy outwardly on my skin as well inwardly, mentally, and physically, all of it. Not one doctor [in the north] ever diagnosed me". Later in her recovery, Dana found out from a mental health care provider that her milk allergy was significantly contributing to her depression. Dana felt that if the northern mental health care providers (including psychiatrists) had been trained to look for a wide range of contributing factors to mental health conditions, then she may not have lived with her condition for so long.

Finally, the participants recommended an increase in the number of current mental health services. For example, Alex thought that it is ridiculous to be turned away from mental health facilities, such as the hospital, because the place is full. Alex expressed that if a person is suicidal, and "you get there, the psych ward shouldn't be full. I mean, it is exactly the same as if somebody gets a stab wound and you go to the hospital and they say, 'sorry we can't take you the beds are full, go home'". To alleviate this problem, Sue suggested that there should be an increased number of psychiatrists and general mental health staff. Sue stated, "I know it would be good if they had more staff, more psychiatrists and more psychiatric nurses. It's hard for people to get in".

The participants thought that is was important to improve the current mental health system and its services by providing sensitivity training to mental health care providers, allowing assessment procedures to include family members. They also thought it was important to provide education to mental health care providers in alternative therapies, and to increase the number of mental health services available.

Needing Additional Support

The participants suggested adding new services, such as crisis intervention and support services, and new community mental health programs to improve the mental health system. Some of the participants felt that people in mental health crisis need a supportive and informative place to either go or call in to. For example, Alex suggested that:

> You could just walk in somewhere and talk to someone like face to face for as long as you want. I mean, he will listen and he will tell you I think this is what is wrong, you have a chemical imbalance or you are stressed. Here are some of your options for help; you can call mental health, you can go to mental health, you can see your doctor, there are these kinds of antidepressants, here is some information on antidepressants.

The participants felt that crisis intervention services and facilities were lacking and were definitely needed for the future. They also recommended drastically improving the support services for consumers, because they felt that mental health conditions often require long term support. For example, Stacy reflected on the long term nature of mental illnesses and the need for appropriate support when she stated, “It’s just that mental health is a long process. It’s not something that is just over in a matter of a year. It’s just something that you need constant support and not that you want to be coddled, but you need a lot of support and help”. Jeff spoke about specific mental health support and suggested that each person living with a mental health condition have a mental health worker assigned to them for the purpose of ensuring appropriate support. Jeff expressed, “You need more follow up and more support. Having workers that can do that. Make visits to people who are kind of shut in. When you get depressed, man you want to hide”. Tom felt that in order to improve this support, a knowledgeable mental health person should be made available to new people accessing services as an advocate. He expressed, “Well, it’s almost as though you need a guide. You know when you first hit the system you need a guide to really tell you what they [mental health services] can do, what they can’t do. What you can do and what you can’t do”.

To further improve the support of the mental health system, the participants suggested that community programs be implemented. Sue recommended a facility for people living with mental health conditions who are not well enough to be on their own. Sue explained this idea when she said:

> I would like to say almost like a cottage setup for people 'cause the hospital isn't like being in a home. Maybe a halfway house, yah. Sort of when people are good enough to be out of the hospital, but maybe not good enough to be on their own yet.

Fred also suggested that a mental health care provider, such as a mental health nurse be located in every community for better access to services. Fred explained:

> We should have a mental health nurse based in each doctor's clinic or something like this. This is one of the things, or by region [of the city]. Can we have a mental health nurse, a community mental health nurse, based in [each neighbourhood]?

Fred felt that increasing community programs would help improve accessibility for the people who can not easily travel to services.

Improving Education

The subject of improving education was talked about several times by the participants when discussing recommendations. They felt that education about mental health needed to be wide spread and accessible to the general public. For example, Tom discussed the need for information on mental illnesses in order to dispel the myths and public stigmas surrounding it:

> There should be public education about the illness and the people who suffer from these illnesses and what these illnesses really mean. And what it does to people and what the ramifications of all this is and how wide spread it is. So public attitudes have to be not changed in the sense that people have to be forced to think a sort of way, but they just have to be offered the information.

Fred also felt that it is important to educate the public about what mental illnesses really are, but felt that it was also important to educate people on how to access mental health services:

> There should be some sort of bulletin that's displayed in doctor's [offices] and all medical centers and public centers, "if you are suffering from this, this, and this then please contact your doctor for a referral to mental health or where ever".

All of the participants felt that education on mental illnesses and mental health services is important for the general public and people living with mental health conditions, and each recommended improving this education on a massive scale.

Increasing Government Funding

All of the participants agreed that there needs to be more government funding for mental health services. Dana was adamant about this point of view when she stated, "More funding, more funding, more funding!" Darryl also felt that there is a lack of financial support for mental health services by the government and stated, "[There is] not enough money in the system". All of the participants agreed that the government needs to spend more money on improving the mental health system in northern B.C.

Facilitating Consumer Participation

Some of the participants recommended that people living with mental health conditions need to be more involved in government decisions about mental health policies to ensure that their opinions are taken into account. Tom expressed this point of view when he discussed that:

> People who have the experience, consumers, have to be at every level of the decision-making process. Because even a professional who deals with us everyday doesn't really understand. Otherwise it becomes all one sided. It becomes all the doctors and the nurses and they go overboard sometimes because they aren't seeing it from the point of view of the patient.

Reflecting the barriers to mental health services described by the participants were the recommendations the participants made to help improve the mental health system. All of the participants recommended increasing and improving the amount of services and support available in northern B.C. Some of the participants also suggested improving the general public's knowledge of mental illnesses with education, increasing funding for mental health services by the government, and facilitating more consumer involvement in the creation of mental health policies and programs.

Chapter Summary

This chapter explored the experiences of the participants based on the research questions generated to guide this study. It was discovered that the experiences of the participants who were feeling well supported were very different from the participants experiencing the other three pathways, suggesting that the major differences might be the key elements to having a successful mental health recovery. The participants who were feeling well supported had good relationships with their family physicians and had satisfying experiences with accessing and using mental health services. These experiences were unlike those participants experiencing the three other pathways, who described poor relationships with their family physicians, and a lack of satisfactory responses to the mental health services they accessed and used.

The barriers to satisfying and ongoing mental health care described by most of the participants reflected the problems they experienced with accessing and using mental health services. These barriers centered on the limited amount of support within mental health services available in northern B.C., and the lack of access to and education about these services. Consequently, the recommendations given by the participants also centered on these barriers, with the main emphasis being on improving support from the mental health system.

CHAPTER SIX

Synthesis and Discussion

Key Concerns

The results from this research will add to the body of knowledge on access and barriers to the mental health system in northern British Columbia. No research in northern B.C. to date has asked people living with mental health conditions to share their views of the challenges or barriers facing them when they attempt to access mental health services. This research has identified key areas of concern for these individuals.

Several key concerns have emerged from the practical research and the literature regarding the perspectives of people living with a mental health condition who want to achieve a successful recovery from a mental illness. Allot et al. (2002) revealed that people living with a mental health condition describe recovery as a process with eight important categories:

> a) the process of coming to terms with the illness, b) the variety of activities which facilitated recovery, c) aspects of the environment which facilitated recovery, d) the effects of medication, e) aspects of self and coping strategies which helped in recovery, f) the role of various networks of people, g) the role of hospitalization, and h) the non-facilitatory factors which hindered the recovery process. (p.20)

These categories are very similar to the key concerns, or important steps to be taken that the participants in this research described in order to recover from their depression while living in northern B.C. These key concerns were: a) knowledge of mental illnesses and the mental health system, b) accepting the presence of a mental health condition, c) having a good personal support system, d) playing an active role in the recovery process, e) having a good relationship with family physicians and specialized service providers, and f) adequate mental health services being available with efficient mental health support systems.

This research has found that it is important for people living with mental health conditions to have knowledge about mental illnesses and the mental health system in order to facilitate the self-recognition of a mental health condition and the choice to seek professional help in northern B.C. For example, the participants in this research admitted it was their lack of knowledge about mental illnesses and services that contributed to a delay in seeking assistance. Other studies have also found that a lack of knowledge concerning mental illnesses can be a significant barrier to accessing services for people living with mental health conditions (Li & Browne, 2000; Schmidt, 2000). Some people will agonize for years with their symptoms, not aware that they have a treatable medical condition.

This research has discovered that it is often difficult for people living with mental health conditions to admit or accept their mental illness, which is an important step towards seeking mental health care. For example, the participants in this research reported fearing what others would think if they admitted they were experiencing a mental health condition. This fear or stigma is commonly reported by other participants in other research (Fuller et al., 2000; Li & Browne, 2000; Schmidt, 2000). Fear and stigma can be strong barriers for people living with mental health conditions seeking help. Fox et al. (2001) discovered that an intervention providing information about mental illnesses and services available did not produce significantly higher rates of help-seeking among people who were assessed to exhibit a mental health condition. In other words, even when people were told they may be living with a mental health condition and were provided with information regarding services and free mental health care, some could not be persuaded that accessing services was a desirable option.

This research has shown that a good personal support system is important in facilitating the recognition of a mental illness, seeking help, and navigating the mental health system in northern B.C. For example, the participants in this research agreed that they all had reasonable support from their friends and family when they considered seeking help for mental health concerns. In fact, many of these participants approached their friends and family for help before deciding to seek professional assistance. This personal support system for people living with mental health conditions becomes even more important when one considers that, Fox et al. (2001) found that 71% of their respondents considered going to friends and family for help more frequently than all other help providers, such as ministers, social workers, psychologists, nurses, or physicians.

This research has discovered that in northern B.C., a person living with a mental health condition must play an active role in their recovery process. In other words, a person must actively seek out mental health information and services. For example, the participants in this research felt that they had to have some mental health knowledge in order to convince their family physician or the emergency physician at the hospital of the seriousness of their situation. They also described having to investigate what specialized mental health services or programs were available to them. This active role can be a serious barrier to access for people living with mental health conditions, since mental illnesses often make it difficult for people to face stressful and unknown situations or effectively express themselves (Boydell et al., 2002).

This research has revealed that it was important for people living with mental health conditions to have a good relationship with their family physician and other specialized mental health providers. Allott et al. (2002) emphasized the importance of relationships with professionals and mental health services in aiding recovery. In particular, the relationship with a family physician becomes valuable when one considers that, Fox et al. (2001) discovered 80% of their respondents considered going to their family physician for help if they thought they were experiencing a mental health condition. The use of the family physician as the first access point requires the average family physician to have an adequate amount of mental health knowledge in order to assist their patients, or to be willing to refer if they are not able to assist. If a good relationship with a family physician cannot be established, a significant barrier to accessing proper mental health care occurs. For example, most of the participants in this research described poor relationships with their family physicians concerning mental health concerns. Consequently, most of the participants changed their family physician several times during their mental health care journey. The participants also described poor relationships with some of their specialized mental health providers and chose to discontinue seeing them; the participants felt this hindered the progress of their mental health care. The participants, in consumer satisfaction research conducted by Mason et al (2004), also revealed that bonding with mental health care providers was important to achieving satisfying care.

Finally, this research has found that adequate mental health services must be available with efficient mental health support systems in place to ensure successful access and continuous use of the mental health system in northern B.C. For example, many of the participants in this research complained of service gaps, which they felt contributed to long waiting periods between appointments, and concerns of discontinuity. Major service gaps contributing to barriers to access have been reported in many studies (Allott et al., 2002; Boydell et al., 2002; Li & Browne, 2000; Schmidt, 2000). Service shortages become more evident when people living with mental health conditions reside in smaller or northern communities. For example, several of the participants in this research struggled to find adequate mental health professionals and services when they lived in smaller, northern communities. They felt that these service shortages considerably hindered the success of their recovery. Several recent studies focusing on rural and isolated communities also noted that follow-up care, including support groups and community programs, was lacking (Allott et al., 2002; Li & Browne, 2000; Schmidt, 2000).

This research has shown that many possible barriers exist for people living with mental health conditions in northern B.C., which can hinder mental health service access and utilization. These barriers are a lack of knowledge about mental illnesses and mental health services, the stigma surrounding mental illnesses, a lack of a personal support system, a limited number of mental health support systems, a shortage of family physicians and mental health specialists, and a limited number of appropriate services. Improvements can be made to the current mental health system to help alleviate some of these barriers in northern B.C.

Recommendations for Improving the Mental Health System

The research results reveal gaps in the existing northern B.C. mental health system. Important steps must occur along the mental health recovery pathway to facilitate a successful outcome. It is the mental health system's responsibility to ensure that these key concerns be addressed. Therefore, based on the findings in this research, recommendations for improving the mental health system in northern B.C. are presented. These recommendations also reflect some of the initiatives presented in the B.C. government's Mental Health Plan in 1998 for improving B.C.'s mental health system (B.C Ministry of Health, 1998).

Clearly supported by other studies conducted on small or northern communities (Fox et al., 2001; Li & Browne, 2000; Schmidt, 2000), and the B.C. government's 1998 Mental Health Plan, is the recommendation to promote public awareness and understanding of mental illnesses and available services. For example, Morrow and Chappell (1999) suggest that early education about mental illnesses and positive recovery representations would help young people grow up with less prejudice against and fears of people living with mental health conditions and the mental health system. This education could help reduce stigmas associated with mental illness and help alleviate the problems surrounding self-recognition and acceptance of mental illnesses by people living with mental health conditions. It is also recommended that all mental health care providers, such as family physicians, psychologists, counselors, teachers, community centre coordinators, and clergy, have continual education on current mental health treatments, services, and policies.

The participants in this research stated that they were uncertain, and at times confused, by the workings of northern B.C.'s mental health system once they had accessed the system and become a client. Therefore, this research recommends that education and information be provided to people accessing the mental health system concerning services and access. In fact, a service provider in Schmidt's (2000) research stated, "There's a real need for information- to know what services are available. This need is apparent in Prince George as well as in the remote communities" (p. 83). This education and information could be provided in a recurring seminar for people who have been assessed as experiencing a mental health condition.

According to the findings of this research, support is important to people living with a mental health condition in northern B.C. This support needs to come from a person's personal environment and the mental health system. Morrow and Chappell (1999) suggest that more support, including financial, be given to the family or caregivers of a person living with a mental health condition by the B.C. mental health system. They also suggest that the B.C. government should supply support groups with more financial and mental health resources. In 1998, the B.C. Mental Health Plan recommended more availability and accessibility of formal and informal personal supports for people living with mental health conditions and their families (B.C. Ministry of Health, 1998). Julie Kerr (personal communication, February 16, 2006), Regional Manager of Mental Health Services for Northern Health, described many improvements to support services for people living with a mental health condition in the past five years. These improvements included the addition of recreational and vocational therapy for people experiencing a mental illness. These therapies are designed to help support people reentering their community after experiencing a mental illness.

B.C.'s 1998 Mental Health Plan refocused the mental health system's efforts on the seriously mentally ill, restricting access to psychiatric units at some hospitals for those mentally ill people who do not fall into the 'seriously ill' criteria. More efforts need to be made by the government to increase and improve community mental health services. For example, most of the participants in this research noted how the limited availability of mental health services in northern B.C. negatively influenced their recovery. The 1998 B.C. Mental Health Plan recognized that timely access to well-trained physicians and specialists does not always occur in northern and rural areas because of inadequate numbers of physicians and other mental health professionals. To help recruit physicians and other mental health specialists, and to alleviate the low numbers of mental health professionals practicing in northern and rural areas, the CFHCC (2002) recommended exposing physicians and mental health specialists to northern and rural settings as a part of their training and education. The belief is that increased exposure to rural and northern settings increases the likelihood that graduates will choose to practice there. McEwan and Goldner (2002) also recommend improving and expanding community services to correct the imbalance between institutional and community-based care. These community mental health services could include: transportation to specialized services; independent supportive housing; mental health crisis centers in each major area of a community; improved outreach services; improved crisis response and emergency mental health care needs; and improved data collection on access, appropriateness, and use of mental health services in order to ensure accountability in the mental health system (Provincial Co-ordinating Committee for Remote and Rural Health Services, 2002).

Some steps have been taken in northern B.C. to help alleviate the concerns of discontinuity. The Northern Health Authority (2005b) brought mental health and addictions services together in 2002 in hopes that clients would, "receive coordinated care in a seamless process" (p. 13). Recently, improvements have been made to the accessibility of mental health services in northern B.C. For example, the city of Prince George has implemented the Community Response Unit (CRU). This program ensures that no matter where a person makes contact with the mental health system (eg. family physician, mental health unit, CMHA, Emergency Department of the hospital, etc.), a CRU member will be contacted and sent to their location. The CRU member will then assess the person and give them information about mental illnesses and mental health services. CRU provides rapid and flexible response to mental health calls (J. Kerr, personal communication, February 16, 2006).

This research has shown that mental health care providers play a key role in the recovery from a mental illness in northern B.C., especially family physicians. It is typically these care providers who people living with mental health conditions look to for guidance and answers to their mental health concerns. Therefore, a good relationship between mental health care providers and people living with a mental health condition is critical to their recovery process. To improve this relationship, mental health care providers need to receive ongoing training in sensitivity and the latest mental health updates on treatments and policies. This recommendation is especially important for family physicians, since they do not specialize in mental health care, yet they are typically the first contact for many people living with mental health conditions. The participants in this research, and other research studies, suggest that physicians and mental health professionals be given training that exposes them to people living with mental health conditions and their families in their own environments in order to sensitize them to the needs of their clients, in hopes of improving relationships (Boydell et al., 2002; Li & Browne, 2000; Schmidt, 2000). More recently, an Enhancing Interdisciplinary Collaborative Primary Health Care (EICP) Initiative has begun in Canada to develop a set of principles and framework for the collaboration for primary care providers on the front line, with tools to help primary health care providers work together more effectively. These primary care providers can include physicians, nurses, psychologists, pharmacists, social workers, and any other first contact point professional a person has with the health system. The hope is the implementation of this initiative will promote better health outcomes for all Canadians (EICP, 2006).

Finally, this research recommends that people living with mental health conditions and their families need to be included in decisions regarding the mental health recovery process, mental health programs, and policies to help improve the overall mental health system. For example, several of the participants in this research stressed that mental health care providers did not want the opinions of their families during their recovery. These participants also suggested that people living with mental health conditions and their family members should be included in government decisions regarding mental health funding and policy making. Allott et al. (2002) argue that governments need to employ people living with mental health conditions to "develop and deliver effective recovery-oriented services" (p. 29). In Boydell et al.'s (2002) research, people living with mental health conditions, family members, and mental health care providers found the family perspective to be missing. Their research went on to describe the importance for the mental health system to promote the success of a person's recovery. To improve the rate of success, the expertise of people living with mental health conditions and their families is needed. B.C.'s 1998 Mental Health Plan also outlines the importance of developing consumer and family advisory committees and acknowledging the perspectives of these committees regarding services, treatment, and system planning. As indicated earlier, most people living with mental health conditions prefer to ask family members for help with mental health concerns. Therefore, it seems logical to include the involvement of family in a person's mental health care.

Limitations

Some limitations exist in this research. A small sampling group is recommended when conducting qualitative research (Miles & Huberman, 1994), and my sample of 10 individuals was sufficient for this qualitative descriptive research. The participants in this research were homogenous in that they had been living with their depression for at least one year and had accessed mental health services in northern British Columbia. All of the participants were also considered to be an employed or middle class status, and did not require social assistance or welfare. If this research had included participants who were already supported by a government funded system or the homeless, different experiences and barriers may have emerged. The decision to include only participants living with depression may have limited the discovery of other problems associated with different mental health conditions affecting access. All of the participants in this research had accessed mental health services in northern B.C. If more participants were included that had only accessed mental health services in other communities, different experiences and barriers may have also emerged. If the family members of all the participants in this research were interviewed, other barriers to service access and use may have been revealed. Finally, when conducting this research, I did not know the severity of symptoms for each of the participant's mental health conditions, which could have contributed to the diversity of their experiences.

Recommendations for Future Research

Northern B.C. has seen a recent increase in the availability of family physicians and specialized mental health services, including psychiatric services. The 1998 B.C. Mental Health Plan recommended that future evaluative research be conducted to determine the effectiveness and value of mental health services. This research reflects this recommendation by examining the barriers to access and use of mental health services in northern B.C. Because the data for this research were collected in 2001, this research anticipates the recommendation by the Enhancing Health Services in Remote and Rural Communities of British Columbia report in 2002 to conduct current research on mental health access with the perspectives of people living with mental health conditions. The CFHCC (2002) also acknowledges that there is not enough research conducted in rural and northern areas, and calls for more large scale research projects focusing on improving health care. Furthermore, the Regional Manager of Mental Health Services for Northern Health reports that many improvements have been made to accessibility and community support concerns in northern B.C. for mental health services, since this research was conducted in 2001 (J. Kerr, personal communication, February, 16, 2006). Therefore, another research study on the perspectives of people living with mental health conditions accessing or attempting to access mental health services in northern B.C. is necessary in order to understand whether the improvements to the mental health system have increased accessibility and alleviated some of the perceived barriers to service since 2001.

McEwan and Goldner (2002) suggest accountability and performance indicators for mental health services and supports be used in future studies concerning the proficiency of the mental health system. These indicators are, "(a) acceptability, (b) accessibility, (c) appropriateness, (d) competence, (e) continuity, (f) effectiveness, (g) efficiency, and (h) safety" (p. 6). These indicators parallel the perceived barriers the participants in this research revealed that negatively influenced their mental health recovery and are compared in Table 1. The findings in this research validate the use of the service performance indicators recommended by McEwan and Goldner, since the performance indicators were reflected in the data. Also revealed in the data were the significant personal barriers to service (i.e. denial, stigmatization, and low motivation) the participants faced, which McEwan and Goldner's indicators do not address. Therefore, future research on service performance would need to include indicators, which reflect personal barriers to service experienced by people living with mental health conditions.

Table 1

Performance Indicators Recommended by McEwan and Goldner Compared to Barriers to Service Described by Participants

McEwan and Goldner's recommended indicators	Participants' perceived barriers to service
Acceptability	Participants complained that some of the treatment received from service providers was unacceptable.
Accessibility	Participants repeatedly stated that they experienced many barriers to accessing services, such as limited services and lack of diagnosis.
Appropriateness	The limited choices of mental health services were barriers, since some of the participants did not find the services available appropriate for their needs.
Competence	Participants revealed that a lack of knowledge about mental illnesses and treatments by some service providers was a barrier to accessing and continuing services.
Continuity	Participants stated many times that discontinuity of services was a barrier to continuing care.

Effectiveness	Participants' experiences revealed that the depression medications they were prescribed were quite often ineffective, hindering their recovery process.
Efficiency	Participants complained that long waiting periods between services and appointments were a barrier to recovery.
Safety	Participants described that a lack of knowledge about anti-depressant medications by some service providers led to them being over and under-medicated. They also described the side effects from some of the medications being more detrimental to them then their depression symptoms.

This qualitative descriptive research of the experiences of people living with mental health conditions in northern British Columbia is an initial step in the development of knowledge in this area. Many other research questions can be developed from this research that focus on other mental health conditions, other northern communities, the poor, and family members or caregivers of people living with mental health conditions. If future research studies are conducted, that include these other groups of people and elicit information rich data, it could be shown the concerns raised and recommendations made by the participants in this study are transferable to other people living with mental health conditions in different contexts.

Other research studies could be created around some of the ideas given by the participants to help improve the mental health system. First, several of the participants suggested that a navigator or case manager be assigned to every person accessing services to help guide them through the mental health system. A pilot project should be created and studied. Second, several of the participants indicated how important it is to have a good relationship with your service provider. A study should be conducted on the relational issues between clients and their providers. Finally, a few of the participants suggested that family and care providers should be involved in the mental health care plan of a person living with a mental health condition. A study should be conducted on the concerns and privacy issues surrounding this family oriented approach to mental health care.

Conclusion

In order to ensure effective and solid mental health programs and services, it is important to understand and explore the experiences and perspectives of the people served by these services (Denzin, 1989). This research on the experiences of people living with mental health conditions, who accessed or attempted to access the mental health system, has shown that the pathway to adequate mental health services may be difficult and inconsistent in northern B.C. The WHO (2005d) and the MNHW (1989) both describe mental health and wellness as a balance between a person and their environment with physical, psychological, and social factors influencing this balance. The participants in this research have shown that they faced two challenges when attempting to access mental health services, the barriers between them and their psychological well-being (e.g. denial, motivation, and stigmatization concerns), and the barriers between them and their personal, professional, and mental health care environments (e.g. limited accessibility, limited choice, and discontinuity concerns).

It is apparent from this research that the first challenge a person experiencing a mental health condition must face is acknowledging and accepting their mental illness. Then they must overcome the symptoms of their illness and fears of the stigmas surrounding mental illnesses in order to ask for and seek help. Even if the current mental health system had an overabundance of care providers, services, and programs, it does not ensure that a person experiencing a mental health condition will overcome this personal challenge and seek out this care. This means that future research on the accessibility of any mental health services must also focus on the personal barriers that people living with mental health conditions face, impeding them from seeking help. Therefore, it is my observation from the results of this research that the mental health system must reverse the help-seeking process. In other words, the mental health system needs to adopt new policies to create programs and services that seek out people experiencing mental health conditions in order to inform them that help is available and that support is forthcoming with regards to their mental health care choices.

As described by the participants in this research, the pathway to satisfying mental health care for many people experiencing mental health conditions in northern B.C. is not an efficient highway with many side streets of services, but a road with few side streets and some potholes. If a person experiencing a mental health condition is able to overcome their personal challenges and seek help, their mental health care environment should be efficient and supportive. The mental health system needs to provide continuous care for people living with mental health conditions that encourages a supportive environment in all aspects of their lives. This could be achieved by the mental health system adopting new policies to actively involve the friends, family, and care providers of a person experiencing a mental health condition during their recovery process. Many mental health sources in the past have stated that the people experiencing mental health conditions and their families should be included on policy and decision-making mental health boards and committees (eg. B.C.'s 1998 Mental Health Plan). Interestingly, it is the feeling of the participants in this research that there is still not enough of this inclusion taking place, especially involving northern residents. The northern mental health system also needs to adopt new policies for recruiting and maintaining adequate numbers of mental health care providers to provide quality services and programs free from concerns of discontinuity.

The purpose of qualitative research is to objectively describe the perceptions of people in their setting and not to determine what actually happened (Morse, 1995). In other words, all perspectives of a situation or event are needed to fully understand the phenomenon that is taking place. For example, a patient's description of a visit to the doctor may be different from the doctor's description of the visit, but both are needed to understand the personal and environmental factors involved in a visit to the doctor. To date, most of the research in the area of mental health service access and barriers in Canada has not included the experiences and views of people living with mental health conditions. It has also not included the experiences and views of people living in rural and northern landscapes, cultural groups, such as the First Nations, and new immigrants. It was my intention with this research to start to address this gap and give those people a voice. It is clear that the participants in this research are saying that the mental health system in northern B.C. needs to improve to prevent future people from falling victim to the same barriers to access they experienced. As Tom stated, “It’s just the system in itself is inefficient, and the people who suffer are the people in the system”.

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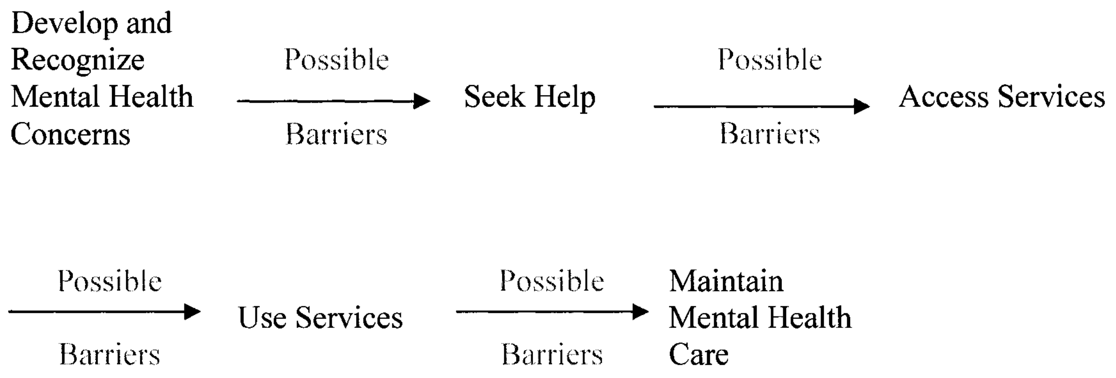
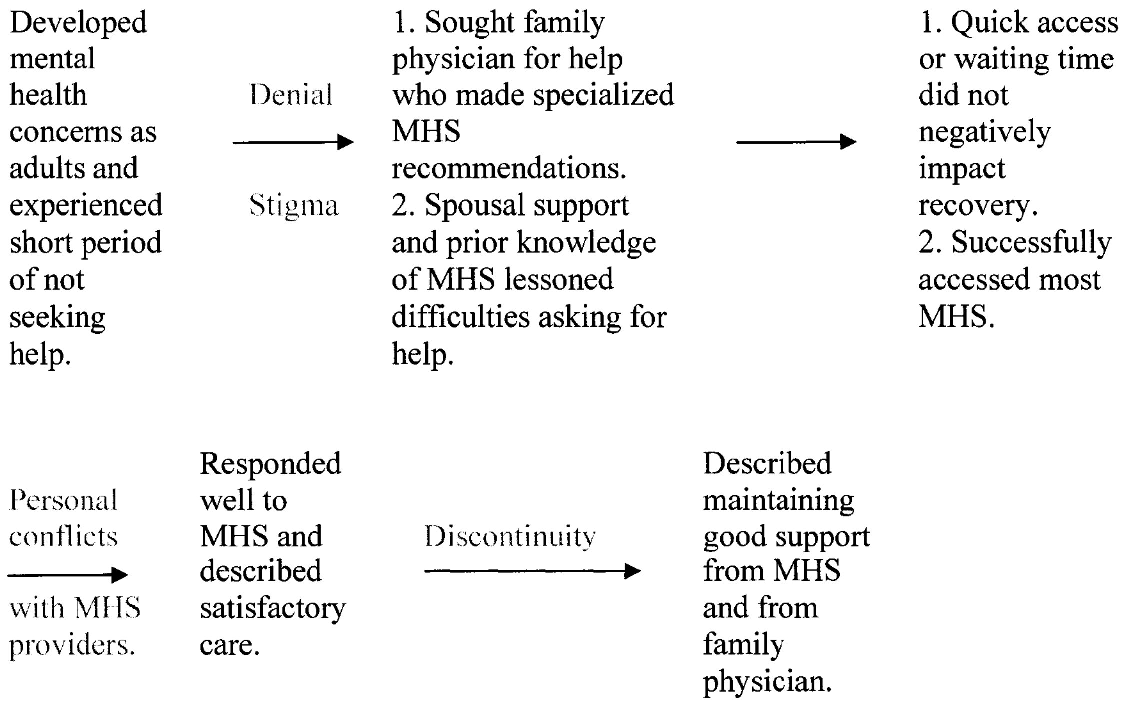
APPENDIX 1

Pathways

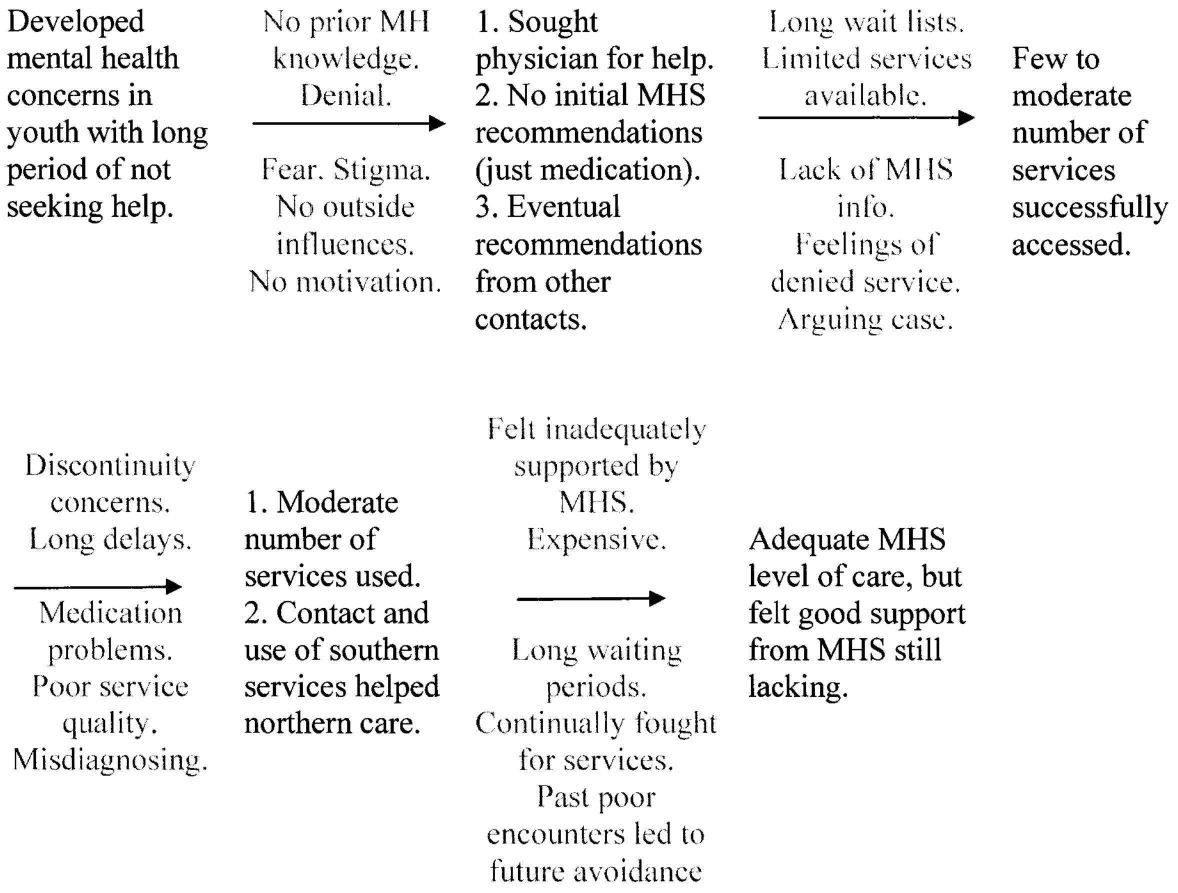
Original Research Pathway



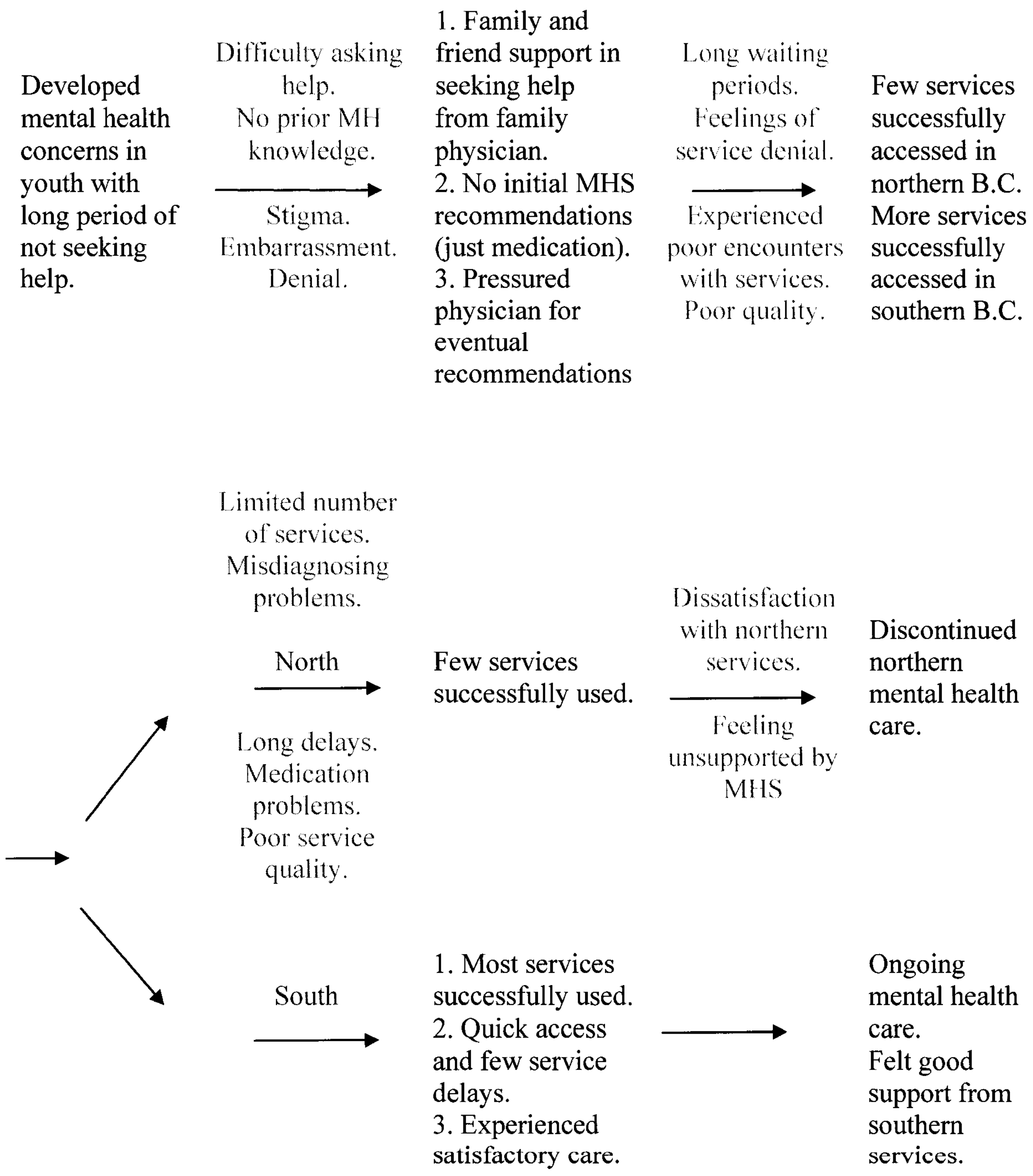
Feeling Well Supported Pathway



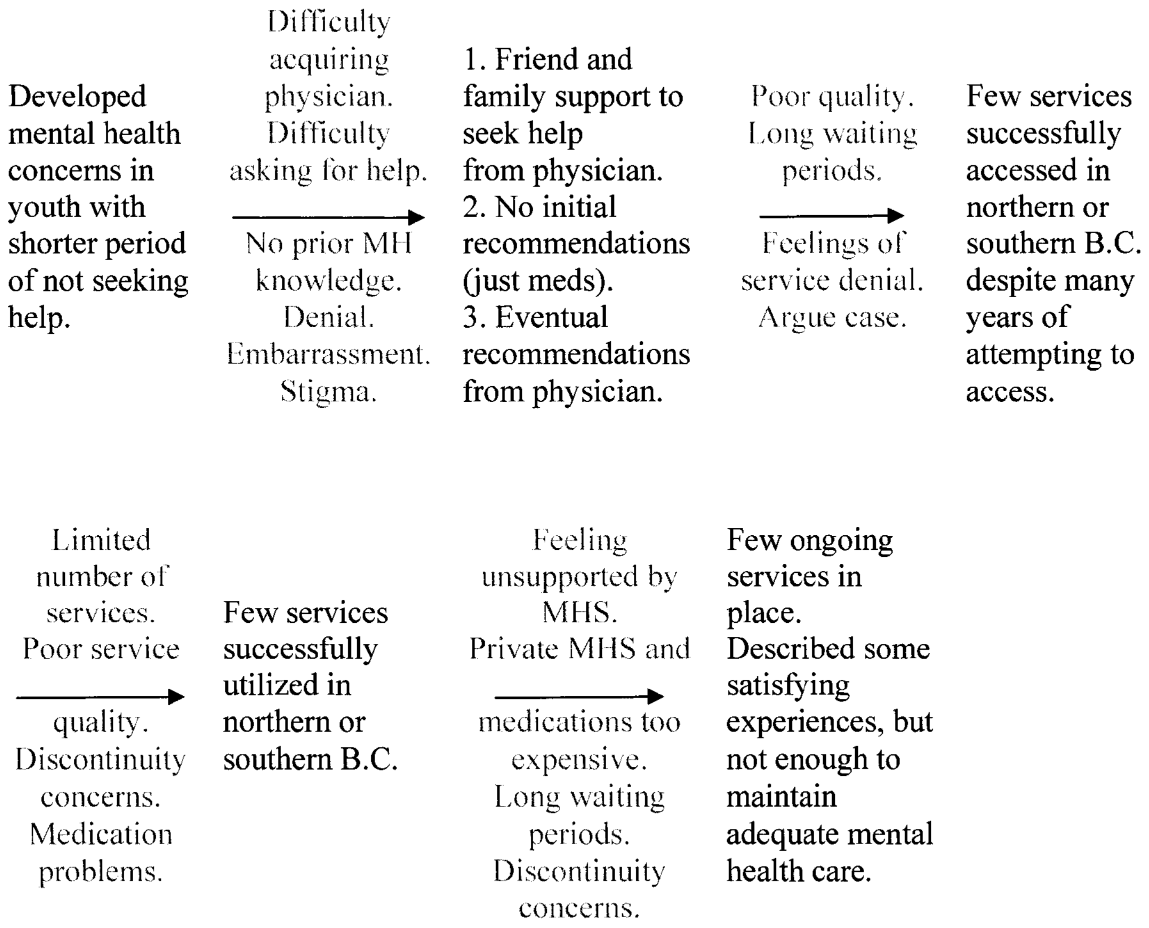
Feeling Somewhat Supported Pathway



Feeling More Supported in the South Pathway



Feeling Unsupported Pathway



Developed mental health concerns in youth with shorter period of not seeking help.

Difficulty acquiring physician. Difficulty asking for help. → No prior MH knowledge. Denial. Embarrassment. Stigma.

1. Friend and family support to seek help from physician.
2. No initial recommendations (just meds).
3. Eventual recommendations from physician.

Poor quality. Long waiting periods. → Feelings of service denial. Argue case.

Few services successfully accessed in northern or southern B.C. despite many years of attempting to access.

Limited number of services. Poor service → quality. Discontinuity concerns. Medication problems.

Few services successfully utilized in northern or southern B.C.

Feeling unsupported by MHS. Private MHS and → medications too expensive. Long waiting periods. Discontinuity concerns.

Few ongoing services in place. Described some satisfying experiences, but not enough to maintain adequate mental health care.

APPENDIX 2

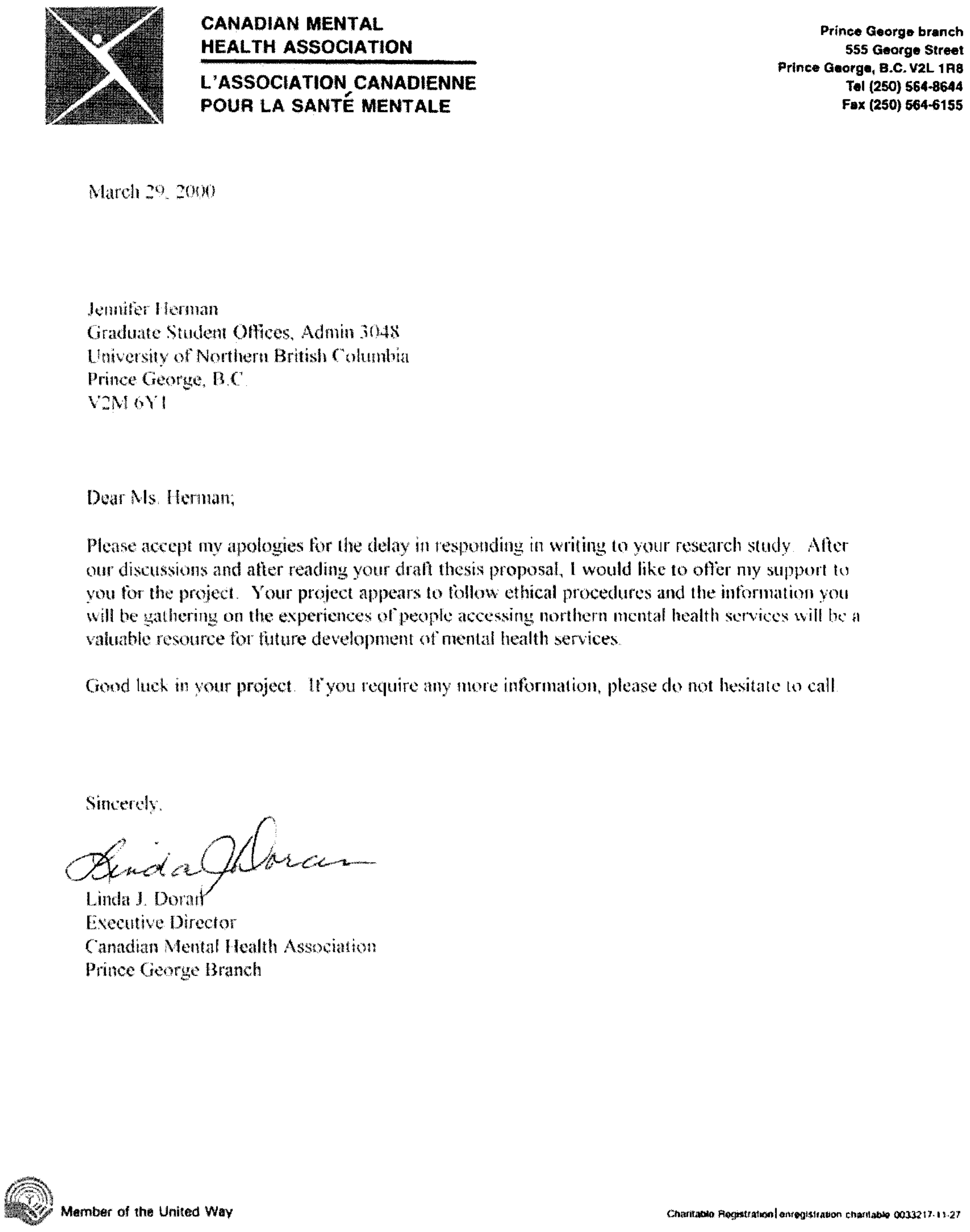
Focus Group Contract

I, ____________________________, agree that I will not reveal any of the identities of the other focus groups members to anyone outside of the focus group. I agree not to discuss any of the stories, subjects, or ideas talked about during the focus group to anyone outside the focus group. I agree to respect the views of the other focus group members and I will allow them to voice their views with no prejudice.

Signature: ______________________

APPENDIX 3

Canadian Mental Health Association Approval Letter



CANADIAN MENTAL HEALTH ASSOCIATION
L'ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE

Prince George branch
555 George Street
Prince George, B.C. V2L 1R8
Tel (250) 564-8644
Fax (250) 564-6155

March 29, 2000

Jennifer Herman
Graduate Student Offices, Admin 3048
University of Northern British Columbia
Prince George, B.C.
V2M 6Y1

Dear Ms. Herman;

Please accept my apologies for the delay in responding in writing to your research study. After our discussions and after reading your draft thesis proposal, I would like to offer my support to you for the project. Your project appears to follow ethical procedures and the information you will be gathering on the experiences of people accessing northern mental health services will be a valuable resource for future development of mental health services.

Good luck in your project. If you require any more information, please do not hesitate to call.

Sincerely,

Linda J Doran

Linda J. Doran
Executive Director
Canadian Mental Health Association
Prince George Branch

Member of the United Way

Charitable Registration | enregistration charitable 0033217-11-27

APPENDIX 4

Participant Package

Letter of Intent

Dear Participant,

My name is Jennifer Herman and I am a candidate for the Masters of Community Health Science. I am currently working on my thesis at the University of Northern British Columbia under the supervision of Dr. Tom Strong, Assistant Professor in the Education Program. I have chosen to conduct research that requires me to interview people for the purpose of exploration.

The purpose for my research is to talk with people about their experiences accessing the mental health system. I will be asking you in an interview session questions relating to your experiences about how you discovered you had a mental health problem and how you choose to deal with this problem. I will also be asking for your recommendations for improving the accessibility of mental health services. It is my hope that the outcomes of this research study will help influence policy making decisions.

To participate in this research, a mental health professional (i.e. physician, psychiatrist, psychologist, or counselor) must have diagnosed you with depression no less than one year ago. I have chosen to talk to people diagnosed with depression because it is widespread, effecting many people.

If you choose to participate in this research, you are agreeing to participate in a one-on-one interview with me that will last about one hour. Before you participate in the one-on-one interview, you will be required to sign a consent form indicating that you have chosen to participate freely. This interview will take place where you are most comfortable such as your home. You are also agreeing to participate in a focus group that will include you, four other participants, a trained facilitator, and myself. The trained facilitator will be present as an observer only. Before participating in the focus group, you will also be required to sign a consent form. This focus group session will take place at a location to be agreed upon by all focus group members. The one-on-one interview and focus group session will be tape recorded and then transcribed by myself.

If you choose to participate in this research, your confidentiality will be guaranteed. Your tape-recorded interview and focus group session, transcripts, and my research findings will be locked in a cabinet that only my supervisor and myself have access. In the final report a pseudonym (that you could choose) will be used in the place of your name. For example, if your name is Cheryl, in the final report your name could become Lucy. Your chosen pseudonym can also be used during the focus group session to protect your identity from the other participants. You will have the opportunity to review copies of the transcripts from your interview and focus group session. You will be allowed to keep the transcripts from your own personal interview, but the focus group transcripts can only be reviewed in the presence of the other focus group members and no copies may be kept. You will also have access to the final copy of the research report through myself or through the UNBC library.

I can guarantee that anything we discuss during the one-on-one interview will not be disclosed to anyone but my supervisor. This confidentiality can not be guaranteed during the focus group session, but every effort to maintain confidentiality will be made. I will explain to everyone participating in the focus group that anything we discuss cannot be disclosed to anyone outside of the group.

Since we will be talking about past events which may pertain to a painful time in your life, a counselor will be available for you to talk to after the one-on-one interview and focus group session.

Remember: You have the right to refuse to answer any question and you have the right to withdraw from this research study at any time without prejudice.

In summary, you have the chance in participate in a research study that will describe your experiences using the mental health system and will ask for your recommendations to improve the accessibility of this system. This study will take approximately two and half-hours of your time and your confidentiality is guaranteed.

Thank you for taking the time to read this letter and I respect your choice to participate or not to participate.

Sincerely Yours,
Jennifer Herman, Masters of Community Health candidate.

If you choose to participate or want more information on this research study you can contact myself at:

Graduate Student Offices, Admin 3048.
University of Northern British Columbia,
Prince George, BC V2M 6Y1
Tel: (250) 960-5671 (office) or 564-2659 (home) Email: hermanj@unbc.ca
You can contact my supervisor Dr. Tom Strong at:
Tel: (250) 960-5401

Interview Questions

How did you come to decide to seek assistance with the way you were feeling?

What mental health services do you understand are available to you in northern British Columbia?

What was the experience of asking the 'other' for help like?

What helped you decide to seek a mental health professional?

What mental health services were recommended to you?

What was your experience in trying to access these services?

What was your initial experience in using these services?

How has it been for you to get the continuing care you need?

What personal or external barriers do you feel you had to overcome to receive the services that you have had so far?

What recommendations do you have for improving accessibility of the mental health services?

Participant's Letter of Informed Consent: One-on-One Interview

Dear Interview Participant:

I will be conducting research as part of the requirements for my Master of Community Health Science thesis work. Research will be carried out in Prince George from April to July 2000, with an expected thesis completion date of December 2000. You must be diagnosed with depression by a mental health professional (eg. psychiatrist, psychologist, counselor, etc.) no less then one year ago. This work will involve a one-on-one interview with person who has utilized or is still utilizing mental health services in Prince George. This interview will take place in a desired location of your choice such as your own home. During the one-on-one interview which will last about one hour, I will be asking about:

- your experiences in deciding to seek mental health services,
- the mental health services that were recommended to you and the services you eventually utilized,
- your experiences in trying to access and receive mental health services,
- how starting and continuing to receive mental health services has been for you,
- the barriers you have encountered in trying to get the mental health services you need,
- your recommendations for improving mental health service accessibility.

Should you agree to participate in this thesis project, you should be aware that the interview will be tape recorded and you will be asked questions pertaining to the above research purposes. As I may be quoting you and other participants in my thesis, I will ensure your confidentiality by choosing or allowing you to choose a pseudonym in the place of your name for the research report (e.g. If your name is Shannon, I will change your name to Carrie in the research report). <u>You have a right to refuse to answer any question or to withdraw from the study at any time without prejudice.</u>

This research is focusing on past experiences, which might be painful for some participants. A counselor will be available for these participants should the need arise.

Transcripts of the interview will be given to you for review and revision. Otherwise they will be kept in a locked filing cabinet, accessible only to myself and my supervisor. The transcripts will only be kept until the completion of this research project and then destroyed. Should you wish to see the transcripts of your interview and research outcomes at any time, I may be contacted at:

Graduate Student Offices, Admin 3048
University of Northern British Columbia,
Prince George, BC V2M 6Y1

Tel: (250) 960-5671 or 564-2659 E-mail: hermanj@unbc.ca

I will be working under the supervision of Dr. Tom Strong, Assistant Professor in the Education Program at the University of Northern British Columbia.
Tel: (250) 960-5401

You may also contact UNBC Research and Graduate Studies Office (Tel: 960-5820) if you have any questions or concerns about the research.

If you wish to participate in this research, please sign below.

I have discussed the proposed thesis work on *Perceived Barriers and Meanings: The Experiences of People Accessing Northern Mental Health Services* with Jennifer Herman. I agree to participate voluntarily in an interview session with Jennifer Herman as part of her research.

Signature Date

Witness's Signature Date

Participant's Letter of Informed Consent: Focus Group

Dear Interview Participant:

I will be conducting research as part of the requirements for my Master of Community Health Science thesis work. Research will be carried out in Prince George from April to July 2000, with an expected thesis completion date of December 2000. You must be diagnosed with depression by a mental health professional (eg. psychiatrist, psychologist, counselor, etc.) no less then one year ago. This work will involve a focus group session with you and other individuals who have utilized or are still utilizing mental health services in Prince George. This focus group session will take place in the desired agreed upon location of you and the other focus group participants. During the focus group session which will last about 1 and a half hours, I will be asking about:

- your experiences in deciding to seek mental health services,
- the mental health services that were recommended to you and the services you eventually utilized,
- your experiences in trying to access and receive mental health services,
- how starting and continuing to receive mental health services has been for you,
- the barriers you have encountered in trying to get the mental health services you need,
- your recommendations for improving mental health service accessibility.

Should you agree to participate in this thesis project, you should be aware that the interview will be tape recorded and you will be asked questions pertaining to the above research purposes. Also, you are agreeing to keep all the information from the focus group confidential. As I may be quoting you and other participants in my thesis, I will ensure your confidentiality by choosing or allowing you to choose a pseudonym in the place of your name for the research report (e.g. If your name is Shannon, I will change your name to Carrie in the research report). This pseudonym can also be used during the focus group session to protect your identity from the other participants. You have a right to refuse to answer any question or to withdraw from the study at any time without prejudice

This research is focusing on past experiences, which might be painful for some participants. A counselor will be available for these participants should the need arise and a trained facilitator will be present during the focus group session.

Transcripts of the focus group session will be reviewed in the presence of the other focus group members for clarification and revision. No copies of the focus group session transcripts will be given out and the transcripts may only be reviewed in my presence. Otherwise they will be kept in a locked filing cabinet, accessible only to myself and my supervisor. The transcripts will only be kept until the completion of this research project and then destroyed. Should you wish to see the transcripts of your interview and research outcomes at any time, I may be contacted at:

Graduate Student Offices, Admin 3048.
University of Northern British Columbia,
Prince George, BC V2M 6Y1

I will be working under the supervision of Dr. Tom Strong, Assistant Professor in the Education Program at the University of Northern British Columbia.

You may also contact UNBC Research and Graduate Studies Office (Tel:
if you have any questions or concerns about the research.

If you wish to participate in this research, please sign below.

I have discussed the proposed thesis work on *Perceived Barriers and Meanings: The Experiences of People Accessing Northern Mental Health Services* with Jennifer Herman. I agree to participate voluntarily in focus group sessions with Jennifer Herman as part of her research, and I agree to keep all discussions within the focus group confidential.

Signature ______________________ Date ______________

Witness's Signature ______________________ Date ______________