SHARING STORIES:
MARGINALIZED WOMEN'S EXPERIENCE WITH DEPRESSION

by

Nadine English

B.A. Simon Fraser University, 2000

THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS
IN
INTERDISCIPLINARY STUDIES

UNIVERSITY OF NORTHERN BRITISH COLUMBIA

June 2011

Library and Archives
Canada

Published Heritage
Branch

395 Wellington Street
Ottawa ON K1A 0N4
Canada

Bibliothèque et
Archives Canada

Direction du
Patrimoine de l'édition

395, rue Wellington
Ottawa ON K1A 0N4
Canada

Your file Votre référence
ISBN: 978-0-494-87569-8

Our file Notre référence
ISBN: 978-0-494-87569-8

NOTICE:

The author has granted a non-exclusive license allowing Library and Archives Canada to reproduce, publish, archive, preserve, conserve, communicate to the public by telecommunication or on the Internet, loan, distrbute and sell theses worldwide, for commercial or non-commercial purposes, in microform, paper, electronic and/or any other formats.

The author retains copyright ownership and moral rights in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author's permission.

AVIS:

L'auteur a accordé une licence non exclusive permettant à la Bibliothèque et Archives Canada de reproduire, publier, archiver, sauvegarder, conserver, transmettre au public par télécommunication ou par l'Internet, prêter, distribuer et vendre des thèses partout dans le monde, à des fins commerciales ou autres, sur support microforme, papier, électronique et/ou autres formats.

L'auteur conserve la propriété du droit d'auteur et des droits moraux qui protege cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

In compliance with the Canadian Privacy Act some supporting forms may have been removed from this thesis.

While these forms may be included in the document page count, their removal does not represent any loss of content from the thesis.

Conformément à la loi canadienne sur la protection de la vie privée, quelques formulaires secondaires ont été enlevés de cette thèse.

Bien que ces formulaires aient inclus dans la pagination, il n'y aura aucun contenu manquant.

Canada

Abstract

I am interested in the experiences of women living with diagnosed or undiagnosed depression and accessing services at the Phoenix Transition House in Prince George. For the past two decades, the universal Canadian health care system has been dismantled and decentralized by neoliberalist economies. These changes drastically affect the regional health services available to women who provide unpaid care, who work for lower wages, and/or who have been victimized by personal violence. This situation creates a 'feminized' landscape of depression and mental health services.

Eight months of participant observation serves as a background for understanding the daily lives of women accessing services at the Phoenix Transition House. Interviews with seven women were digitally recorded, transcribed, and analyzed to yield eight themes. The most pervasive themes were barriers to mental well-being, limited access to mental health supports, unrecognized symptoms of depression, and stigmas related to depression.

Table of Contents

Abstract ii

Acknowledgment vi

Dedication vii

Chapter 1: Women and Depression 1

- Prelude 1
- Introduction 3
- Re-Thinking Marginalized Women 6
- Deconstructing Women and Depression 10
- Gendered Mental Health 12
- Changing the Paradigm: Approaches to Women's Mental Health Experience 14
- Conclusion: Women and Depression 16

Chapter 2: Research Methodology and Methods 18

- Introduction 18
- Participant Observation 19
  - Dilemmas 20
- Journaling 22
- Interviews 24
- Textual Analysis 27
  - Primary Sources 27
  - Secondary Sources 28
- Feminist Ethnography 29
  - Theory 30
  - Aim of Research 32
  - Role of Researcher 33
- Conclusion: Methodology and Methods 34

Chapter 3: Characterizing Federal and Provincial Mental Health Efforts 36

- Introduction 36
- The Characteristics of Federal and Provincial Mental Health Efforts since 1996 39
  - Background of Canadian Health Care 39
  - Health Transfer Program Changes in 1996 40
- The Influence of Neoliberal Ideology on Federal Health Care of Women 43
  - Dynamics of Blame, Neoliberal Ideology, and Kim 45
- Federal Health Priorities, Women, and Mental Health 48
  - Anne's Story is not a Priority 51
- British Columbia Responds: Centralizing Women's Mental Health and Fears 54
- Impacting Women's Mental Health 58
  - Women and Depression: Listening to Francis 61
- Conclusion: Reflecting on Federal and Provincial Mental Health 63

Chapter 4: The Landscape of Regionalized Mental Health in Prince George 65
- Introduction 65
- Regionalized Health Care 67
- Regionalized Mental Health 69
  - Tracy and Nicole's Experience with Regionalized Mental Health 72
- Geography and Prince George: A Context 77
  - The Influence of Place 78
- Gaps in the Landscape of Mental Health Care 80
  - Community Resources Available to the Seven Women 84
  - Gwen and Living with Diagnosed Depression 85
- Conclusion: Regionalized Health Care 88

Chapter 5: Angie's Story 91
- Introduction 91
- Angie: "The Quiet Mouse in the House" 92
- Re-Constructing Women's Mental Health 96

Themes of Fragmentation: Shared Stories of "Falling through the Gaps" ... 98

1. Diagnosed Depression ... 100
2. History Associated with Depression ... 100
3. Dealing with Feelings Related to Depression ... 101
4. Limited Services Accessed for Depression ... 101
5. Mental Health Service Experience ... 102
6. Perceived Barriers to Accessing Mental Health Services ... 102
7. Personal Feelings Associated with Mental Health Services ... 103
8. Support from Family ... 103

Conclusion: Angie's Story ... 104

Chapter 6: Engaging and Supporting Women ... 106

Post Script: Final Notes ... 115

Dialogue between Disciplines ... 115

The Larger Picture ... 116

The Process of Research ... 119

Bibliography ... 123

Appendix A ... 138

Appendix B ... 141

Appendix C ... 143

Appendix D ... 144

Acknowledgment

I wish to thank Dr. Angèle Smith for her support, knowledge, and intellect. I benefitted from Dr. Smith's expertise on spatial and ideological marginalization of women. As well, her commitment to my intellectual development made me a better student, researcher, and ethnographer. I am very appreciative of the guidance Dr. Smith provided me to produce feminist research. I also wish to thank my committee members Dr. Neil Hanlon and Dr. Theresa Healy. My sincerest gratitude to Dr. Hanlon and his invaluable knowledge of health care that provided me with additional insights. Dr. Healy offered wonderful perspectives and creativity, thus making the women's stories richer and more personal. It was a long journey, so thank you!

Thank you to the seven women who participated in the interviews, they provided information selflessly and demonstrated generosity with their time and personal stories. As well, I feel fortunate for the time I spent with the women and children living at the Phoenix Transition House. I also want to thank all the staff who supported my research, answered my questions, and made me feel welcome. I would like to extend a special thank you to: Sharon, Karen, Linda, Carol, Shirley, Sheri, and Brenda who bridged learning and real life so effortlessly.

Finally, I wish to thank all my friends for their continual support. I feel privileged to have such great people, especially Kathy, Alana, and Peter, who promote my mental well-being. I also want to say thank you to my mother, Meredith, for her encouragement. Lastly, and most importantly, to my partner Phil, my step-son, and daughter. I love you all and I know that during this research, I could not always give each one of you the attention you deserved but you never hesitated to give me the love I needed.

Dedication

This work is dedicated to the seven women who shared their stories: Kim, Anne, Francis, Tracy, Nicole, Gwen, and Angie. It is also dedicated to my four year old daughter Séverinne, who provides laughter and joy to my life each and every day.

Chapter 1: Women and Depression

Prelude

SATURDAY, DECEMBER 27th 2008 - Participant Observation Notes (excerpt)

I arrived at the Phoenix Transition House at 9:30 am and was greeted outside by two residents, Rachel and Anna, having a 'smoke'. I asked them about Christmas and was happy when both remembered my name and indicated that their Christmas Holidays went very well. During my last visit to the shelter, I was introduced to three of Rachel's children. Currently, these three reside in foster homes. The children ranging from eight to fifteen (roughly) were well-mannered, eloquent in their speech, and all very beautiful. I had a chance as we all entered the Shelter to tell Rachel it was a joy to meet her children. Rachel seemed pleased. Entering the shelter, I was greeted by a staff member and two women sipping coffee and reading the newspaper in the kitchen. I introduced myself to the weekend staff and entered the office where I found little Robby (six weeks old) sleeping. Robby's mom, Anna picked him up and took him into the living room.

In the office, I learned most of the rooms were full and two rooms were being held for women arriving at the shelter the next day and for another woman, from Prince Rupert, seeking shelter from an abusive relationship. I asked about chores and if I could help out staff but little direction was given. I learned that Saturdays are days that residents relax and staff members make lunch and clean up donations left outside the main entrance. I ventured into the living room where I found Rachel and Anna. Anna was bottle feeding Robby while Rachel made a phone call. I asked more details about Rachel's Christmas and children. Two children had made reference to a present they desired and I learned that the little girl did receive her 'Holiday Barbie'.

I returned to the office where I was asked by Anna to hold Robby while she went out for a 'smoke'. I walked around the adjacent living room and kitchen with Robby. Rachel and I began discussing the smell of young babies. We both agreed that it is intoxicating. When Anna took Robby back, I served myself, Rachel, and staff member large cinnamon buns with cream cheese icing. We sat around the kitchen table licking our fingers and discussing the classes at the College of New Caledonia (CNC). The staff member was a young student at CNC in psychology. We all agreed that classes, in order to stimulate and encourage students to pursue certain programs, needed to be more interesting and 'sexy'. Rachel used her Narcotics Anonymous as a parallel to being in class; she may not know always what is expected but presenting examples to her makes the program more accessible and easier. When the staff member left, Rachel revealed that her last relationship was abusive and her partner was very manipulative. She told me that her husband died four years ago and she started dating his best friend a month after his passing. He introduced her into heavy cocaine use which she said helped her cope with the death of her husband. She said that her family and his family abandoned her after her husband's death, and she could not even get out of bed. The cocaine gave her energy to live and deal with her three children. She explained that she still suffers from depression. I asked if anyone saw the symptoms of depression or drug addiction. Rachel said no, she had always done drugs 'recreationally' on the weekend, but for two years after her husband's death she hid the addiction and mental health *issue. In fact, her physician is one of Prince George's addiction doctor's and she simply avoided him. Rachel explained that she gets migraines so she could never tell her doctor about her addiction problem because then he would deny her migraine medication. Eventually, she and her new partner started smoking the cocaine because she could not get the same high. Our conversation was then interrupted by Anna who wanted to go out for a 'smoke' and asked if I would watch Robby (tucked in his car seat and waiting for grandma to pick him and mom up) while she went outside with Rachel.*

I rocked Robby gently and began another conversation with Edna. Edna is an older aboriginal woman who is soft spoken and very likeable with a compassionate and kind personality. She explained to me that yesterday she had an altercation with an older male in a van. Edna was in her vehicle yielding onto the highway. The car behind her was not watching and almost hit her. Edna was upset because it was a yield sign and both traffic and road conditions were bad so she was being more careful. When she stopped and realized the car behind her was close she got out of the car (to make sure he was ok). She realizes that she compromised her safety at this point and is distressed she simply did not get his plate numbers. I understand he got out of his car and screamed profanities at Edna. She explained that this man screamed these awful words in front of his wife who was in the passenger seat. We discussed the situation and how safety is first and decided that road rage is a problem. No one has a right to treat others in such a manner. Edna left the kitchen as Anna entered and took over rocking her son. I asked Anna her plans for the day. She explained that she was heading to her apartment to spend 'family time' with Robby, her husband, and 6 year old daughter. Anna stated that her daughter goes back to the foster family tomorrow so she wanted some quality time. I asked how things were going with the foster family. Anna said good now but they had wanted her daughter for the holidays and she had been very upset about this. Anna's mother arrived and I helped her out the door with all the baby gear and baby.

As soon as Anna left, Francis arrived and was wandering around the house. Francis arrived in PG five years ago and was delivered to Phoenix where she began her recovery and continues to work on it. You can tell that life for Francis has been rough; there is a physical appearance that seems to stay with women who are survivors of violence, addictions, and poverty. Francis was very engaging as she explained that another resident that was leaving was back on drugs. She knew because of 'the look'. As a staff member helped the resident pack-up, Francis began questioning my presence at the Shelter. She asked questions about what I do, where I work, and who I knew. In order to work or complete research at a shelter, there is a dance (in most cases) that both the staff and residents engage in. I usually wait for the residents to make the first move, a challenge of sorts to which I must respond. My response is then analyzed for value and, from this point, I am either accepted or denied. For Rachel, the dance involved motherhood; not only do I genuinely care about children but I have my own. For Francis, it was my knowledge of social programs and who I knew (residents and staff) at other Shelters and my Northern John Howard work with Sharon, her mentor.

Francis opened up about her life on the streets of Vancouver, while living in the Hastings street area. I only asked one question, "how did you end up in PG"? Francis explained that a bottle picker had found her in a garbage bin. She had been raped, beaten, robbed, and left for dead. She was unrecognizable and spent the first two months in the hospital for reconstructive *surgery on her face. She was sent to the Phoenix for recovery which was slow and tumultuous. Francis explained that she did not even know what to do with a toothbrush or a bar of soap. She even had to be told by staff and shown how to use a fork and knife at lunch and dinner. She said she had been on the streets since the age of 12, where self-care was not a priority. She arrived at the Phoenix weighing 90 pounds and left at 160. She said the staff would take her to all her appointments at first until she could find the courage to do it herself. Francis also admitted she was put in Riverview in Burnaby for a period of time (in the 90's) after her six week old baby died of SIDS. She explained that she brought the baby home, put it to bed, shot up heroine, and when she woke the baby was not breathing. She called 911 and the ambulance attendees told her it would be OK. Two days later she was asked to identify the body. The baby was black and blue and had incisions from head to toe (autopsy I presume). She "lost it" and from there was taken to Riverview. She talked about how prison and an institution was easier, no bills and no stress to live with and sometimes she wants to go back there. She finds it difficult to see the women at the Shelter who are still using because she feels she is leaving them behind. It is her faith that keeps her going.*

As I entered the office for the last time of the day, the door bell rang, and through the security cameras, I could see a female RCMP officer and a young teenage girl. The officer and young girl entered the office and the youth explained she needed a safe place to stay. She had been held hostage for the last five days by gang members because her mother owed them money for drugs. The RCMP found her and since this young girl was familiar with the shelter, she asked to stay at the Phoenix. I learned that she and her mother have been residents at the shelter at various points throughout her lifetime. The young girl was asked if she was 'clean' from drugs, and she said she had not used in the last few days because of being held hostage. The female officer asked her 'to stay safe' and left. She asked to eat before an intake was complete, at which point I also left the office and headed home.

Introduction

The prelude to this chapter took place on my second day of fieldwork, a regular day for the residents and staff at the Phoenix Transition House, and a reader's glimpse into the lives of women, facing multiple barriers and various oppressions, who need a safe space. The following thesis explores *how* seven women experience mental health services in Prince George and the influence of ideologies of gender, inequality and practice. Depression, although highlighted in the media and health care, continues to affect women at an increasing rate. Yet both women and depression continue to be marginalized in the health care system because of ideologies, inequalities, and practices[1] . Although gender-based inequalities in the mental health system have been documented (Denton *et al* 2004), there has been a lack of feminist research about how women, more at risk of depression, encounter and experience services because of these inequalities (Burstow 2005). I focused on women who hold answers about accessibility and support from mental health services, because it is logical to ask individuals if a system designed to provide support is available. The women's lives are shaped by inequalities and barriers that contribute to their risk of depression and their ability to access mental health services and programs. This research is a chance to re-think how funding and service-delivery affect those who want or need access to services. As Cole (1995) notes, recording women's stories gives representation to the diversity of women's experiences and recognizes the "multiple subject-positions generated under even the very particular social, economic, and historical conditions" (188). The landscape of mental health, like other landscapes, is "made by the people that engage [in that space], and in making landscapes, the people themselves are made: their sense of place, belonging, and their social identity is constructed", however, sometimes their participation in making that place is also excluded (Smith 2008a: 13). Although I focused on a sub-population and specifically seven women, their experiences draw attention to the larger picture of gendered mental health inequalities in political, economic, and social structures. Therefore, I examined how federal, provincial, and regional health care systems are immersed in ideologies of gender, mental health, and space to produce structures that limit mental health services rather than promote them. I argue that stigmatization and marginalization of women's health care and mental health needs has "emerged as a dominant ideological framework for legislative policy,

---

[1] Pierre Bourdieu (1930-2002) developed a theory that places the social actor at the centre of social process. Bourdieu argued that persons and social arrangements are created by human agents who assemble their cultures through practice. Practice is about creating, reproducing, and changing structures that both represent and construct the world. Practice is intricately linked to power (Erickson and Murphy 2003).

and administrative actions" (Young 2007a: 1) in both federal and provincial governments. As the federal government decentralizes and decreases health care funding, provinces centralize mental health care and develop policies to minimize costs and force communities to be fiscally and socially responsible for services (Lewis and Kouri 2004; Ward and Bedford 2004). The end result is that particular populations encounter a decrease in services, reduced access to programs, and changing criteria in a continuously under-funded mental health system. So, it is important to challenge "gender-normative notions of who cares, how, and where [as well as] critically assessing health care restructuring practices" (Thien and Hanlon 2009:156).

I wanted my research to act as a tour that begins with my entrance to the Phoenix Transition House, demonstrates how structures designed to target and help women at risk can increase marginalization, and culminates with the stories of seven women. In order to achieve the tour, I incorporated, throughout the paper, my interview notes and many of my participant-observation excerpts related to barriers encountered by women accessing the shelter. As a feminist ethnographer, I recorded the mental health experiences of seven women in Prince George and integrated their words, their experience, and their issues around access into a discussion about political-economic changes (Cole 1991: xiv). Women-centered health research, according to Morrow *et al* (2007), offers practitioners a chance to improve women's health, to understand barriers experienced by marginalized women, and to address issues of inequality practiced in social structures. It is also a chance to resist, reinforce, or transform practices that hinder mental well-being. The women's stories of mental health experiences must be heard, understood, and considered when developing policies, directing funding, and delivering services. The more we study and understand issues around social inequality, the more we realize that they cannot be understood in isolation since they are systemic problems that are interconnected and interdependent (Capra 1996: 3).

In this chapter, I introduce myself, the research, and why it is important to understand how women accessing the Phoenix Transition House experience mental health services. I also explore the prevalence of depression in women, the gendered construction of mental health, and the need for new approaches to women's mental health care.

Re-Thinking Marginalized Women

The Phoenix Transition House is a shelter in Prince George which opened in 1974. The shelter's mission statement is "Working towards Eliminating Violence against Women and Children". Nestled close to downtown on a quiet street, the shelter is unassuming from the outside because of its gray siding, flower beds, and residential location. The only signs that the house could be different are the larger drive way and carport which hosts staff vehicles, a house vehicle, and boxes of donations. The main entrance is located in the carport and monitored by a security camera and buzzer. Inside, the house is larger than expected with three floors. The basement has a storage room, a large pantry, and a laundry facility; the main floor contains a living area, office space, and bedrooms; and the top floor has more bedrooms and a playroom. All three floors are covered with sterile gray hospital laminate; however, it is balanced by a clutter of donated seventies and eighties furniture, craft projects, busy women, and homemade meals. There are 27 beds for women and children, and the shelter offers various programs for the women during the day and night to promote confidence and 'healing'.

Although this was my first time working with the Phoenix Transition House, I have spent the last 10 years working in Prince George with individuals who are marginalized. I recently crossed into the world of academia so I could explore with theories how ideologies of gender, mental health, and space work to perpetuate marginalization. I have watched as girls and women in group homes and shelters, their lives shaped by poverty, sexual-exploitation, homelessness, addictions, and poor mental health, are unable to access quality health care regularly and consistently. The women I worked with vary in ages and backgrounds. However, collectively they are mothers, sisters, and daughters and they are connected by threads of commonality: neglect within social, political, and economic spheres. In many cases, the social structures and environmental spaces surrounding these women have worked to produce depression. According to Smith (2008a, 2008b, 2009) space and inequality govern the location of marginalized people, effectively governing and maintaining their marginality because, "landscape is inherently connected to social relations, power, meaning, and social identity, and because of those it is often a site of contestation" (2008a: 16). Furthermore, there exists minimal examination of mental health allocation of resources, in regionalized health care, has succeeded in fulfilling mandates that respond appropriately to the needs of community-based care (Lewis and Kouri 2004: 25). So, I am curious about why we build structures and spaces, metaphorically speaking, but never explore their foundation. There is value in deconstructing how and why these social structures of inequality are produced and maintained, as well as, why oppressive ideologies that define women's mental health treatment are so prevalent.

So, why am I here? I am here because the research is personal; I am a woman, mother, and front-line worker who has encountered and witnessed almost four decades of discriminatory and violent acts based on gender. I believe that every woman deserves mental well-being. However, I know it is less achievable for women who face daily obstacles such as addictions and trauma and who are also marginalized by socio-economic factors. My privilege is that I am white and a Master's student, who has the opportunity to write about oppression and provide a space for seven women's voices to be heard. I wanted to engage with women and remind them that they are a valuable resource for communities and future generations. I also wanted recognition and an understanding of the daily oppressions encountered by women marginalized that de-value and challenge their participation in society I am here because I enjoy my front-line work and I know there are always alternative ways of seeing life, experiences, and their effects. I want people to re-think and re-examine the approach to women and mental health, as well as the intersecting oppressions and barriers that can lead to poor mental health (see Stuart 2010; Romans and Ross 2010). I admire Burstow (2005), who called herself a feminist anarchist committed to co-building a world where help is not commodified. I would like to use this thesis to co-participate with the voices of seven women and challenge regionalized mental health by examining if there is a disparity in services, especially for marginalized women in Prince George (see Conradson and Moon 2009). It is important to recognize and be held accountable in areas of inequality. My examination of mental health, gender, and space and women's resultant experience is imperative for the kind of social change needed in health care structures.

In my time as a front-line worker, I have witnessed a drastic decline in services and funding for women living with poor mental health. This decline runs parallel to governments moving away from the social welfare net to free market economy. Eliminating services and reducing funding for women living with mental health, demonstrates for society that women's mental health lacks importance. It can take years, even decades to change the unequal practices, gender constructs, and mental health policies that are associated with this particular production line of neoliberal governance. I want to return to front-line work and incorporate the skills and knowledge provided by this thesis.

I chose the Phoenix Transition House because of the Executive Director, Sharon Hurd (now Strategic Planner). I admire her commitment to the advocacy of women. Sharon who recently turned 70, is an attractive woman who I have watched for years, fight for the needs of women and children. I remember, one staff lunch in particular, where Sharon pointed out, "a resident told me that our house curfew makes her think of her husband's control over every move she made and every outing she took". She gave the staff time to absorb the information and continued, "we should consider how we think about rules and the effect on women from abusive relationships". Sharon deconstructed the practices of the shelter and it is a talent I strive to emulate. Therefore, my focus on northern women's mental health provides a unique view of how community practices are influenced by both federal and provincial ideologies, as well as, local constructions of gender, mental health, and space. This group of women face barriers that prevent access to mental health services because of societal ideologies, policies promoting inequality, and health service practices. Yet, these same women never lack attention from the media and government who scrutinize, stigmatize, misrepresent and maintain negative ideological frameworks (see Rose 1998). In Canada, studies involving women and mental health tend to focus on large, densely populated urban areas. My study gives a select group of women in Prince George a space for their voices. Their stories illustrate how regional practices are influenced by gender inequalities, mental health ideologies, and neoliberal policy (see Leipert and Reutter 1998, 2005; Leipert 1999). Those people in charge of developing policies, directing funding, and delivering services must consider and strive to understand women's stories of health experiences in order for the necessary social and structural changes to occur.

Mental health services need to recognize the validity and diversity of a woman's life experience and should be supportive in her choice of treatment and give her the opportunity to achieve mental health, as defined by her (Morrow and Chappell 1999; Morrow *et al* 2007). If women are to recover from depression, mental health services need to address physiological differences, systemic inequalities, ideologies, and social issues, all of which can contribute to poor mental health status (Martin 1990; Hamilton *et al* 1995; Stoppard 1994; Anderson 2000 Women's Health Bureau 2001; Stewart *et al* 2004). My thesis research uses an interdisciplinary approach drawing from the disciplines of anthropology, geography, and gender studies. I wanted to use personal stories to demonstrate how regionalized mental health care services are experienced by a sub-population of women. By examining how theories focused on ideologies of gender, inequality and practice are structured into federal, provincial, and regional health care, I address the following three issues:

1. What are the characteristics of federal and provincial mental health efforts since 1995? Specifically, how have federal transfer programs affected provincial policies regarding marginalized women and mental health services?

2. How has regionalized mental health care changed in the last decade under the British Columbia Liberal government? How is mental health organized in Prince George and specifically what are the facilities and resources available to the women I interviewed?

3. What are the women's stories and experiences with mental health services in Prince George? Who are the seven women sharing their stories and why is it important to hear their voices?

Deconstructing Women and Depression

I chose to examine women living with diagnosed or undiagnosed depression because it affects more women, is treatable, and is caused by a myriad of social, physiological, and environmental factors. Depression is a mood disorder and a perfect example of an individualized response to external and personal factors (Simmie and Nunes 2001; Bentley 2005). A "depressive disorder is characterized by disabling symptoms and is responsible for a substantial amount of disability and suffering" (Greden 2001). The stories of the seven women contribute to a richer understanding of barriers, challenges, and experiences that affect recovery. Depression is considered an illness when feelings of worthlessness and self-blame, and sadness are severe. It becomes a disability when feelings last for several weeks and interfere with women's home life, work and social life. Women with depression experience: helplessness, sleeplessness, over or under eating, lack of concentrating, loss of interest in activities, loss of energy, decreased sex drive, and avoidance of others. Currently, treatment for depression includes medication, psychological counselling, self-help groups, and support from family and friends (Canadian Mental Health Association 2006). Interestingly, these treatments are often not available or accessible to women accessing services at the Phoenix Transition House who do not have a physician, money for medication, extended medical coverage, or a 'healthy' support network.

Research indicates that women and adolescent girls are at higher risk for depression than their male counterparts, with a ratio of 2:1 (Health Statistics Division 1998; Gagnon and Patton 2002; Parry *et al* 2006:18). There is also a link between physical and/or sexual abuse of women, substance abuse, and mental ill health (BC Women's Hospital and Health Care 2008). As well, women use mental health services more often than men, however, those services continue to overlook the specific needs of women (Simmie and Nunes 2001). There has also been little examination of why depression, eating disorders, and borderline personality disorders are diagnosed more frequently in women. These higher rates of mental health issues in women may reflect the differential impact of socio-cultural factors, as well as, gender-specific patterns in seeking help (Morrow 2003). Often experiences with diagnosis reflect assumptions about women rather than the appropriate assessments of their health problems, and such misdiagnosis can be perpetuated (Armstrong and Armstrong 2008: 83). According to Harraway (1991), women's health is a concept in the making because cultural constructions are entrenched in scientific and medical understandings in which gender has "interwoven modern histories of colonial, racist and sexual oppression" (13). There also exists a "disconnect between the kind of care women with depression seek and that which is available [...]. Counselling, information, support, protection from violence and help with access to housing, training, and income supports" are needed (Parry *et al* 2006: 19). Although women with poor mental health often have experiences with male violence and abuse, mental health policy and practice does not prioritize safety because it is gender specific and there has been a lack of recognition of gender as a determinant of health (Morrow *et al* 2007: 10). Even if women are seeking treatment, they may not find recovery due to limited services or limited access.

Gendered Mental Health

Freud used the dictum 'Anatomy is Destiny' to explain gender roles. Its notoriety and acceptance enabled a medical society to use gender stereotypes unchallenged (Morrow 2007b: 36). Historically, medical and health sciences were dominated by male researchers and practitioners in the 19th century, who focused on the needs and concerns of men. Medical practices used men's bodies as the 'standard', thus organs, health issues, diagnosis, and treatment became 'naturally' endowed with gendered traits. The male body was seen as ordered and contained, reflecting strength as a male characteristic (Broverman *et al* 1970). In opposition, the female body was 'messy' due to menstruation, lactation, and birth. This construction of female physical traits was associated with disorder and a need for regulation which was linked to mental states of irrationality and hysteria (Martin 1997; Morrow 2007a: 35). 'Weaker' states of mental health such as melancholy and depression became feminine traits. The association of gender and depression clearly and purposely neglected women's determinants of health such as social inequalities and violence (Busfield 1994, 2000; Morrow *et al* 2007).

Butler (2007) counter argued Freud's dictum, 'biology is destiny'. She argued that "the distinction between sex and gender serves the argument that whatever biological intractability sex appears to have, gender is culturally constructed: hence gender is neither the causal result of sex nor as seemingly fixed as sex" (8). According to Butler (2007), gender is not equivalent to culture just as sex is not equivalent to nature as once purported by Ortner (1974) but that "gender is [...] the discursive/cultural means by which 'sexed nature' or 'a natural sex' is produced and established as 'prediscursive'" (9). Therefore, depression is not a result of gender but the result of discursive and cultural structures that have established the 'natural sex' of women as being depressed. The idea of an established "sexed nature" is supported by Scheibinger (1987) who wrote that female representation in medicine during the eighteenth century was defined by women's position in society and the maintenance of social positions. So, when women fought for equity, medicine found physical and mental differences in anatomy, a "discourse of representation for female inequality" (42) that could be practiced in structures designed to provide health. Deconstructing women's inequality, once seen as truth, in medical structures is a key to understanding the "culprit in the scrutiny, surveillance, domination, control, and exertion or authority over the body [...] of women" (Martin 1997: 69).

Although, the 'making'[2] of women's mental health is constructed in structural, discursive, and material inequality, I do not want to imply subjects are passive (Ortner 1996). My intention is not to suggest, as others have argued, lack of agency on women's behalf but rather to

---

[2] A term I have appropriated from Ortner (1996).

demonstrate how the construction of structures (physical and social), negotiates agency and the making of women's experience of mental health services. 'Making' then becomes a re-appropriation of a term for women to understand their own agency. Simone de Beauvoir (Butler 2007) suggests "one is not born a women, rather, becomes one" (11) believing in both cultural construction and agency. I argue that construction of inequality is a powerful obstacle, and agency difficult to find, especially for women living with symptoms of depression and various oppressions. This is why it is valuable to understand the vantage point of women accessing services at the Phoenix Transition House. Women's strength in recounting their experiences with services illustrates their agency through which they 'make' and defy construction. According to Gramsci (1972) hegemonic inequality in political, social, and economic structures are dominated by ideologies. Dominant structures then use persuasion, consent, and force on marginalized groups to create acceptance (see also Glendill 1997). Even though Gramsci (1972) never discussed gender or feminist perspectives, this argument denies agency and denotes a space where cultural meanings are only inscribed (Ortner 1996; Butler 2007). Resistance and 're-making' is difficult, though not absent, for women from a disadvantaged location rather than Ortner's subjects' elite locations. This is why I want a space for the voices of women to share their own stories.

Changing the Paradigm: Approaches to Women's Mental Health Experience

Deconstructing gender ideologies and mental health in relation to theories of power and inequality is integral to understanding the structuring of the Canadian health care system as a whole. Although 'woman', as a category, has varied across space and time, it continues to be linked to women's social position in society (Moore 1988: 12). Gender continues to be an implication that an already sexually differentiated body exists. Women are marked by gender and thereby defined in terms of their sex and not their personhood (Butler 2007:13). The production of knowledge and the maintenance of structures, according to Harraway (2003), are influenced by power not truth. The idea of objectivity, scientific method, and knowledge is therefore constructed. Only in the late 20th century were ideologies around mental, cultural, and social structures examined for how the acquisition of scientific knowledge involves power differentiation (see Kuhn 1970; Gramsci 1972; Giddens 1979; Foucault 1980; Bourdieu 2001). Kuhn (1970) theorized that science does not necessarily progress towards clearer understandings but gives answers that are deemed appropriate by a scientific community, who ultimately control the knowledge. Kuhn called this group collaboration a 'paradigm' in which, just like ideologies, scientific revolutions become absorbed into our past and present understandings. These authoritative discourses or paradigms, whether neoliberal ideology, mental health care practices, or gender inequalities, exert power and define what society accepts as objective truth and scientific knowledge. Social institutions and structures become 'discourses of power'; shaping all relations, where some control and others become controlled. Foucault (2002) understood power as intricately linked to knowledge which creates and causes new objects of knowledge and new bodies of information. Anthropologists have claimed that privileging this form of knowledge leads to forms of representation, "impoverishing the complex whole that actually exists" (Martin 1990: 69). Therefore, using feminist ethnography to present a more complete picture is necessary for seeing more of the story and the larger picture. Part of the story is deconstructing structures and demonstrating to an audience how practices within social institutions affect marginalized women. One way to do this is to re-examine these issues from a feminist's perspective. Feminist theory then provides a direction for rethinking the conventional understanding of 'women' and mental health (Butler 1999:50) toward an understanding of how depression is an individual lived experience shaped by spaces (Smith 2008a).

Conclusion: Women and Depression

THURSDAY, JANUARY 1st 2009- Participant Observation Notes (excerpt)

Anna came into the house and asked if I would hold baby Robby, he immediately started to cry and fuss (nuzzling included). I knew he was hungry and asked Anna if she could make a bottle for Robby and I would feed him. Anna sat down at the table and relaxed while I held and fed the baby. She said she was tired from the night before because Robby did not sleep well. She said that her husband, Allan, is at St Patrick's for addictions counselling and the Ministry of Children and Family Development (MCFD) will not let them return to their apartment with the children yet. She said she feels like a single parent. I learned that Robby was three weeks early because his twin died in uterus so an emergency c-section was performed. Anna told me she used to have a great MCFD worker that went beyond work expectations and genuinely was concerned for the whole family's welfare. The new social worker has not even met her daughter and has been the family's worker for over four months. We talked about the expectations placed on her for recovery and parenting while living at the shelter with a newborn, her daughter in foster care, and her husband unable to help her, Anna exclaimed "having a baby and then being placed in a shelter without family support is difficult"!

While examining mental health practices is not new, a re-examination of marginalized women's mental health experiences from a feminist perspective is less well understood. The fact is that gender and economic inequalities in health and mental health care exist (Morrow *et al* 2007:3) and require a closer examination. According to Parry *et al* (2006), gender-related-services, especially for women at higher risk, need to shift in ideological framework and foster new practices. It is ironic that the physical, social, and economic experiences that are associated "with being a woman in this society [not only] contribute to depression" (18) but also inhibit access, services, and ultimately recovery. There needs to be an acknowledgement that a variety of factors influence women's mental health. These factors are called 'determinants of health' and they exist within the individual, within the family, and within the broader community such as the economy, education and housing.

The purpose of the following thesis is to re-think how mental health care is structured and the services provided to marginalized women with increased risk of depression. In Chapter Two, I explain the methods I employed to accomplish my research and why a feminist ethnographic approach was integral for this thesis. In Chapter Three, I examine how federal and provincial health documents and policies, even those with the intent to provide services for marginalized women, can foster disparities and be ineffectual for women seeking help for depression. Chapter Four examines how regionalized mental health care is influenced by federal, provincial, and localized ideologies of gender, inequality, and practice. I discuss how regionalized health care has changed access to mental health services and the influence of the physical northern landscape. In Chapter Five, I introduce my key interviewee Angie and analyze the stories and experiences recorded in my interviews with the women. Lastly, in Chapter Six, I reflect on the research and my findings of gendered mental health in Prince George.

Chapter 2: Research Methodology and Methods

Introduction

Like many feminist researchers, committed to "redressing the sexist imbalances or masculinist scholarship" in ethnography, I selected my research project on "substantive grounds and personal interest" (Stacey 1988: 115). I wanted to listen to the stories of women, marginalized by poverty, addictions, and lack of extended care, and see if they were being provided mental health services. I used feminist ethnography to write a more personal, complete, and richer picture about seven women's access to mental-health services in Prince George (Moore 1988; Stacey 1988; Gibson-Graham 1994; Cole 1995; Harraway 2003; Lyon-Callo 2004). I decided to examine the connection between ideologies of gender, inequality, and practice structured into the health care and the resultant mental health service provision for marginalized women. I wanted to know if there exists complacency in the acceptance around the practice of 'scientific truth and knowledge' (Kuhn 1970) in the form of treatment provision, and accessibility to services.

In the following paragraphs, I discuss my approach to feminist research methodologies in the project. I review methods of data collection I used in order to learn about general experiences of women accessing the shelter and specifically the stories of seven women using 1) Participant Observation; 2) Ethnographic interviews; and 3)Textual analysis of policies and practices. The remainder of this chapter focuses on the methodology of feminist research and the role of the researcher.

Participant Observation

My fieldwork at the Phoenix Transition House started in December 2008 and ended in September 2009. I entered the shelter with a preconceived idea that because of my extensive background within the social sector, I would gain acceptance from residents, gain the women's confidence (humorously, through my 'wonderful' personality and my baking wizardry), and in March 2009 start my interviews. My committee members had valid concerns regarding the original and shorter participant observation time-frame. They suggested more time to gather a richer source of ethnographic data, gain insight into the lives of women, and understand how to approach the women when asking them to participate in an interview. Their influence and guidance resulted in the participant observation time-frame being extended and interviews occurring when I felt integrated into the shelter's daily routine, comfortable with the residents, and ready to ask women for interviews. The outcome was more complete stories and interviews with women who I knew personally.

Participant observation helps a researcher understand the dynamics of how people relate to one another. It helps the researcher recognize patterns of etiquette, political organization, leadership, social competition, cooperation, and hierarchies (Lecompte and Schensul: 1999). It helped me understand many of the personal barriers encountered by the women using services at Phoenix Transition House. It also helped me develop a rapport with the women I would interview and understand how the women exemplified the larger issues concerning health care and mental health care in Prince George. The time I spent with the women and children informed my exploration of women's specific needs (including housing, violence, and covered medical expenses) as I conducted my textual analysis. I used participant-observation excerpts in areas of this thesis to provide the audience with insight between text and the reality of oppressions.

According to Schensul *et al* (1999), participant-observation is a process of learning "through exposure [and] involvement in the day-to-day routine activities of participants in the research setting" (91). I used a combination of extended duration of time, interacting with the women and staff, contributing to household chores, and participating in activities to provide me with a wealth of notes and insight.

I established a schedule at the Phoenix Transition House of three consistent shifts for the first two months of the participant observation. After two months, I scheduled two shifts a week to meet the needs of my family and job. Those two shifts were Wednesday and Thursday night where I 'paid my dues'. During these shifts, I cleaned kitchens, washed floors, tidied playrooms, prepared meals, watched supervised MCFD visits, burned cookies, changed diapers, cared for infants and children, and heated baby bottles. I also laughed, joked, played cards, baked cakes, made crafts, coloured with children, went for coffee, and made friends.

The 'Participant' Component of Participant-Observation

THURSDAY FEBRUARY 26th 2009 Participant-Observation (excerpt)

I found Josie's mother curled-up in the fetal position holding her baby and crying. I asked if I could take Josie downstairs for cookies and milk. We ate cookies and coloured. The little girl asked me, "can I come home with you"? I responded with "you need to stay here with your mommy but I will color with you next time". She replied "PLEEEEASEEE".

Dilemmas

According to Stacey (1988), the difficulty encountered by other researchers and by myself is that fieldwork and:

> Participant observation represents an intrusion and intervention into a system of relationships, a system of relationships that the researcher is far freer than the researched to leave. The inequality and potential treacherousness of this relationship seems inescapable [...]. The lives, loves, and tragedies that fieldwork

> informants share with a researcher are ultimately data, grist for the ethnographic mill, a mill that truly has grinding power (117).

According to Wolf (1996), feminist dilemma in fieldwork revolves around power, often displaying conflicting, difficult, and contradictory positions of the researcher. This power dimension is "threaded throughout the fieldwork and post-fieldwork process" (1). As for my difficulties encountered while performing fieldwork, I had two residents and three staff members question my integrity and my intrusion. The staff members asked to view my consent forms which I happily supplied. I had one resident, Natalie scream 'confidentiality' at me as we were introduced. As well, Francis explained to me that the label 'researcher' fosters distrust for her, even after five months of participant-observation. Francis also told me "you don't look like you should be here or work here". Like other researchers, I struggled when I entered the fieldwork with how to represent myself in regards to dress, class, and connections to staff (Wolf 1996). Ironically, even though Francis challenged my presence as researcher and was clear that she hated researchers, she agreed to be my fourth interview. The following excerpt occurred with Francis. I thought I had established a small level of confidence with her:

THURSDAY MAY 7th 2009 Participant Observation (excerpt)

Francis came into the office and made a derogatory comment to me about being a researcher. I asked her to explain the "you researcher types" comment. Francis talked about the abuse of women living on the streets at the hands of researchers. How they give women 20 dollars to participate in sharing their sexual encounters while prostituting. Francis questioned me about the integrity of consent, when women are high or need the money to get high, "fuck, I would fucking give a blow job for $5 and with $20, I would stick the needle in my neck once I had the money". I explained to Francis that I do not pay for women to participate.

Issues of power and 'researcher' as intruder, became very 'real' when I attended a Grief and Loss Support Group on Christmas Eve 2008. I remember one woman in particular. She recounted the story of her previous Christmas with her children, who are now in the Ministry of Children and Family Development care. Her body shook and trembled as she cried telling the story. I decided not to attend any more group sessions because the information was intensely personal and emotional. I decided to focus on individual interactions and communications that occurred during evening activities.

Journaling

During the process of research, writing, and fieldwork, I kept two journals. The first journal was a hard covered black book where I documented all the meetings with my supervisor, our discussions, and my goals. I used the information in the black book to keep me focused on my research objectives and to reflect on my intellectual journey. The second journal I kept detailed my participant-observation. This journal was electronic and documented my experiences with the staff and residents at the Phoenix Transition House. My electronic journal was password locked on my home computer to ensure security. At first, I thought I would maintain two distinct electronic journals. In the first, I intended to describe the number of women, the age of children, their backgrounds, and where, how and why conversations took place. In the second electronic journal, I intended to write my personal reflections. However, in order to have complete backgrounds on the women and children, I would either require access to their files, which would be unethical, or I would have to be completely intrusive during my conversations. As well, it was unrealistic to think that I could keep my own feeling separate. I decided to keep one electronic journal and simply write about what I observed and the information freely given to me by the women during our conversations. With one electronic journal, I could write more efficiently and honestly, even if the writing was influenced by emotions. I compensated by highlighting sections that were my personal feelings in yellow, my perception of a humorous activity in pink, sad moments in blue, and anything that could influence the research in red. The color-coding opened up my writing to self- scrutiny and an examination of how my feelings, ideologies, and personal experiences could influence my writing and the participant observation notes. As well, as the next two excepts demonstrate, the writing also gave me a chance to explore how the research influenced my own life and vice versa:

SATURDAY FEBRUARY 7th 2009 Participant Observation (excerpt)

Today was slow and exhausting. I believe I have to re-think the shelter schedule if I am to continue working on notes and school work. I know that I am only there three days of the week but between my own children, job, house cleaning, and notes, there is little left for 'breathing'. I feel that I am expected to carry much more of the housework and childcare than my partner. Last week he was late getting home so I was late getting to the shelter. When I suggested that a phone call next time would be helpful, he replied "you're just volunteering, who cares if you are late". Aghhh!

MONDAY APRIL 27th 2009 Participant Observation (excerpt)

I have accepted another contract in order to pay for school and daycare. The added daycare will allow me to have at least have one morning to do school work. Currently, I have my two year old daughter all day, I take my step-son to Kindergarten, work Monday and Tuesday evening, participate in fieldwork Wednesday and Thursday evening, and do school work only a few hours on weekends. My school work and fieldwork are a constant source of tension.

At the end of my fieldwork, I had 80 pages of single spaced participant-observation notes saved on my computer. Each page represented glimpses into the lives of many women and their stories ranged from the sad to the funny, yet, they are often overlooked. At the end of my thesis and writing process, my black book was full of ideas, arguments, conversations, and desired outcomes that I discussed with my supervisor. I recognized that both these journals operate as the marrow of the research, the 'real' expressions of life lived and processes of examining marginalization. The journals represent simple and concrete demonstrations of the experiences of women, myself, and my supervisor as we encountered and experienced ideologies of gender, inequality, and practice.

Interviews

Interviewing seven women, who are marginalized and impacted by social and economic barriers, provided an illuminating case study for understanding mental health delivery for a particular sub-population within a northern regionalized health care system. The purpose of this feminist ethnographic research was to record the stories of these seven women and understand their access to mental health services in Prince George. It was an opportunity to explore, through stories, lived experiences of inequality and themes of gendered mental health access. With the approval of the University of Northern British Columbia's Research Ethics Board, permission from the shelter, and consent from the women accessing the Phoenix Transition House (see Appendix A), I conducted the interviews based on the guidelines set out by the UNBC Ethics Review (see Lecompte and Schensul 1999: 189-190). I wanted to ensure the research was conducted in an ethical manner and participants understood consent. I interviewed seven diverse women for this project: Kim, Anne, Francis, Tracy, Nicole, Gwen, and Angie. I asked eight women but one woman was unable to participate before her departure from the Phoenix Transition House. For Stacey (1988), textual analysis without stories is incomplete and unsatisfactory for the reader. It is the hands-on, "face to face research experience [that is] more compatible with feminist principals" (115). To promote anonymity and confidentiality and not expose the private lives of women living in Prince George, I asked the participants if they wanted pseudonyms. Four of the women chose anonymity. I kept all interview documentation in my home, in a secure location to be destroyed when the research was finished.

My intention was to use a chain referral selection in order to find other participants once an "index" individual with specific criteria was found (Schensul *et al* 1999: 241). However, I found using chain referral challenging because women were constantly entering and leaving the shelter, therefore, connections between residents were short in duration. Women who resided at the shelter for longer periods of time were attending recovery programs and busy, therefore, it limited relationships. I also observed that connections formed between residents conformed to 'smoking buddies', 'recovery program buddies' and 'room-mate buddies'. I changed my approach and asked women to participate in the interviews who I had developed a rapport with during my participant observation. Furthermore, the support of Sharon Hurd, the current Strategic Planner and past Executive Director, solidified the interview with Francis and a staff member named Shirley[3] helped secure interviews with three other women. I learned that while fostering relationships with the women accessing the Phoenix Transition House was vital, it was also extremely important to be engaged, passionate, and develop ethical and professional relationships with management and employees who the residents considered trustworthy, fair, and honest.

I used semi-structured interviews and covered a list of topics with the women that I interviewed (see Appendix B). According to Bernard (1995), this interview style is ideal when a researcher may have only one chance to perform the interview. Since access to the women changed on a daily basis, this was the best choice. I had one interview in April 2009 with Anne, one interview in May with Angie, and the other interviews occurred in July and August 2009. The interviews were conducted at four different locations, the Phoenix Transition House, Second Cup, Kim's home, and Gwen's home. Each interviewee provided consent to the interviews being recorded and transcribed so I could understand themes of mental health access. While my preference in conducting an interview was in a quiet office at the Phoenix Transition House, this was not always possible because of groups, children, scheduled one on one's in the office, and

---

[3] Shirley, a staff member at the Phoenix Transition House, provided me with consent to use her real name.

the general busy nature of the shelter. So, the interviews were completed with distractions occurring. However, when I conducted the interview in a public space, such as Second Cup, I kept the tape recorder in a pencil case so other patrons were not aware of the interview.

The interviews were generally about 40 minutes to an hour long. I gave the women a copy of the consent form, an information sheet about the research, and a copy of the 25 questions I intended to ask. I reviewed all the forms with the women. Tracy was the only interviewee unable to complete all the questions because she started to experience an anxiety attack, at which point, I turned off the tape recorder and we changed the topic of conversation. However, because of my fieldwork at the Phoenix Transition House, I was able to contact all women after the interview, except Anne, to ensure I understood what they were saying after a review of the conversation. Follow-up interviews were completed with Gwen, Kim, and Angie. Upon reflection, fine-tuning and more practice would have produced more information. I discovered interviews require finesse and skill on the part of the interviewer. As well, interviews can often be “poignant, funny, and informative” as well as emotionally “painful” to hear (Healy 2001: 9). However, the time I spent participating at the Phoenix Transition House created the situation where I knew the women, therefore, there was a level of comfort between the interviewee and myself.

I started each interview with a general conversation about the weather, children, or activities to add to a relaxed atmosphere. During the interview, I asked simple questions, such as “Do you have a physician?”, “Have you ever felt bad, sad, or blue for more than two weeks?”, “What mental health-care services have you been offered?”, and “How do you feel about using mental health services”? The intention of using open-ended questions was to allow for an expansion of the topic. However, in hindsight simple and direct questions would have worked better because the women often asked for concrete examples when the questions were open-ended. All the interviews were followed-up by taking the women for coffee, except for Gwen and Francis. Francis did not have time but she did ask that I accompany her clothes shopping which I followed up by emails but her schedule was always too busy. Although Gwen wanted to go for coffee, she was busy with children. I also purchased, with permission from Sharon Hurd, each woman a small 'thank you' gift.

Textual Analysis

In order to understand the political and economic structure of women's mental health, I needed to examine how the structure of health and mental health was influenced by gender, inequality, and space. I wanted to connect ideologies of inequality to federal and provincial health policy in order to demonstrate how cultural ideals perpetuate mental health service disparities (see Bailey and Gayle 1993, 2003; Eagleton 1994, 2000). Lorber and Moore (2002) wrote that health is shaped by cultural and moral values, yet influenced by the hegemonic belief about well-being. Therefore, I needed to demonstrate a relation between hegemonic ideas and the discrepancies in women-specific mental health needs. I could then ask the question, if women's place within the social structure determines treatment modes and produces a paradigm of legitimate medical knowledge, are women's mental health needs truly being addressed?

Primary Sources

In order to understand the mental health services available to marginalized women living with depression, I used my participant-observation notes, my discussions in my black journal book, and interview notes to identify the issues of limited access. I also used provincial and regional health related document such as the *Select Standing Committee on Health Report: Patients First 2002*, the *Depression Strategy 2002*, and *Let's Talk About Addictions and Mental Health Community Report 2007*. I also used more local resources such as the Crisis Centre Resource Book, computer searches, and resource pamphlets. These resources were community-oriented and intended to target local individuals requiring mental health services in Prince George. These information sources were limited, however, they presented a picture of mental health service delivery in Prince George.

To examine the reason for limited mental health resources available to women, I located research completed by women's advocacy groups. The documents focused on the lack of support from federal and provincial mental health policy. However, they all discussed how women's mental health needs continue to be ignored, creating discrepancies in mental health care especially for women living in rural and northern locations (Morrow and Chappell 1999; Denton *et al* 2004; Parry *et al* 2006; Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions 2006; Morrow *et al* 2007). The documents confirmed that women- specific barriers increase the likelihood of developing mental health issues, yet mental health policy is gender neutral, and thus not compensating for the gender-specific needs of women. These documents were also written specifically as recommendations for regional health boards and governments to improve mental health policy-making.

Secondary Sources

To confirm primary sources, I used secondary sources that characterized federal and provincial mental health efforts since 1995 such as the *Health Act*, the Canadian Health and Social Transfer (CHST) program, and *Best Practices*. I examined where and how women's specific mental health needs were being discussed and addressed. As well, I wanted to know how mental health services were being provided during this era of federal decentralized health care. I then looked at how geographical location, specifically Prince George, contributed to the development of women's mental health programs and if this coincided with the vision of regionalized health care.

In order to understand how health care, as a structure, is influenced by inequality and gender discrimination, I looked for academic writing on the subject. I used theories in feminist anthropology (Scheibinger 1987; hooks 1984; Moore 1988; Martin 1997; Butler 2007) to understand how historical ideologies of women's mental health influence today's mental health service- delivery. Theorists, such as Bourdieu (1990), Foucault (1980), Kuhn (1970), supported the idea that knowledge is enmeshed in the practices of power, the social government, and the management of individuals. Even when new information emerges, it can be confined to past practices of inequality and ideology (Kuhn 1970; Gramsci 1972; Foucault 1980, 2000; Bourdieu 1991). I wanted to link these understandings of gender and knowledge to federal and provincial health policy, as well as to the limited resources available to marginalized women living in Prince George.

Feminist Ethnography

Feminist ethnography is not simply about the seven women in the research but how they are part of ideologies, structures, space, and relationships related to their access to mental health services. Smith (2008a) incorporates Lovell, into a discussion about how "people themselves become synonymous with their geographical locality, ultimately constructing a heightened sense of meaning of place while also creating a boundedness to the social unit on the landscape" (17).

Gibson-Graham (1994) used the term “discursive destabilization” (140) to describe the political project to dismantle dominant hegemonic practices and reclaim the experience of the participants. By using feminist ethnography, I incorporated the women as collaborators in the research, through their narratives and stories. However, while ethnographic research is full of substance and “depends upon human relationship, engagement, and attachment, it [also] places research subjects at grave risk of manipulation and betrayal by the ethnographer” (Stacey 1988: 117). This internal conflict is an inescapable feature of ethnographic method. I was conscious of power-imbalances between the women and myself and I thought of this often when I spent time with Angie, my key interviewee, who I introduce in the chapter five. Angie opened up so unabashedly with earnest and heart, however, the reason we formed the relationship and the reason Angie divulged the information was for my research. In engaging with Angie and others, I discovered that there would always be “conflicts of interest and emotions between the ethnographer as authentic, related person (i.e. participant), and as exploiting researcher (i.e. observer)” (Stacey 1988: 118).

The time spent at the shelter and with the women was personal, intimate, and real. Although objectivity has been promoted as idealistic, it is unrealistic and biased in its own assumptions of truth and uncomplimentary for my research. To be void of emotion was impossible and unacceptable to me. These emotions were valuable and needed to be re-examined when writing notes, interviewing, and re-telling their stories and experience.

Theory

By using feminist ethnography, I could tell the stories of the women I interviewed. Ideally, I wanted this thesis to change how people think, believe, and act towards women living with depression. Using feminist theories was a strategy of focusing on the desire to end inequality (Scheibinger 1987; hooks 1988; Moore 1988; Martin 1997; Butler 2007). The privilege of feminist research and feminist ethnography was in that "feminist objectivity makes room for surprises and ironies at the heart of all knowledge production" (Harraway 2003: 369). Feminist ethnography, similar to women's mental-health, has been undervalued for years. Feminist ethnographers promoted "innovative, dialogic, reflexive, and experimental" writing that audiences found refreshing (Behar 1995: 4). According to Harraway (2003), there existed a power game, where feminist researchers fought "an imagery of high-tech military fields" and battled over socially negotiated reality and validation in the presentation of history, stories and writing (362). Feminist research is thereby able to generate rich descriptions about the relationships involving gender, culture, and how people think, believe, and act "that are situated in local time and space" (LeCompte and Schensul 1999: 8). This creates a valuable space, especially for women marginalized, for their stories to be told and heard.

I used feminist ethnography to observe themes that affected seven women's access to mental health service. As well, I was also able to write about 'moments' in the lives of other women using services at the Phoenix Transition House and incorporate the barriers they experienced in accessing mental health services. According to Visweswaran (2003), "ethnography foregrounds the question of social inequality vis-à-vis the lives of men, women, and children" (593) Similarly, Lyon-Callo (2004) describes an "ethnographic account [as a] detailed, thorough method for exploring my questions about the seeming acceptance and about how issues of [gender, inequality, and space] seemed to be transformed into issues of individual pathology" (Lyon-Callo 2004: 21). Ethnography is a place to write interesting stories with multiple perspectives of truth (Visweswaran 2003). According to LeCompte and Schensul

(1999), ethnography is "an approach to learning the social and cultural life of communities, institutions, and other settings" (1). It is a scientific mode of investigation where I, the researcher, am used as a primary device for data collection to build on the perspective of the people in the research setting (LeCompte and Schensul 1999) and share their stories.

Aim of Research

My research aimed to demonstrate that the construction of gender coincides with difficulties, although both similar and different, for seven women and their access to mental health service. I wanted to contribute to the "development of theories relating to gender identity and the cultural construction of gender, [or more clearly], gender as a principle of human social life" (Moore 1988: 187-88). I chose Prince George and women accessing the Phoenix Transition House because I wanted to know, without marginalizing further, if there existed mental health delivery imbalances to women of this subculture (Lyon-Callo 2004; Moore 1988). Feminist anthropology acknowledges there is no unity or universality in the perspective and construction of gender. It is the differences in cultures or subcultures that create the meaning of woman. I wanted to use the seven women's stories to demonstrate that ideologies of gender and inequality have serious individual consequences. Feminist anthropology recognizes that fundamental differences exist between women and those differences need to be theorized (Moore 1988: 189-193). So, while women do share similar difficulties and "experiences worldwide; it is simply that these similarities must be demonstrated and specified in each case, and not assumed" (Moore 1988: 198).

Feminist anthropology takes as its subject, not women, but the implications of woman and while it does not "purport to speak for women, it certainly speaks extensively about women"

(Moore 1988: 186). I wanted issues that affect the seven women's access to mental health service to be brought to the forefront. Examining the relationship between gender and ideologies was critical in understanding to the interaction of cultural, class, race, and history processes (Moore 1988: 187-192) and development of mental health care in Prince George. I used feminist ethnography to bear testament to the disparities and injustices of systemic discursive processes (Behar 1995; Visweswaran 2003) that produce experiences of mental health systems. When I figuratively 'pulled' myself out of the subculture focus, I examined the systemic "discursive processes" (Lyon-Callo 2004:19) that produced and legitimized mental health systems of care.

Role of Researcher

My role was to look for ways to better represent women lives more truthfully. I was to document the experiences of marginalized women and specifically the seven women I interviewed. I wanted to write with passion and deconstruct claims of 'fact' within policy and public structures. According to Behar (1995), the researcher is a necessary form of witnessing which is complemented by ethnography. However, Behar (1995) wrote, for her, there exists a fear of the researcher "observing too coldly" (3) or creating a barrier between the tape-recorder and participant. My role was to continue to navigate the slippery slopes (Harraway 2003) of research and experiences feelings of despair and powerlessness interacting and writing about participants that I could not help. This is another issue that Behar (1995) found challenging, should we tell the story of despair or turn away because the information is so intensely personal? It was my job to recognize my personal feelings and redirect the focus to the women. I spoke at great lengths with my supervisor about my own reservations, however, the fact remained that the story needed to be seen, told, and heard.

There should be no surprise that my background and relationship with the women informed my writing. When I put myself into the research and lives of the women, I was a witness and feminist anthropologist. I used feminist ethnography to bear testament to the disparities and injustices of systemic discursive processes (Visweswaran 2003) that produce experiences of mental health systems. My role was to see the interconnections between marginalized women living with depression, Canadian health care, and the mental health system.

Conclusion: Methodology and Methods

This chapter challenged me to examine my own accountability and ethical dilemmas in relation to the research, the research population, and my own position as researcher. Most of these women were in distress, they were facing court cases, battling addictions, mending wounds, dealing with abuse, living with the loss of their children, and fighting to survive. I witnessed these events with a tape recorder and consent forms ready. Therefore, I needed to be cognizant that the same ideologies of practice, inequality, and gender that foster disparities in mental-health services naturally exist in my relationship to the project and the research population.

In the following chapter, I examine how federal mental health efforts since 1996 have influenced the provincial delivery of mental health care. The chapter demonstrates how the historical ideologies of gender and depression, continue to be structured into health care that influence policies and practices surrounding women's mental health. When the federal and provincial government create policy related to mental health, they implement programs or re-direct funding that is restrictive and punitive. Therefore, structures presenting the image of better mental health still function within ideologies that perpetuate social inequality (Lyon-Callo 2004).

Chapter 3: Characterizing Federal and Provincial Mental Health Efforts

What are the characteristics of federal and provincial mental health efforts since 1996? How have federal transfer programs affected provincial policies regarding women and mental health services?

SATURDAY, JANUARY 10th 2009-Participation-Observation (excerpt)

I was in the kitchen and helping with lunch, which was homemade soup, when I heard the door bell ring. A staff member opened the door and two women and a little girl entered. I watched as they dragged belongings into entrance and the little girl said "bye Grandma".

Introduction

Mental health continues to be marginalized within health care, despite the fact that it affects one in five Canadians and causes severe social, employment, and economic implications (Canadian Association of Mental Health 2005). Since women are at greater risk of interpersonal victimization such as childhood abuse, partner abuse, and sexual abuse, their rates of living with mental health increase while their ability to access services for depression decrease. Theories related to gender inequalities demonstrate that historically, gender and mental health have been intricately linked. For example, during the nineteenth century 'hysteria' and 'nervous' disorders were associated with the uterus and ovaries, thus promoting women as non-persons who could be denied voting rights, equality, and education (Ehrenreich and English 1978; Lerman 1996; Nicki 2001). This ideological link between gender and mental health persists and allows women to be pathologized, over-medicated, and their specific needs undervalued. In fact, for much of the 20th century, professionals in health care were defined by their skill set and adhering to practices of their peers (Armstrong and Armstrong 2004). It clearly shows that the structural barriers, experienced by women, such as poverty, abuse, or violence are not validated (Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions 2006). Although decades of lobbying have increased women's rights and mental health care, there still exists no examination of how women experience mental health services (Morrow 2003).

Gender and specifically the needs of women, has never been adequately addressed by the health care system, even in a climate when understanding gender-differences is predominately acknowledged publicly by governments and health boards. Many proponents have argued mental health needs to be brought to the mainstream. Governments pretend to move forward, define issues, and even financially support groups who make recommendations for improving conditions. Yet, according to Henry *et al* (Morrow *et al* 2007), the fact remains that there exists a unacknowledged neoliberal prejudice, "in which Canadian values for fairness, equality, and social justice coexist with discrimination and institutionalized racism, [which] deflects attention from inequalities" (22). The basis of the Medical Care and Canada Health Acts is to provide "substantial proportion of the funding of provincial health care" and in return provinces agree to meet five key principles: *universality, comprehensiveness, accessibility, portability, and public administration* (Armstrong and Armstrong 2008; Wiles and Rosenberg 2009:86). However, it ignores critical health care benefits desired by marginalized women that are unattainable without income or extended benefits. This makes many mental health services inaccessible.

One of the problems is that mental health and women are at the mercy of the Canadian political/economic climate, resulting in a landscape of a constant flux of ever-changing policy and delivery of women's mental health care. Mental health evolves alongside structured images, changing definitions, limited access, and inconsistent political climate (see Glendill 1997; Foucault 2000; 2009). Currently, the political and economic climate has labelled health and mental health care as too large of a proportion of federal and provincial budgets. If health care cuts are supported and mental health care is deemed too expensive, inefficient, and unsustainable (Fuller 1998), then an elimination of services for marginalized women is simply a consequence of an economically difficult period. Ironically, these policies contribute to increased levels of mental health troubles and are costly to society because they eliminate a person's contribution to society during their most productive years (Standing Committee on Social Affairs, Science and Technology 2002).

In the following chapter, I examine how federal mental health efforts since 1996 have influenced the provincial delivery of mental health care. I discuss the premise of Health Care, the landscape of Canada's Health Program since 1996, and the response by British Columbia.

Addressing the Needs of Women

SATURDAY JANUARY 17TH 2009-Participant-Observation (excerpt)

I attended a forum on violence against women hosted by the Canadian Federation of University Women. Speakers were from the Phoenix Transition House, the Northern John Howard Society, PGNAETA, the RCMP, and the Soup Kitchen.

Sharon Hurd, Executive Director of the Phoenix Transition House talked about women wanting a place to stay on the weekend when their husbands came back into town from the bush and were drinking. Sharon also talked about her personal experience with rape and violence in her first marriage. It was not until 1975 that women were 'allowed' to press charges against their husbands. Currently, the RCMP press charges if they believe that domestic violence has occurred. This prevents men from becoming more violent towards the women and the women from feeling guilty. However, pressing charges appears quite different than actually getting a conviction. Sharon discussed that new issues are arising in the transition home "world", they are dealing with addiction problems, women leaving jail (federal and provincial), violence, and gangs. Sharon would like a place where women in recovery can live with their children. She is currently working in conjunction with others community members to build a centre that houses women and children during their recovery phase (Hutda Lake).

Francis was also in attendance. She ended up doing an impromptu speech. Her talk was very commanding and although she was not prepared, her rawness, truth, and feeling made her a great orator. She spoke of being raped and sodomized and going through three trials to prove she was violated. Her comment was that the rape was easier because it was over but the courts were dehumanizing and victimizing. She spoke of mental health and addiction recovery but needing more time. Francis said she was given three months at a recovery institution but it was *not enough time. She needed three years minimum. She spoke highly of the Phoenix and Sharon who "saw something in her" and helped. Francis also stated that although shelters are great, they do everything for you so while they cook and clean for you and provide services (and you still receive a form of social assistance) they do not offer enough assistance in life-skills. Francis also admitted to mental health issues but never clarified what she meant exactly. She did state that when she entered the Phoenix she was taking nine pills and today she takes none. In order to get rid of the pills she needed mental health services and programs to help her cope with the trauma of her past life experiences.*

After the presentation, I spent some time in the shelter. Rachel and Farah opened up about having their children taken away by the Ministry of Family and Children (MCFD). They were forthcoming in the fact that MCFD was quick to remove the children, tell the mothers to accomplish certain things (part of recovery) and then deny them access to their children after the steps were taken. We also discussed foster families, Farah, Rachel, and Olivia (mother of little baby girl Roxanna) all commented that good foster families are rare and all have had their children abused in the homes of foster families. Both Rachel and Farah mentioned that in order to have access to their children they had to have no-contact orders against their ex-partners. However, Farah states that they took the children away because of her ex and when she denied access, MCFD then asked her abusive ex-partner if he wanted to become the full time parent of her youngest.

The Characteristics of Federal and Provincial Mental Health Efforts since 1996

Background of Canadian Health Care

Health Care is considered Canada's "commitment to shared responsibility and our recognition of shared vulnerability" that supports women, children, and those with disabilities who are marginalized and generally comprise Canada's poorest population. The majority of citizens value health care as a human right, not as an entitlement based on economic status or to be used as "a source of profit" (Armstrong and Armstrong 2008: 8-9). Canadians and the federal government desired, formulated, and supported the concept of Health Care after World War II to promote a thriving population. Health and social services that Canadians currently see as legitimate responsibilities of the federal government were once "seen to be private concerns and were undertaken by charitable or religious organizations in the nineteenth century". In fact, provinces had complete authority over hospitals, charities, and asylums under section 92(7) of the Constitution Act in 1867 (McIntosh 2004:7-8), except in the case of aboriginals, military personnel, Territories, and prisoners (see Vayda and Deber 1992; Pierre *et al* 2007). According to Armstrong and Armstrong (2008) the catalyst for better health was a recognition that many of the Canadian men, conscripted during WWII, were not healthy enough to go to war. So, in 1982, only four decades after WWII, the ideology of health was accepted. Canada created the *Health Act* to "protect, promote, and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers" which was a legitimate federal prerogative (McIntosh 2004; Armstrong and Armstrong 2008: 9). The federal government had the financial resources to convince provinces of the benefit of the Act by implementing a shared-cost program of money transfers (Braën 2004; McIntosh 2004). While health care improvements were provincially led, the federal government and the shared-cost program ensured innovations, based on conditions and standards, were implemented across Canada. This created a more uniform health system. Transfers were written into Section 36 of the Constitution Act 1982 to, "entrust the federal and provincial government to promote equal opportunities for the well-being of Canadians" and provide "essential public services of reasonable quality to all Canadians" (Banting and Boadway 2004: 5). The "structure and evolution of federal fiscal transfers, [since 1996, is especially] critical to understanding federal-provincial tensions in the [health] field" (Banting and Boadway 2004:10) and the impact on women's experiences with mental health services.

Health Transfer Program Changes in 1996

Only 50 years after the inception of a national health care program, the federal government moved towards more of "a sustaining role, maintaining and reinforcing the pan-Canadian model" (Banting and Boadway 2004: 8). The federal government under both Progressive Conservatives (from 1984 to 1993) and Liberals (from 1993 to 2006) embraced a neoliberal approach to health care. Since 2006, the current Conservative government has continued to promote private profit in health care and has continued to support decreasing national health care spending and programs (Armstrong and Armstrong 2008: 24). Neoliberalism became a health care reality when federal funding for Health, Post-Secondary Education, and Social Welfare dropped drastically in 1996 and "the Canadian Health and Social Transfer (CHST) was introduced, rolling the three programs into one and reducing funding to an amount once given for only [social welfare]" (Armstrong and Armstrong 2008: 23, 24). While decreased health spending was blamed on federal financial difficulties, the federal government never altered constitutional distribution of powers, it legitimately stepped in, allowed by the constitution, to establish national health standards as a public objective (Braën 2004:28-35). This leaves us with the question: if the federal government has carved itself an important role in health care, are marginalized groups such as women living with depression, more affected when transfer payments and conditions decrease?

The alleged purpose of the CHST was to reduce deficit and debt. Although transfers from the federal government had been decreasing since the late 1970's (Banting and Boadway 2004: 16), the CHST cuts were significant. Unlike the previous transfers, the CHST was not formula-based but decided at the discretion of the federal government. 'Guess work' was implemented to calculate the amount of federal transfer money needed by provinces to maintain health services. Therefore, money intended for health, post-secondary education, and social welfare became inconsistent and changed yearly, allowing for unexpected changes to the transfer program (Banting and Boadway 2004: 14). Furthermore, the breakdown of money was purely nominal; consequently, no mechanism existed to ensure that provinces spent their allocations according to the ratios set forth by the federal government's 'guess work'. Prior to the CHST, federal transfers were based on cost-sharing; therefore, the federal government matched every dollar of eligible provincial expenditure. As well, federal funds, previous to the CHST, were spent as intended by the federal Parliament. Federal guidance through initiatives preserved accountability to the executive of the legislature and federal responsibility for basic minimum social entitlements and consistency for all Canadians (Banting and Boadway 2004: 11). While the priority of mental health care has always been limited, the transfer changes provided no incentive to increasing and supporting mental health services.

With the introduction of the CHST, the federal government's health care politics noticeably moved away from the welfare state, where social programs and their access were promoted, towards neoliberalism[4]. According to Bonisteel and Green (2005), the reassignment of transfer payments was a "reprehensible action [where] federal contributions to the provinces were slashed and nationally enforced minimum standards were removed" (8). This changing role was a response to international pressures, national pressures, and a shift among supporters. The landscape of health and mental health, in a short period of time, changed from supporting a healthy population (although originally with a male bias) to promoting free market economy and government autonomy from the private bodies of citizens. 'Doom and gloom' economic projections, according to (Berger 2000), were advertised to erode public confidence and the generosity in accepting the financial costs of health care (Glouberman and Zimmerman 2002).

---

[4] By neoliberalism,I am referring to a theory and practice of running the economy in a way that frees markets from state and bureaucratic controls. Historically, neoliberalism was a reaction to both the widely experienced authoritarian practices of the mid-twentieth century and Keynesian-Fordist regime of accumulation that characterized the post-World War II societies in the West (Boudreau *et al* 2009:24).

Federal health care support "moved away from Keynesian[5] economics and back to the old ideal of reliance on markets to meet all needs. The recycled approach rejected government support of social programs and pushed for less government intervention in existing social policy fields" (Armstrong and Armstrong 2008: 23). This is an important component to marginalized women's mental health. In order to promote women's mental well-being, government practices need to recognize gender discrepancies in health care and support mental health programs.

The Influence of Neoliberal Ideology on Federal Health Care of Women

Neoliberalism, according to Harvey (Boudreau *et al* 2009) involves political economic practices that propose an individual's well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an "institutional framework characterized by strong private property rights, free markets, and free trade" (24). The theory ignores social and economic disparities such as poverty, gender discrimination, and disability and convinces society that the resultant poor mental health is "normal" (Lyon-Callo 2004:11). It constructs the dynamics of blame for individual health problems and mental-health concerns (Bolaria 1995). As Day and Brodsky argue, (Bonisteel and Green 2005) since 1996, public goods, services, and programs such as those that address violence, promote economic security, ensure access to legal aid, housing, and appropriate health care, have been eliminated or reduced. In particular, social welfare reform and declining social conditions have had detrimental health impacts for women, especially for women who face intersecting forms of oppression (Morrow *et al* 2007: 20). In essence, neoliberal ideology provides the support and justification for the production of social

---

[5] Keynesian Economics is a method of analysing economic variables such as output, employment, inflation and interest rates. John Maynard Keynes argued that a healthy, skilled labour force was both critical to the economy and a government responsibility (Armstrong and Armstrong 2008:13).

inequality and the elimination of health and mental health services. The "insufficiencies of liberal welfare" support "masculinist ideals of independence and self-reliance" (Thien and Hanlon 2009:156) and foster a situation where marginalized women's mental health concerns become their own responsibility.

Although the Canadian government had endorsed national and international documents that outline equality and health for women starting with the *Charter of Rights and Freedoms* (1982), there needs to be commitment to these endorsements. According to Scheingold (Young 2007a, 2007b) governments politically act in denial of discrimination, gender inequalities, and poverty, however they "stigmatize it socially" by not reacting to the numbers of women experiencing depression or the need for accessible mental-health care services (1). For example, when the political and economic climate promotes changes to the social welfare system, particularly changes to the eligibility requirements for income assistance and disability benefits, governments leave women living below the poverty line. Without safe and affordable housing or the income to foster well-being, women's mental health is "dramatically impacted" (Davis 2006; Morrow 2007a: 368). Without a public agenda that supports women's mental health, 'token' commitments and initiatives in the area of women's health are not fully supported politically, adequately resourced, or implemented evenly (Morrow *et al* 2007: 20). Neoliberal ideologies "run counter to understanding the complexity of women's lives, their interrelationships with others, their environments, and the impact of those interrelationships" (Morrow *et al* 2007: 21) and serve as obstacles to addressing the needs of women's mental health (Burt 1995; Browne 2001).

Ideology that does not recognize the impact of socio-economic discrepancies is particularly harmful to marginalized women because it reinforces how women experience mental health services. According to Bourdieu (1991, 2001), structures promoting inequality and the various practices reproducing and normalizing those structures have always been largely utilitarian and for economic purpose. Giddens (1979) argued a similar point about power being entrenched in social production, capitalist class relations, and structures (discussed in Ortner 1996: 3-4) and the maintenance of those relations and structures. As provincial psychiatric institutions were deemed too costly starting in the 1960's, the economic solution was to remove financial support. Mental health care has become the responsibility of communities, families, and women, ultimately creating a situation where the most "vulnerable individuals and groups faced a political environment that dismisses the injustices in their lives as personal failings" rather than the failings of political, social, and economic systems that foster disadvantage (Lyon-Callo 2005; Young 2007a: 1). Federal structures then maintain capitalist class relations and desired social production. Furthermore, Kipfer and Keil note (Boudreau *et al* 2009), by employing an "arsenal of authoritarian measures to regulate social problems [such as] a media attack on the poor, the homeless, the marginal, the alternative, and their political advocates" (20, 23), images of feminized mental problems and marginalized women burdening the 'good' taxpayers remain in place and service-eliminations are accepted.

Dynamics of Blame, Neoliberal Ideology, and Kim

Kim, a mother of two young boys and in her late twenties, wanted support from the Phoenix Transition House in Prince George, BC. She told me she recently left her emotionally abusive husband. I interviewed her on a hot summer day in August 2009 in her new rental house. She wore jeans and a baggy sweat shirt and tried to hide her face by allowing her blond hair to fall forward. Kim had pretty sparkly blue eyes and a soft voice and laugh, which were difficult to hear and find at times. I worked hard to make Kim comfortable. I purchased Tim Horton's coffee for us and Tim-Bits for her children and we talked for a long time before the interview started. I was able to learn that she loves gardening, talking with friends, and going for walks but was restricted from such activities by her ex-husband. While married, Kim was a stay-at-home mother and the money she collected from small jobs such as babysitting, child-tax, or universal child care was given to her husband. She had not graduated from high-school, she had no formal training, had not paid into the Canadian Pension Plan, and never had extended benefits. Without the education and the necessary work-experience, it was challenging for Kim to secure work and safe housing. Kim was on social assistance, however, she needed financial support from her mother to afford her new place, even though it was on a busy road in a less-desirable neighbourhood.

At the time of the interview, Kim told me she was having difficulty getting out of bed, feeling good about herself, finding direction, and setting future goals. Kim agreed to an interview with me because she felt that systems designed to help her made her life more stressful and she wanted to tell her story. I noticed that during the interview, Kim constantly looked over her shoulder at every car that drove by. When I asked about the nervous behaviour, she told me she feared her ex-husband would show up.

Nadine: *"What do you think are the largest stressors in your life?"*

Kim: *"Everything..... an ex that stalks me, has threatened to kill me, financial stuff, money for housing, fear of the court system...my ex makes a lot of money but he does not pay anything for the children. I did get a restraining order....the police got it for me...then he said he would not give me my kids back. The police found my children in Smithers. Then he was put in jail and then they were put into a foster home by the Ministry of Children and Family Development and I had to find my way up and pick up my kids in Smithers. He was in jail over night for kidnapping the* *children...until I picked up the children. He came back to PG and threatened to kill me...and he did drive by's and the police did nothing. It took my neighbours to convince the police when they reported he said 'crack whore, going to kill you, and you will die by my hands' but then they came in to investigate my house because he said I was a crack whore and they wanted to make sure I had no drugs in my house. To make it worse, I could not get legal aid, but he had representation in both family and criminal court."*

Nadine: *"Have you ever felt bad, sad, or unhappy for more than two weeks?"*

Kim: *"Depressive moments all the time...my doctor has never picked up on it...and even if he did, - I don't know if social assistance would pay for the drugs that are supposed to make me feel better"*

Nadine: *"Are you attending any programs or counselling?"*

Kim: *"Friendship Centre....because I can't afford anywhere else...but it is too difficult to get an appointment and too difficult to find someone to watch my children. I also feel that it is my fault and that I am a bad mom if I can't just cope. And when my ex called me a crack whore in court, the judge questioned my counsellor taking my side and so I was referred to a Nechako drug counsellor so I could have an evaluation to prove I do not drink, which I don't! Then my counsellor at the Friendship Centre had to write a letter to the judge stating I did not appear to have addiction issues."*

Nadine: *"How do you feel about your health"?*

Kim: *"Emotionally beaten down...I am not happy every day...I smile and laugh for my children but I am drained...I get headaches...I only hope I get a moment to myself at night."*

Nadine: *"What will make you feel better about your health"?*

Kim: *"Money...financial security...knowing that my child support was there...not having to fight for everything...knowing my ex was not going to hurt me or the children physically or emotionally."*

Kim's story exemplifies structural barriers and *how* she experienced mental health in terms of lack of access to health services, community services, and even her own physician. Her story shows how women encounter social structures that foster poor mental health and symptoms of depression. Rather than examining the discursive processes that are working against Kim such as lack of education, poverty, lack of social supports, lack of access to legal aid, lack of RCMP cooperation, and lack of judicial support, she was made accountable for the abuse inflicted on her by her ex-husband. Furthermore, Kim's emotional state, created by various social and political structures, was her responsibility. The fact that poverty, no health care benefits, and no mental health support denied Kim mental well-being was overlooked and ignored. Kim told me that she felt she was supposed to accept everything because it was simply part of being a woman and mother[6]. I immediately envisioned a landscape of feminized mental health formed by the daily barriers encountered by marginalized women.

Federal Health Priorities, Women, and Mental Health

In regards to federal government's support of mental health care, Roy Romanow, who headed the Commission on the Future of Health Care, stated in 2002, "after examining the evidence and consulting Canadians widely, healthcare is about our values and it is sustainable as we collectively want it to be" (Armstrong and Armstrong 2008:10). The First Ministers in the 2003 *Health Accord* reaffirmed that the public considered the healthcare system a priority. The *Accord* stated that the key to efficient, timely, quality healthcare reform needed to be decentralized federal and provincial health care accompanied by a concentration of services at a regional level. This provided the foundation of the new vision of devolved health care in general and specifically mental health services that were limited to particular regionalized locations (Ward and Bedford 2004: 57). To clarify, as the federal government decentralized accountability through decreased block funding, the provincial government devolved responsibility for health and mental health services to regionalized health authorities. Health authorities were then given the authority to consolidate resources and services into more limited central locations. Therefore, neoliberal priorities superseded the promotion of health and mental health, even when there was

---

[6] Women with a history of mood disorders, and women in an unhappy marriage, are at greater risk of developing depression. It is thought that in these situations, depression is under-diagnosed because women fear being seen as bad mothers or having their children taken away. However, most women respond well to treatment which consists of phychotherapy-especially interpersonal therapy and antidepressants (Simmie and Nunes 2001).

support of the viability of the health care system. Ideologies about mental health and women are formed within historical practices of inequalities, yet they persist, control, and influence how governments and senior bureaucrats make decisions around funding, the creation of policies, and the idea of acceptable mental health. According to Corrigan *et al* and Monahan (Davis 2006), governments make mental health policy by drafting legislation and those legislators are influenced by "current ideologies, economics, and practices" (92).

Critics fighting for a better mental health system have stated that the federal government has been an "absent stakeholder" because "mental illness is simply not on their radar screen" (Davis 2006:91). The Commission on the Future of Health Care in Canada 2002, emphasized that in *Building on Values: The Future of Health Care in Canada*, the Romanow Report (2002) the authors spoke about "mental health [...] as one of the orphan children of Medicare" and discussed the need to "bring mental health into the mainstream of public health care" (Davis 2006:92). However, mental health generally and specifically the recognition of women's health care needs remained under-recognized and de-valued even in the Romanow report, which devoted only 2 of the 357 pages to the topic. The topic of mental health was slotted in as a subsection of a chapter on '*Home Care*'. While the report was being prepared, Kennedy noted (Davis 2006), Canada remained the only G8 nation without a national action plan on mental health, a fact addressed in a Canadian Senate report released in 2004. Canadian mental health has been described as a "badly organized and under-funded" (92) system. Although federal and provincial health initiatives acknowledged the necessity of improvements regarding mental health and gender differences, little has been done. Recently, the federal government established the Mental Health Commission of Canada (MHCC) to be a catalyst for improvements in mental health policies and for the promotion and dissemination of mental health information, releasing the report, *A Time for Action: Tackling Stigma and Discrimination 2007* (Ministry of Healthy Living and Sport 2009:6). Yet, Canada continues to demonstrate its lack of commitment to health and mental health care by implementing government cutbacks and reduction in health-care spending unlike any other advanced industrialized country (Yalnizyan 2004), even when the federal government reported a budget surplus from 1997 until 2003 (Day *et al* 2004).

The fact is that documents such as the *Health Act* and the *Constitution Act* do not protect marginalized women and their mental health needs. These are political documents through which ideologies of inequality can be maintained or contested. It has been argued that although social rights are discussed in the constitution under the *Charter of Rights and Freedoms*, courts and governments must balance the rights of individual citizens and maximize the benefits of public health care for the greatest number of people (McIntosh 2004). Choices must be made regarding which services to ensure, prescriptions to cover, and facilities to operate, however, choices and social rights are determined by traditional practices, such as text and precedent, and by dominant ideologies associated with Canada's constitutional culture. Therefore, while social welfare and equality *could* be argued under the *Charter of Rights*, section 7 and 15(1), its wording allows for varying interpretations of 'rights' and 'sound policy-making' which can work to neglect social and economic inequality concerns, especially for marginalized women. Furthermore, Pothier (2007) believes that claims about inequality and discrimination which challenge policy and programs made under section 15(1) of the *Charter* are rejected not because there is lack of evidence but because the programs and policies were designed to help those challenging it (43). As well, feminist organizations since the 1990's have been limited in their capacity to directly participate in advocacy[7] and decision making about policy and legislation. The federal government and provincial governments have placed restrictions on advocacy by threatening the loss of charitable status (Bonisteel and Green 2005)[8]. When the federal government demonstrates women's mental health is not a priority, then provincial policy is given unwritten consent to do the same.

Anne's Story is not a Priority

I first met Anne in February 2009 when she became a resident at the Phoenix Transition house. I interviewed Anne in April 2009. Anne was in her 50's and already had endured the loss of two children, both young men when they died. The loss of her youngest was the hardest according to Anne because she had the "most honest and caring relationship with him". He always said "love you" and made time to meet. They had a ritual of grabbing two coffees from Tim Horton's (double, double) and enjoying their coffee together. After his death, which was during her stay at the shelter, she told me she would go to Tim Horton's and order two coffees. She said it gave her a chance to sit with her son, "it takes a lot longer to consume two coffees and gives me lots of time to think and talk to him".

Anne left her ex-husband because of the physical and mental abuse. She used prescription drugs and self-medicated to deal and cope with living with an abusive and alcoholic husband. Anne is a hard-working woman with silver curly hair just above her shoulders, deep facial lines,

---

[7] Advocacy, according to Harvie (2002), is a means by which socially marginalized groups gain voice, power, and access to individual, systemic, and public benefits in a socially exclusive environment (Bonisteel and Green 2005:1)

[8] "The feminist anti-violence sector was significantly curtailed in the 1990's, when tightened restrictions on the charity sector activities produced the 'advocacy chill' (Bonisteel and Green 2005:1). Advocacy is the "act of speaking or of disseminating information intended to influence individual behaviour or opinion, corporate policy or law" (Volunteer Sector Task Force 1999:58). Organizations created with the express purpose of government lobbying can be barred from registration as charities. According to Bridge (2000), only 10 percent is the maximum allowable portion of an agency's resources that can be used to advocate on behalf of those agencies. This exclusion from direct participation redefines the purposes of feminist organizations (Bonisteel and Green 2005:5-6)

and a raspy voice from years of smoking. At first glance, Anne looks slender and frail but years of children and hard work have made her tough and strong. Her arms and hands are sinewy and tell the story of hard work when you look closely. She is quiet but, when engaged funny and full of laughs. She takes her time to think about what she says and never talks for the sake of talking. There was purpose behind her words and with whom she chose to share them with.

Anne raised six children and was a stay-at-home mom who had not contributed to a pension-plan. After her children moved out of the house, she worked small jobs gardening, house cleaning and cashiering but currently was unemployed. Although Anne was a hard worker and lately completed job training, she found it difficult to find a job. Recently, she applied for a cashier job but was told that she was too old by an employee in her twenties. Anne applied for social assistance which the Ministry of Housing and Social Development (MHSD) allots $375 for housing and $531.42 for living expenses; however, single dwellings usually start at $500 - $700 minimum which leaves Anne with $307.42 -$102.42 a month for utilities, food, and activities. Anne applied to BC Housing but was denied because she did not meet the criteria and Elizabeth Fry Housing had a long wait-list. While looking for accommodations, Anne was once told "we are too expensive for people like you" by the rental manager. Anne was disheartened by her future prospects and felt that she only had two choices: to live with a roommate which worried her; or live in a less-desirable neighbourhood. One day in the kitchen, while she cleaned (her chore), I talked to Anne about counselling and mental health services. Although her husband had continuously battered Anne and police had been involved, there was no offer of victim services, counselling, or referral to PG Stop. She said at one point, for a very short time, she talked to her priest. Anne had also accessed the hospital because of various illnesses but her abuse of pharmaceuticals had not been noticed nor her bruises. No addictions counselling was offered and no referral to counselling was made by the shelter staff during her stay, but Anne did not want to be a "bother by asking for assistance anyway and I can't afford it". Anne did not have a dependable income and did not have extended health benefits.

Nadine: "What do you think are the largest stressors in your life"?

Anne: "Not having a home...not having a job...not having an income."

Nadine: "So having these things would make you happy"?

Anne: "I am not looking for something elaborate...for a job...you know...I don't need a lot...I have lost these things a few times because of my relationship."

Nadine: "What do you mean"?

Anne: "He threw me out (husband)....I was gone for eight months and that is why I went to school...I left due to his drinking...he does not recall doing any of the abuse."

Nadine: "Because of the abuse, were the police ever called"?

Anne: "Several times the police were involved...last time they let me leave with some of my possessions but I had to get them to let me back in to get the rest of my stuff."

After the interview, I asked Anne if I could buy her a coffee. We laughed all the way to Tim Horton's at the amount of change she picked up. Anne would pick up the money and say "if you give it away, it comes back to you in fortune". She found so many nickels, dimes, and quarters that she looked at me, laughed, and said "I think I'm buying my own coffee now", followed by her common phrase, "shit that's funny".

Anne's experience with mental health counselling was non-existent because she was overlooked by various institutions and care-providers. Anne's mental health and addictions issues were not a priority and without support there was no promotion of recovery. She is quiet and subdued, not outlandish, violent, or irrational and therefore is not viewed in need of the few resources available. With the impending move, she was concerned with: her husband finding her; her lack of income; her inability to find safe and affordable accommodations; her addictions (she had attended a few AA meetings but without a vehicle this could become problematic); her lack of family support; and her lack of access to counselling. Therefore, Anne's health, mental-health, earnings, and safety were her responsibilities.

British Columbia Responds: Centralizing Women's Mental Health and Fears

British Columbia responded to the CHST and lack of federal mental health leadership by implementing a cost containment agenda which was explicitly reflected in a document such as *Better Teamwork, Better Care 1996* and *Patients First 2002. Patients First* was "the resulting report [which made] 88 recommendations dealing with ways to make the health care system in British Columbia more equitable, more accountable, and more focused on patient needs and effective treatments" (*Select Standing Committee on Health Report, Patients First: The Path to Reform 2002*: 4). While the province had already devolved health care to 52 regional health authorities, the report streamlined that number into six, which included five regional health authorities (RHAs) and one provincial health authority (PHA). Mental Health Reform was explicitly reflected in documents called *Best Practice* 2002 guidelines. The landscape of mental health changed (see Smith 2008a), as provincial administration decentralized mental health services and established regional health authorities as responsible for the planning and operation of all mental health services for a 'defined' population (Goreing, Wasylenki, and Durbin 2000: 347). In adhering to *Best Practices*, mental health services were consolidated into concentrated and more densely populated locations at the regional level. As the efficacy and efficiency of mental health care became paramount for policy makers, *Best Practices* forced mental health into evidence-based practices or result based funding (Davis 2006) which undermines "the philosophical foundation of feminist choice-based approaches and women's access to supports that include gender-analysis (Bonisteel and Green 2005: 38). A British Columbia Ministry of

Health (2002:10) article suggested that, among other objectives, *Best Practice* outcomes in mental health should demonstrate evidence of "decreased use of more intrusive and/ or more costly services" (Davis 2006:93). For example in 2001, the Liberal government focused on "redesigning" and devolving the one provincial psychiatric hospital to communities. In 2002, the British Columbia Ministry of Health suggested, "programs [related to mental health] be integrated and in particular that hospital and community services [be] unified into a single system within a local mental health area" (Davis 2006:112). The move was supported by memos and reports that promoted the benefits of localized community services. The ideology was to provide tertiary mental health in regionalized areas. It was promoted as a more complete continuum and practice of mental health services for families and patients closer to home that was supposed to be cheaper on provincial budgets. For example, "the *Riverview Hospital Redevelopment Project* decentralizes tertiary mental health authorities [because] better mental health outcomes can be achieved in smaller community settings" (Davis 2006:113). *Patients First 2002*, recommended "that care plans and community and residential services must be in place before people with mental illness are moved from facilities like Riverview" (Select Standing Committee on Health Report 2002: 43). The report refers to need of 30 long-term care facilities that were never built. Currently, the Northern Health operates 14 long-term care facilities. Furthermore, the report only dedicates one and a half page to *Mental Health*, although it acknowledges that more than 120,000 people live with moderate depression or anxiety and it costs 1.7 billion per year in BC (42). In fact, it makes no "specific recommendations regarding mental health in BC, in part because [they] heard back from only a few people who spoke specifically about the issues" thus concluding that those living with mental illness are "often without a voice and their needs can go unrecognized"(42). The report does direct mental health strategies to two reports completed in 2002: *The Provincial Anxiety Disorders Strategy Report* and *Provincial Depression Strategy Report.*

The *Provincial Depression Strategy* was initiated by the Minister of State for Mental Health and reported that each year, 1 in 25 British Columbians "will have depressive illness and because they are so often disabling, these illnesses create a profound health burden. Depression and stress disorders at work account [for] the fastest growing category of disability claims" (Goldner 2002: i). The report was created to identify and pursue strategic opportunities to improve the quality, effectiveness, prevention and treatment of depression. The Provincial Depression Strategy Advisory Committee recommended that six topics be addressed: depression in the workplace, depression in children and adolescents, depression in the elderly, concurrent substance use disorder and depression, cultural expression and depression, and postpartum depression. The report never included women or gender as a specific topic.

In fact, completely contradictory to the strategy, *Best Practices* continued to decrease mental health services by further reducing hospital beds and shortening of the average length of stay in both general hospital psychiatric units (GHPUs) and provincial psychiatric hospitals. For example, in provincial institutions, the average length of stay decreased from 250 days in 1994-1995 to 160 days in 2000-2001. Information from GHPUs covering the period from 1987 to 1999 indicate that the length of stay fell 20 percent for persons diagnosed with depression, to 15 days on average (Davis 2006:128). While the briefer hospitalization is the result of cost containment, there is also an issue of scarcity of inpatient resources and changing philosophies with respect to treatment, the role of hospital, and the psychosocial impact. According to McEwan and Goldner (Davis 2006), *Best Practices* promoted "inpatient stays [should be] kept as short as possible without harming patient outcomes" (128). In 2004, a new Minister of State for Mental Health and Addiction Services, continued to ignore women, and focused on increased youth addiction services, a postpartum depression strategy, a best practices guide for mental health and addictions clinicians working with suicidal adults, and planning guidelines to assist health authorities and other service providers.

Best Practices, decentralizing health care, and decreased transfer payments represented, specifically to mental health programs, cutbacks and closures. Suspicious "practitioners, front-line workers, and consumers have learned that phrases such as 'least intrusive services' are code words for 'no services'" (Davis 2006: 116). "*Best Practices*" refers to the outcomes desired by the provincial government and health boards, not the outcomes desired by Kim or Anne. Other consequences of federal health transfer cuts to women in British Columbia included less patient health education and increased numbers of patients caring for themselves. As well, institutional care for women living with mental illness and disabilities declined as hospital spending declined, leaving hospitals understaffed and practitioners with increased workloads and stress. In some communities, the lack of hospital beds caused overcrowding in facilities or delays in treatment. Since Medicare covers medications and supplies used by hospital patients, if discharged, then women must purchase these same medications and supplies out of pocket. As hospital care cannot provide patient support, home care is being used as the alternative. It is delivered by the public health care system or private for profit companies and includes nursing, homemaking, meal preparation, and personal care. However, the premise is that home care primarily the responsibility of the family until this avenue is exhausted (Wilson and Jackson 2002; Women and Health Care Reform 2002).

Impacting Women's Mental Health

The British Columbia government and provincial structure of health care are accountable to the public for their health care because the health system is tied to the constitutional mandate and funding source (Braën 2004). While the province can decentralize authority to regional health authorities for the delivery of healthcare, the province cannot devolve responsibility (Davis 2004:51). However, because the provincial government determines and defines the "form of health reform, including identifying the most appropriate and achievable goals related to the governance and management structures of the respective organizations" they have, if they chose, the power to improve women's mental health services at the regional level (Ward and Bedford 2004: 58). The federal government, while still participating in the health care process becomes less directive and accountable to national standards for the management of health and mental health care of Canadians. The federal government's focus on deficit reduction through transfer programs such as the CHST, undermined the mental health needs of women. It pushed provincial governments to focus on their own priorities, increase private sector involvement, and decentralize mental health to the control of regional health boards. Women's mental health care in British Columbia previous to the CHST was not a priority. However, the decreased transfer money for social supports and decreased accountability further marginalized women, specifically those needing mental health services and support (see McIntosh 2004; Bonisteel and Green 2005).

In 1987, the Canadian Mental Health Association completed a report dealing with women's mental health issues such as the feminization of poverty. The outcome was recommendations to develop affordable child-care, pay equity policies, recognition of unpaid care, and programs for women's mental health. Other studies have reinforced the need for improving the same issues yet to date, these programs have not been implemented by the various levels of government (Ad Hoc Working Group for Women, Mental Health, Mental Illness and Addictions 2006). In fact, the opposite is occurring; neoliberal ideals endorse or ignore declining social conditions that directly impact women's health, especially women who face intersecting forms of oppression (Morrow *et al* 2007) and support decreasing health and mental health services, less extended benefit eligibility, dismantling universality, glorification of paid work, reliance on voluntarism, and an increase in the regulatory presence of agencies in the lives of individuals who rely on services and assistance (Bashevkin 2002; Hanlon *et al* 2007). Current policies, home and community-based care increase women's health care bills and place more care giving demands on their shoulders. If women need support for depression, it is important to recognize that many women do not have safe homes or family caregivers with the time and skills to provide adequate care (Women and Health Care Reform 2002). While BC's *Mental Health Reform, Best Practices* produced seven reports relating to mental health which are still used today, *Best Practices 2002: Housing*, was the only report that discussed gender under *Populations with Specialized Service Need.* The one page allotted to the subject of women, suggests that the province and health authorities focus on housing options designed to meet women's needs. It also recommended focusing on emergency housing for women who are victims of violence and who have a mental illness, training to transition housing staff related to mental illness, and encouraging collaboration between health authorities and the Ministry for Children and Families (Ministry of Health Website 2011, *Best Practices Housing* 2002:45). Ironically, these suggestions continue to be barriers for the women that I interviewed.

While depression is considered a mental disorder, only a small number of women diagnosed are considered eligible and appropriate for services in publicly funded community mental health programs according to Goodwin and Guze (Davis 2006: 4). Therefore, many women living with depression, such as Kim, who appear outwardly 'normal' but would benefit from counselling, are ignored or their mental health issues normalized. Today's neoliberal ideology, federal decentralized health care, and limited regional mental health care focuses on priority populations. These are individuals "exhibiting persistence, functional impairment, bizarre behaviour, involuntary behaviour, and who are treatable by medication to be accommodated by public treatment programs" (British Columbia Ministry of Health 2002; Davis 2006: 5,6). For example, *the Depression Strategy Report 2002* stated that although 300,000 individuals reported depression and anxiety to physicians, and 200,000 of those were women and girls, depression is consistently overlooked by family members, colleagues, and physicians, and therefore not treated. There was no discussion related to gender and differences in the numbers diagnosed with depression, nor were there any treatment recommendations for women and girls. In fact, the report focused on 'age' as a general factor to poor mental health (7-8). Women living with depression must therefore not only meet the criteria for accessing mental health services but must also adhere to a treatment plan that provides evidence-based outcomes or *Best Practices 2002* to practitioners. Outcomes desired by the government include a reduction of symptoms, a "decreased use of more intrusive and/or more costly services, an improved functioning in various areas of the clients' lives, an enhanced quality of clients' and their families' lives, and a consumer and provider satisfaction with mental health services" (Davis 2006:116).

While, one of the Canada Health Act's strengths is its simplicity and limited length, the shortcomings have been the inability to truly protect and promote mental health because the Act focuses on 'cure' not prevention. Furthermore, the Act does not guarantee access to a physician and does not cover services such as counselling and pharmaceuticals. These items have to be covered by extended medical care or private insurance, usually associated with employers and well-paid employment. Women who are low-income, home-based workers, seasonal workers, and those unable to obtain extended health benefits are not always able to afford mental-health services (Rooney *et al* 2003). Although there are provisions such as Pharmacare, not all costs are covered. Furthermore, if community mental health services and specialist support is unavailable then help is negligible as a result of lengthy wait lists (Goldner 2002: 9). Women also experience difficulties in accessing treatment services while caring for children and other family members, and women living in poverty have been found to be particularly compromised (see Morrow 2003, 2007b; Goldner 2002). Currently on the Provincial Health Authority website, women's mental health needs are incorporated into *Child, Adolescents, & Women's Programs and Services*. The title of the webpage, categorically associates or inscribes women's health needs to that of children and adolescents (see Ortner 1996; Butler 2007). As well, the site offers only two programs for women, the Aurora Centre and Reproductive Mental Health which are both located at the Women's Hospital & Health Centre (BC Mental Health and Addiction Services 2011 website).

Women and Depression: Listening to Francis

Francis and other women accessing the Phoenix Transition House, told me they do not want to use medications to treat depression because it conflicts with addictions recovery. I was informed they would prefer to access counselling services and deal with the environmental factors that have led to both the addictions and the depression. In fact, the *Depression Strategy Report 2002* acknowledges that when individuals are given a choice of treatment for depression, most people prefer counselling to treatment with antidepressant medication (Goldner 2002). Yet, 'blanket' treatments appear more efficient, collaborations and individualized assessment is plausible if the federal government was made fiscally responsible for women's mental health and provinces and regions became accountable for upholding standards of care uniformly. When I spoke to Francis about her experiences with mental health services, this is what she had to say:

Nadine: "Can you tell me about your experiences with mental health services?"

Francis: "They did not take the time to ask what got you there in the first place...they are prescription happy...they just give you the meds...and the pharmaceuticals companies give them bonuses if they prescribe certain drugs. There is nothing about being pro-active, some doctors who deal with addicts as their client population should not be there looking after a vulnerable clientele because they are not good at it...they don't give a shit 'WHEN DO THEY PRESCRIBE A MEETING?'"

Nadine: "What would you like to change about mental health services?"

Francis: "Try getting into Detox... people are told they need to keep phoning to get appointments but if you don't have a phone or can use it or remember to use it. Everywhere I have been, they have asked me to leave...I have graduated so they kick you out...but you never are over addictions or mental health. And nothing is consistent...there is no stability and there is no coordination of agencies. More programs, I think Northern Health is even trying to get rid of Preventive Relapse"

Nadine: "Why do you think there is a lack of co-ordination?"

Francis: "Most people are kept in crisis because the government gives you more money for crisis...but not for preventative programs".

Francis' comments are important because *how* she achieved recovery was through supportive staff at the Phoenix Transition House. Francis had individuals and organizations advocating for her mental well-being because she, at that point in time, was unable to advocate for herself. Her recovery started ten years ago and she had access to programs which are no longer available because of federal and provincial funding cuts.

Conclusion: Reflecting on Federal and Provincial Mental Health

Currently, the Ministry of Healthy Living and Sport promotes health provincially. It is the responsibility of the Ministry of Health Services to focus on the delivery of regionalized health services and programs, funding and accountability. The Provincial Health Services Authority is responsible for coordinating and delivering programs in regional health authorities including BC Mental Health and Addiction Services. Health Authorities are responsible for identifying and assessing the health needs in the region, and delivering health services (excluding physician services and BC Pharmacare) in an efficient, appropriate, equitable and affective manner(Ministry of Healthy Living and Sport 2009: 6-8).

Even with various levels of health services in Canada and British Columbia promoting standards and accountability, the need for advocates to represent women is still necessary in Canada. Women who are marginalized need support because government images and documents, promoting equality are rhetoric with no substance. The responsibility of challenging policies and increasing mental health efforts has been in the hands of ad hoc groups and women's interest groups because there is no federal and provincial mental health 'watch dogs'. Currently, the BC Mental Health Monitoring Coalition is primarily made up of established organizations that represent mental health care recipients. Non-profit mental health advocacy organizations are pulled into consultation in a variety of different but inconsistent ways across the province. Prior to 1998, there was a consumer advisory committee that was supported by the New Democratic Party (NDP) government, and from 1998 to 2001, there was a provincial mental health steering committee (The Mental Health Population Health Advisory Committee) and in 1998, the BC Mental Health Plan was released. This plan has remained the template for reform and under the NDP (1996-2000) a number of innovative recommendations were implemented, including the establishment of the BC Mental Health Advocate, whose job was to track systemic problems in the mental health care system. As well, BC succeeded in forming a separate funding envelope for mental health services (ie. money from the health budget reserved for mental health). However, under the Liberals (2001-current), mental health program and research promotion funding was lost during a Cabinet reshuffle in 2005, when the position of Minister of State for Mental Health was cut and the Minister's Advisory Council was disbanded (Morrow 2007a) demonstrating the priority of mental health.

Ideologies that influence citizens to deny mental health support to women, perpetuate social inaction, and social "powerful affinities" which normalize or naturalize practices that ignore inequalities (Eagleton 2002). Armstrong and Armstrong (2008), contend that the Canadians supported Health Care's inception because the program proved itself successful. However, as governments promoted public fear about the health care debt and focused on individual-blame for mental health, social programs and dependent individuals were blamed for the crisis. The dynamics of blame occurs, especially for women, "even though research showed that the main causes of federal governments debt were the cuts to taxes for corporations and the rising interest charges" (Armstrong and Armstrong 2008: 23).

In the next chapter, I examine the affect of regionalized health care on women accessing mental health services in Prince George. Exploring regionalized mental health care is a chance to understand how federal, provincial, and regional ideologies and funding trickle down and create the experience of women accessing services for depression.

Chapter 4: The Landscape of Regionalized Mental Health in Prince George

How has regionalized mental health care changed in the last decade (15 years) under the British Columbia Liberal government? How is mental health organized in Prince George and specifically what are the facilities and resources available to the women I interviewed?

WEDNESDAY MARCH 11th 2009 Participant-Observation (excerpt)

Julie came downstairs and asked me to hold her baby so she could check her laundry and help her other daughter. I held the baby while she helped her oldest daughter go to the bathroom. I heard the little girl cry so I took the baby into the office and mentioned it to staff. I learned the little girl had a bladder infection but Julie was not able to pick up the prescription during the day because she had no one to watch both children.

Introduction

As discussed, Canada's health care system has been influenced by economic and political neoliberal pressure. Corporatization and privatization were promoted as the answer to health care resource allocation and the declining ability of the health care system to meet the expectations of Canadians (Morrow *et al* 2007: 6). As the federal government backed away from its post-war role of establishing national standards for social programs, responsibility shifted to the provinces. Provinces, in turn, regionalized (Young 2007a: 8). Regionalized health care was adopted in June 1992 after the release of the Seaton Commission in 1991. The report suggested that progress could be made by adopting a regional health program and that regionalization could improve disparities in access and service-delivery. The idea was to improve the organizational and fiscal dilemmas of health care by completely changing the landscape of health (Weaver 2006; see Appendix C). According to the Canadian Centre for Analysis of Regionalization and Health 2004, regionalization consisted of four key features: regions were defined by geography, authority was at the pleasure of the provincial government, power previously distributed among many programs and communities was consolidated, and responsibility for health services and mental health became greater (Lewis and Kouri 2004: 12). However, regionalized landscapes were seen as the remedy proposed for the diagnosis of fragmentation and incoherence made by commissions across the country in the 1980's and it addressed the organizational problems (Lewis and Kouri 2004: 13). The tumultuous implementation of regionalization in British Columbia began with the New Democratic Party in 1992 and endured through the early 21st century with the Liberal government. However, the changing governments with different platforms created constant restructuring and inconsistent health care services. By 2002, regionalized health was mapped onto five distinct geographical areas, and the health of Prince George became part of the Northern Health landscape[9]. Regional health boundaries were determined by geography, population distribution, and patient flow. Provincial health services were structurally reorganized into the five health authorities and health services were concentrated in particular areas like Prince George, resulting in shared resources across communities and geographical areas.

In this chapter, I explore the ideology of regionalized mental health care and how changes in the last 15 years affect women living in Prince George. I examine how women accessing services at the Phoenix Transition House in Prince George experience the mental health system because of regionalization, geography, and the physical space of Prince George. Prince George becomes a contributing factor because ideologies of identity and space become projected onto specific health authorities. Specific regionalized mental health practice (Razack 2002) influences the experience of women living with depression.

---

[9] Interestingly, the political nature of 'maps' themselves is that they negotiate "identity and place" and they control knowledge, claiming authorship and ownership of knowledge about landscapes, people and their past" (Smith 2003:73).

Regionalized Health Care

The premise of regionalization, according to the Clark Institute of Psychiatry (Davis 2006), was to make health care more "efficient, cost-effective and responsive to local needs" (113). The anticipated advantages of decentralized health care were the identification of location-specific service delivery needs and the creation of "local commitment to the mobilization and reallocation of the resources in the communities most directly affected" (Davis 2006: 113). Church and Barker note (Lewis and Kouri 2004) that the idea of regionalization supported: cost savings, efficiency, equity, enhanced citizen participation, increased accountability of decision-makers, emphasis on prevention, all seen through the lens of an emerging needs-based, population health perspective (15). Regionalization offered the opportunity to streamline services, reduce barriers, reduce duplication and increase local responsiveness to the needs of a community through integrated services and programs (Leatt 2004; Lewis and Kouri 2004: 28). For mental health clients, regionalization promised a "comprehensive range of services" including treatment, rehabilitation, prevention, and promotion in the form of outreach programs, more housing alternatives, early detection programs for depression, and varied rehabilitation programs such as supported employment and peer-support work with other mental health clients. Most importantly, the provincial government promised increased community performances to those living with mental health issues (Davis 2006: 111-112).

So far, regionalization is associated with controlling public expenditures on health care, closure of hospitals, the shift to community and home-based care, the privatization of the delivery of health care services, and the adoption of private sector management practices (Armstrong *et al* 2002). According to Andrews and Crooks (2009), regionalized health care and the devolution of powers and modes of health care delivery are "an increasingly important consideration in mainstream health services research" (25) because resource allocation becomes dependent on individuals who sit on regional health boards (Morrow 2007b:52). Landscapes, especially those incorporating structures of health and mental health, "are often highly political and contested, as different communities of people try to negotiate different interpretations of the same landscape" (Smith 2008a:13). According to Weaver (2006), regionalized health care created a situation where certain community members, such as the regional board members or high profile community organizations, representing particular agendas were increasingly involved in health decisions. Regional boards, without the expertise, became responsible for assessing the needs of the communities and outsourcing many health and mental health services to community organizations. The disadvantage is that without widespread participation, it is easier for particular interests groups to assume power and push through individualized agendas that are not representative of the general population's needs in its health care system. For example, while navigating the Northern Health website in 2011, I noticed that there is section dedicated to '*Men's Health*', however there is no section for '*Women's Health*' and it is also the only health authority to focus on men. This means that women's issues are not uniformly or consistently recognized in all health regions. Even though women's mental health include special circumstances such as "violence, isolation, poverty, low social status and limited access to economic, social, and professional opportunities" which could be supported on the website (Women's Health Bureau 1998:31). Like Harraway (2003), Tomblin (2004) argues that "since the 1990s, regionalization has been a slippery concept, and it is convenient to think about the regional phenomenon as a competitive battleground involving competing ideas, institutions, stakeholders and citizens [and the] result of domestic clashes over priorities on the ground" (61). The implications for women have been an inability to access the specific health care services they want and need such as healthy eating, exercise, self-help, and social support (see Aronson and Neysmith 1997; Cohen 2001, Armstrong *et al* 2002; Armstrong *et al* 2004; Cohen and Cohen 2004; Perry *et al* 2006). As well, there are no clear provincial standards regarding women's mental health initiatives because resource allocation becomes dependent on individuals who sit on regional health boards (Morrow 2007b:52). According to Yalnizyan (2004), smaller governments, such as health boards, act against women because they do not protect the basic needs of women such as economic security, protection against violence, child care and health care.

Regionalized Mental Health

In relation to mental health services, Canadians have seen two major shifts ultimately fostering images and ideologies related to mental health care treatment and fiscal responsibility. In general, the public's knowledge and interaction with individuals living with mental health has been limited and guided by stigmas. In essence, mental health was colonized, it existed through a "process of physical occupation and formal governance over [its] landscape, but it is also a matter of politics of perception, experience and representation. By controlling the images of places, people and their past, colonial administrators are able to control knowledge" (Smith 2003: 71). For example, during the mid to late 1800's, ideology promoted people diagnosed with mental illness were warehoused in large, long stay psychiatric hospitals for their own safety and that of the public. Beginning in the 1960's and through the 1980's, the "development of new psychiatric medications, [caused] the second shift – the move away from the institutions-and the drastic downsizing of the old provincial psychiatric hospitals" (Davis 2006: 105). The idea was for individuals to be released, re-integrated, and re-established within community care. The process was referred to as deinstitutionalization and was a move from provincial care to regional mental health care. The catalysts in this change were new treatments, changing ideologies, and most importantly economics (Davis 2006).

As regionalization was implemented and funding decreased with the advent of the Canadian Health and Social Transfer (CHST) in 1996, British Columbia further promoted the move away from institutions. Outlined in a strategic plan called *New Directions* based on the recommendations of the *Seaton Commission* was the initiative to take health care out of the institution and move it closer to home (Weaver 2006: 19). The *Riverview Redevelopment Project*, as discussed in Chapter 3, promoted specialized mental health services within the health regions. However, while the benefit of mental health care in communities was emphasized as opposed to care in hospitals, the alternative mental health services were never specified or provided. Community-based programs were made responsible for maintaining and working with non-institutionalized patient populations (Davis 2006: 105). Consequently, women with depression were eliminated from services to make room for individuals considered more seriously mental ill. Interestingly, "serious mental illness is as common in women as in men, but men 'act out' more stereotypically" and thus are more likely to receive tertiary level of care [and] because women are less likely to act out, they are often not perceived as needing the same level of treatment" (Women Health Bureau 1998:4). The initiatives also left individuals, families, and communities responsible for mental health care of a larger population without extra funding or necessary resources. Community-based practitioners argued from the beginning that community alternatives such as '"step-down' facilities, outreach programs, or the availability of friends and family-either do not exist or have lengthy waiting lists" (Davis 2006:128). Michael Foucault (Davis 2006) once commented, "systems of care evolve but don't necessarily progress, that is, that coercion/control of clients continues to be practiced, although in new forms" (106, 114).

Best Practices since 2002 has supported and justified health authorities revising or altering their mission statements. In fact, health authorities explaining the closure of programs simply argued that care previously provided to individuals was outside their mandate or were better provided elsewhere (Davis 2006). In their submission to the Romanow Commission, the Canadian Mental Health Association stated that mental health costs continue to increase because of insufficient attention to the social determinants of health, the interaction between physical and mental health, coordination between family physicians and mental health system, and delays in services and treatment. Therefore, mental health concerns that should be treated in a community setting become worse and require more expensive hospital care (Davis 2006: 93).

Currently, health authorities are responsible for the: promotion of mental health, prevention initiatives, reduction in discrimination and stigma, and surveillance and monitoring to clarify the trends in regional mental health (Ministry of Healthy Living and Sport 2009: 10).Yet, according to Davis (2006), there continues to be a lack of comprehensive community support services and it has left individuals with mental health issues socially, politically, and economically isolated. Increasing the problem is the fact that mental health service providers are targeting individuals with severe mental illness and limiting services to women living with depression. Although the definition of this 'target population' has never been defined, provincial policy simply suggests that the most severely disabled be given priority because it would be "medically and morally unjustifiable to limit care" (Davis 2006: 3). Yet, a Health Canada document concluded that investigations into the term "serious mental illness" among mental health service providers and administrators found no uniformity or clarity in the definition. Therefore, a defined 'target population' has been problematic because inclusion criteria "are either vaguely defined or not defined at all, permitting a wide variation in practice" (British Columbia Ministry of Health

2002). Even a provincial government report on subsidized housing for persons with mental disorders referred to persons with "serious and persistent mental illness" as not having a "clear and consistent provincial definition". When policy targets only individuals with 'severe mental illness', it denies mental health services to women living with milder forms of depression and who could benefit from mental health services. For example, a Health Canada 2001 report on concurrent mental health and substance use, limits care to those with "anxiety orders, personality disorders, eating disorders, and mood disorders" (Davis 2006: 4). Without a clear definition and limited resources, mental health services and service-providers can implement their own interpretation of priority individuals.

Tracy and Nicole's Experience with Regionalized Mental Health

In August 2009, I was sitting at the kitchen table with Tracy who is in her 30's, who has been accessing the shelter for three months for addictions and mental health. Although Tracy was on social assistance, she wanted to apply for disability income because of her depression and Cerebral Palsy (CP). She pulled out forms from a large manila envelope, and called them the 'Dl' and 'D2' disability papers. I asked about the difference and if a doctor needed to fill them out. Tracy explained that "both needed to be filled out by a doctor, the DI costs around $45 which you are expected to pay-out of pocket and the D2 costs $150". Another resident, Sarah, contributed to the conversation by stating she had the ministry pay because she was already on Dl. Sarah chuckled and said "they call the papers 'multiple barriers' papers". Was, the humour of the situation was evaluation of what women considered the larger barriers to- navigating the structures and finances to get the papers filled-out or the actual disability? I learned Tracy was having trouble with her doctor filling out the papers. I interviewed Tracy the following week and she discussed her concerns with accessing services for mental health and addictions.

Nadine: "*How would you describe your health"?*

Tracy *"Physically I am fine...I have CP...my mom has diabetes and depression, she lives in Penticton. My doctor there is not a jack ass and fills out the forms for my mom. However, my doctor* **here** *even diagnosed me wrong....he treats me as a child...as if 'I am the one with the education and you don't and if you don't like it, get another doctor'. I have had CP and depression my whole life. I had to fight for the depression meds. I had to be 30 days clean...then he gave me the meds and I am 67 days now. July 2nd I started the meds. June 1st was my first clean day. And I saw him June 30th...and I had a bad day with him I had to eat crow because he almost fired me* ('Firing' refers to physicians terminating individuals as patients). *He referred me to Community Response Unit (CRU) but they have no idea what is going on and if the referral went through. I have a counsellor at SOS but she is on holidays for the summer so now I am seeing a staff member at the house. I was also seeing someone from Community Acute Stabilization Team (CAST) but she is overbooked. I tried two weeks ago but you cannot get in for three weeks, but I am supposed to go see them once a week".*

Nadine: *"Have you ever felt bad, sad, or unhappy for more than two weeks"?*

Tracy: *Since I was young since I was a teenager, my whole family has it and until a month ago when I started the meds I was the only one in my family not on meds. I was almost prideful about being the only one that was not fucked up...so I think 'no I am a loser just like them'. My mom is still in her crack addiction, my brothers are still in their addictions and my dad is a dry drunk... but they are all on meds for depression...and my dad is a jackass. Before June, I was at the hospital three times for suicidal attempts and since being on the meds I have only been once...actually Tuesday and I ended in the hospital. The staff knows and I have an agreement I will not commit suicide in the house. And if I have the thoughts, I will tell the staff and they will get me to the hospital".*

Nadine: "*Why did you access the Phoenix"?*

Tracy: *"Supportive recovery and it was my choice to go to the shelter. I was at another recovery house and I relapsed. Good reputation...faith based worked for me but I would become clean and then relapse. I was not accepted back...because I am gay and I could not have contact with my girlfriend at the time. And I relapsed when she left town. I also did live at AWAC for awhile".*

Nadine: *"Has the shelter recommended any services outside of the shelter"?*

Tracy: "*The Nechako Treatment Centre. At residential you feel like you are on lock down and now you go for the day and then you can practice stuff in your outside life and not feel so confined. They recommend keep in touch with CAST manager ...once a week usually. It is an eight week program".*

Nadine: "*What services would you like to access"?*

Tracy: *"A psychiatrist. I think that I have PSTD...then I can have my personal barriers filled out and then I don't have to work and can go on disability".*

Nadine: *"Did the service provide what you wanted"?*

Tracy: "*I wish they would work more together...but getting a referral from one part to another...takes weeks. My doctor put in a referral and CAST to CRU and I got an appointment within a week because they thought I was suicidal but a basic referral takes months*".

During my interview with Tracy, she explained to me that in order to cope with the depression she used self-harming techniques such as drugs and mixed it with sex with unfamiliar men in order to numb the emotional pain. To treat the addictions, she has attended various recovery treatments which she felt she "failed" because of her sexual orientation, inability to conform, and lack of access to counselling. Consequently, Tracy felt that rather than community organizations working in collaboration, her physicians, the mental health services, and the addictions facilities have been operating against one another. Tracy felt she has been ignored and her co-occurring mental health and addictions issues have made it difficult to find suitable treatment.

Implications of regionalization of health care for marginalized women living with depression has been the inability to access the specific mental health care services they need in particular geographical locations (see Aronson and Neysmith 1997; Armstrong *et al* 2002; Armstrong *et al* 2004; Cohen and Cohen 2004; Dyck 2003). For example, Nicole was accessing the Phoenix Transition House in Prince George because of the lack of available resources in Prince Rupert for dealing with addictions. While staying at the Phoenix, she attended the Nechako day program for addictions. However, in order to attend the recovery program, Nicole was forced to leave her three young children, all Ministry of Children and Family Development (MCFD) wards, in the care of their grandparents. While Nicole struggled with her feelings of guilt and sadness, she did not have a physician in Prince George which made it difficult to be assessed for depression. As well, access to a counsellor was restricted because she did not have extended benefits and the limited business hours of community resources conflicted with the addictions day program. Nicole also talked about wanting to secure a job, in order to afford to bring her children to Prince George and go back to school at the College of New Caledonia. However, the lower paying jobs that Nicole was offered were during the day and she needed to finish the Nechako day program.

Nadine: *"Have you ever felt bad, sad, or unhappy for more than two weeks"?*

Nicole: *"Yes...when my children were taken away...I was pregnant and I already have two kids...and my boyfriend did not want to keep the baby (Britany)...so I ran away to Vancouver and lived on the streets and accessed the programs down there. They have much more resources. I kept her and I went back to Prince Rupert and my ex and I ran into each other but MCFD said I had to find a place for her to live because we were not capable of raising her. So my sister took care of her and we both did treatment and then we got her back. Then I relapsed and was gone for more than a month so my parents had to take her and so I decided to come here and take charge. MCFD just remove children and then give you six months to clean up and then you are told to do programs but they do not help you find the programs or get you in them. I have custody now and this time I chose to do treatment. They were happy I am making the decisions for myself and finally being responsible. My ex is in jail. He says we will clean up but he's been in jail for ten months. But I cannot be worried about him. I just need to focus on myself. Recovery seems selfish....so the six months was dark and even now I don't have my children but my parents have been really good and I am working on my relationship with them...they have been really supportive of me".*

Nadine: *"Do you think being a woman affects your experience of services"?* (This was a hard question for Nicole)

Nicole: *"Boundaries are crossed easier....Nechako seems ok because they are professional...I have been to treatment centres where just anybody seemed to have been hired. Boundaries are crossed at Alcoholics Anonymous and Narcotics Anonymous because ...people date rather than focusing on their own recovery".*

Nadine: *"How does accessing Mental Health services make you feel"?*

Nicole: *"Everyone knows when I entered MCFD and the Nechako...I have just learned to get over it. I have to do what I need to do...at first it was hard...because you are sitting in there because you are in trouble. I don't mind my worker...she is good but entering the building...you know you are there for a reason".*

Nadine: *"Would you change the location of the Mental Health service"?*

Nicole: *"I like when everything is central but not downtown...I avoid downtown because it is too dangerous and then you see more addictions and you have more chance or running into someone you know. And while in recovery, you don't put yourself in the middle of drug areas"*

Nadine: *"How does your health affect your daily/weekly life"?*

Nicole: *"I am much happier but I have moments...I am more balanced but depression and addictions affect my daily life. People now talk through my issues and I know where I am going which is really nice. Staff in the evening have been great...they talk to me and make feel better. In 60 days I have gained 22 pounds...I was not eating healthy at all ...so I feel better and I have more energy"*

I learned, in Prince George, Nicole could attend a day program for addictions but she was unable to find a physician to support her mental health issues. As well, while the Phoenix Transition House offered a safe and supportive place to live, there is no parental support service that would allow Nicole to work on recovery and maintain custody of her children. While children are allowed at the Phoenix Transition House and the shelter does have a child-worker for short durations of shelter programming, the responsibility of daily care is placed on the mother. Therefore, mothers wanting to attend community programs or counselling must find alternative care for children.

During my fieldwork, I observed that many of the mothers accessing the Phoenix Transition Shelter and attending addictions treatment, were not the primary care-givers of their children. I heard many women discuss the fact that their children had been given to family or taken into the care of MCFD. As a mother myself, it was emotionally painful to watch women live without their children. I questioned if the loss of children was not 'a social determinant of health' contributing to depression? Programs are sustainable and possible if individuals are engaged and supported. Successful practices meet the needs of the consumer not the service-provider. It is necessary to question the integrity of community practice in relation to women and improved mental well-being.

Geography and Prince George: A Context

According to Smith (2008a), geography or 'landscape' is not merely a backdrop to human action and life, it plays a critical role in how people live and how they make sense of who they are and what is their identity. The space that we occupy and interact with is more than physical place, it has social and ideological elements (15). Soja (1989) argued that "space" was simultaneously physical, social, and ideological and "along with material space and cognitive space, [it] is contingent on the cultural and historical context (Smith 2008a:15). Prince George started as a fur trading post in the early nineteenth century. It is located in the centre of British Columbia in between the northern and southern Rocky Mountain Trench but it is considered a 'northern town' with a population of 72,000. Its appearance is harsh, concrete, and purposeful. It is known as a resource town that consumes non-renewable resources such as coal, oil, natural gas and timber (Hanlon *et al* 2010:910). Pulp mills sit at the confluence of the Nechako and Fraser Rivers that intersect the city and dominate the physical landscape by billowing white smoke.

The downtown core is relatively small with low rise buildings and cement sidewalks lining the roads. It is the location of many community centres, homeless shelters, youth shelters, food lines, and second-hand stores with a sprinkling of antique stores, bakeries, hardware, and pawnshops. Store front doorways have locked gates and many building windows are boarded up which gives patrons or the casual passer-by a sense of despair. In the oldest part of the downtown core there is 'Historic Fort George Street' but many of its buildings, although lovely because of their heritage, sit dilapidated and vacant. There is a general consensus among the population that it is too dangerous at night, especially for women. It is a downtown lost to neglect and social despair. In response to degrading social systems, prettier landscapes, views, and late night shopping have been constructed further away from downtown. However, those landscapes are less accessible to people marginalized such as women living at the Phoenix Transition House, so this is their downtown. Most people prefer to never venture past the cusp of Victoria, where the larger and newer Bank buildings dominate the landscape and dictate who occupies the space. The downtown core is where I work and it is the world of many of the women who access the Phoenix Shelter. Francis once told me "shit, I thought Prince George was only 6 blocks! I thought the main street was Queensway".

The Influence of Place

How women experience mental health services is a reflection of the attitudes in Prince George. When we 'practice' social exclusion, punitive responses, or lack of service-provision (Mahar, Harker, and Wilkes 1990; Anderson 2004; Allan 2005), we continue the "revolving cycle of interplay between personal economic practice and the external world of class history and social practice" (Mahar, Harker, and Wilkes 1990: 3). These practices conform and confirm the expectations of society, however, they do so without "an examination of why the practice is being performed" (Anderson 2004; Lyon-Callo 2004: 19).

Although place appears innocuous, filled with homes, nature, and buildings that seemingly emerged as a natural consequence over time, space is about unequal economic relations and gender division. The "resource-based industries that dominate northern B.C.'s economy have a masculine and transient nature, which is disadvantageous to women in general because the focal point of such communities is men's work" and men's experience (Healy *et al* 2001:4). Therefore, Prince George, as a 'place', in relation to health, can be understood conceptually, "as a means of organizing population health experiences and, more particularly, as a focal point for discussion about health inequalities" (Thien and Hanlon 2009:156). According to Anderson and Gale (1992), the cultural process by which people construct their understandings of the world is an inherently geographical concern. This is because, according to Soja (Smith 2008a), ideas, ideologies, and interpretations of space, work together to "define the space" (15). While physical space represents how inhabitants interpret the space, 'place' also involves the daily practices that confirm the representation of that space (see Massey 1994; Soja 1989; Simard and Simard 2005; Domosh and Seager 2001; Razack 2002; Smith 2003, 2008a, 2008b). Geographical location is a cultural process by which people construct their understandings of the world (Hirsh and O'Hanlon 1995). Women, specifically those marginalized, learn about themselves and are represented in and through space because it is an "identity-making processes that [is] profoundly shaped by patriarchy" within physical and social structures (Razack 2002:13). The large geographical landscape of health care in Prince George has been "strongly influenced by male dominance, religion and traditional sex-based roles, independence, self-reliance, and pervasive conservatism" (Healy *et al* 2001:4). According to Casebeer (2004), this geographical and cultural interplay with regionalization defines healthcare and "envelopes communities with distinct socio-economic demographics and unique culture [and] particular political orientations and economic realities" (90). Prince George, as a collective experience, reflects social issues such as violence, sexual abuse, gender discrimination, poverty, and economic uncertainty (Meade and Erickson 2000). Better regionalized mental health for women really "depends upon the degree to which the full range of PHC [Primary Health Care] resources available is engaged in the pursuit of population health objectives" (Hanlon 2009: 44). While interest in the distributive feature of health is strong, researchers [need to pay] critical attention to the political and economic processes that contribute to the particular special patterns (Andrews and Crook 2009: 31).

Gender and mental health ideologies are built through local practice and can define the way regions organize their health care systems which contributes to inequalities and poor mental health status of marginalized populations (Casey 1993; Women's Health Bureau 2001; Meade and Erickson 2000: 8). Thus, the relationship between geography and regionalized health care is an important determinant of mental health care delivery, services, and provision (Hanlon and Halseth 2005; Meade and Erickson 2000; Morrow 2007a; Morrow *et al* 2007). Health and mental health care delivery co-exists in "relation to social institutions, processes, and beliefs (Andrews *et al* 2007, Andrews and Crooks 2009: 31) and according to Tuohy "it continues to rely on historical practices to shape current health policy and delivery" (Hanlon 2009:50). However, changing the landscape of mental health, requires nothing more than transformation of how society views heath and healthcare delivery (Lewis and Kouri 2004: 13). If mental health practices continue to conform to local ideologies then support of women's mental health needs in Prince George will never occur.

Gaps in the Landscape of Mental Health Care

Programs and services need to be sensitive to women's health because gender is a determinant of health. Women have unique needs, and the "relationship between women's special circumstances and mental health concerns need to be carefully examined [and] treatment practices need to consider the large picture of relationships, family life, education, work, and recreations and recognize how these factors affect women's mental health (Women's Health Bureau 1998: 6). Regionalization attempted to reform the mental health system at the program level, yet problems clearly exist when recommendations to improve women's mental health services are not being implemented. Women requiring mental health services are not connecting with service-providers in their communities and communities still practice inequalities because of stigma and gender inequalities. Women, in general, living with mental health troubles have ended up homeless, jailed, or in shelters. While practitioners and the public were promised community mental health, there was no clear conceptualization of the term or services that were meant to support the consolidation of regional health services (Davis 2006). For example, in the early stages of regionalization, The Ministry of Health and Ministry Responsible for Seniors and the Women's Health Bureau put together a summary report called *Women's Health in the Context of Restructuring* 1998 to promote women's health care issues in a regionalized health care system. At the time of the report, depression affected eight percent of women in British Columbia "because women are more often affected by social and psychological factors including: poverty, discrimination, domestic violence, sexual assault, and social role expectations" (Women's Health Bureau 1998:2). The report concluded that regionalized health care needed to include women, ensure their participation, collaborate with women, and provide general information on their specific needs. The paper recommended health authorities provide opportunities for women's organizations to provide input, ensure board members are representative of the community, establish a women's advisory committee, assign women's health to a specific board, and appoint a mediator to liaise between the health authority and community women's organizations. This was an endeavour never adapted or pursued by the provincial liberal government after 2001.

While regionalization conforms to provincial neoliberal cost containment, it also has the ability to assess and implement the services 'needed' in the community. Meade and Erickson (2000) pointed out, that what makes people "living in particular places unique is our ability to respond to health" and mental health (310). According to Thien and Hanlon (2009), "health research and policy must be developed through a gender-and-place based lens with a necessity for the specificities of local input" (158). Currently, health authorities through their own ideologies and practice, dictate where services are located and the number of services available which causes particular populations such as marginalized women living with depression to be under-serviced (Meade and Erickson 2000). For example, in *Let's Talk about Addictions and Mental Health Full Report 2007*, completed by the Northern Health, it states that:

> Mental illness knows no gender barriers. In the past, it was often assumed that women experienced a higher incidence of mental illness. However, the gender gap among people with mental illness is much narrower than was once suspected. In Canada, the StatsCan Canadian Community Health Survey on mental health and well-being found that 10 per cent of men experienced symptoms of mental health disorders and substance dependencies, compared to 11 per cent of women (11).

Interestingly, this contradicts the disproportionate numbers of women living with depression as described by the Ministry of Healthy Living and Sport 2009 and the report *Women, Mental Health and Mental Illness and Addiction in Canada: An Overview 2006.* Furthermore, *Let's Talk About Addictions and Mental Health* 2007, reported 'youth' and 'men' as general themes requiring more services in Prince George, arising from the consultation 79 individuals, various organizations but only one women's organization, the Representatives of Women's Shelters (*Let's Talk About Addictions and Mental Health, Executive Summary* 2007: 15-17). In the same report, contradictory information is provided between '*What is Working Now*' and '*What Needs to Improve?*' about the availability of safe housing and supports, the availability of community-based services, the number of staff, the location and times programs, and the ability of staff and volunteers in many agencies to be non-judgemental (39-40).

Two years later, in 2009, the Ministry of Healthy Living and Sport produced the report, *Mental Health Promotion and Mental Disorders Prevention* where half a page out of 79 was dedicated to '*Gender Consideration*'. It was reiterated that by Clark and Power (Ministry of

Healthy Living and Sport 2009), outcomes for women seeking mental health support are more positive if their situation is approached through women-centered integrated services that recognize history. In addition the World Health Organization in 2002 noted that, "socially constructed differences between women and men [account for the] associated responses encountered in the health sector and society as a whole" (BC Ministry of Healthy Living and Sport 2009: 18). Even with all this information, regionalized health care in Prince George continues to function in a situation where there are minimum women-centered mental health supports. Lewis and Kouri (2004) confirmed that regionalization has not been successful in expanding community-based and home care services and in integrating and coordinating services. Women with depression have been eliminated from the 'target populations' and complementary community-based housing and support programs continued to be insufficient or do not exist. Women experiencing depression and psychiatric crisis are not 'headed-off' before inpatient care is required (Davis 2006, Morrow 2007a). The poor integration of mental health services and the disproportionate number of mental health clients treated by general practitioners alone limits recovery. Currently, there appears to be no momentum in "characterizing how a population [in this particular research a sub-population] *actually* makes use of health services available" (Hanlon 2009: 45) and implementing changes to improve women's mental well-being. As well, Latimer notes (Davis 2006), women living with "co-occurring disorders (ie. psychiatric and addictions) continuing to be a 'poor fit' with existing services" (112, 126). The "visibility" factor also determines who gets services, thus those who appear outwardly 'normal' such as Kim, Anne, Nicole, and Tracy are provided limited mental health services (British Columbia Ministry of Health 2002).

According to Davis (2006), the range of services around community programs continue to predominately exist as a 9:00 am to 5:00 pm, appointment only office space, offering little in the way of outreach support to persons struggling to manage activities of daily living. Sadly, the status quo of practice has increased costs and inequity of mental health services to those who could benefit (British Columbia Ministry of Health 2002). Furthermore, little consultation or support has been offered to family members, if family members exist, despite early visions of community care, support, and prevention. Establishing an effective, comprehensive, and responsive system of mental health care for women has been complicated by different and competing interests of stakeholder groups. When client representatives have spoken to issues about choice, empowerment, and civil liberties, the provincial government has not listened and regionalized health continues to focus on" efficiencies, cost containment, and evidence of efficacy" (Davis 2006: 110).

Community Resources Available to the Seven Women

The seven women I interviewed had limited mental health resources and supports. Women living at the Phoenix Transition House face even more barriers because they are further marginalized by their socio-economic situation, co-occurring disorders, and lack of social supports. The unavailability of social programs and mental health services creates a situation of long-term crisis, increasing costs, and lack of recovery for these women. Women living with mental health have expressed dissatisfaction because the treatment approach continues to focus too narrowly on symptom management to the exclusion of other existential concerns and the idea of the client as negligible and the professional as 'expert' rather than both working as collaborators in order to achieve recovery (Davis 2006:11).

Currently, women living with symptoms of depression and accessing services at the Phoenix Transition House have access to the following mental health resources located down-town or near down-town: The Canadian Mental Health Association, The Prince George Native Healing Centre for counselling, Northern Health's Community Response Team or the Community Acute Stabilization Team for an assessment, Northern Health's Mental Health and Addictions Counsellors, and the Crisis Line, the Sexual Assault Centre (SOS), and Elizabeth Fry's Victim Support Worker.

Gwen and Living with Diagnosed Depression

Gwen, one of the women I interviewed, was accessing mental health services in Prince George. Therefore, I was interested in how her experience with mental health services coincided with the vision of regionalization.

Gwen has a history of depression and spent time during her adolescence at a psychiatric institution. She has a physician in Prince George but minimum support from family and friends. She is the mother of two, Adrian, her oldest boy, turned seven in October 2009 and John turned two in May 2009. When we set up the interview in July 2009, she had just moved into her new place. Gwen's rental house was an older run-down duplex close to downtown Prince George. She rented the top right side, and her cousin lived on the top left side and often used Gwen as a babysitter. The street itself was littered with smaller older homes, both kept and unkept. When I arrived, her front door was open and blocked by a child's gate. Gwen explained she was watching her cousin's children and asked if we could do the interview outside on the side deck. Gwen was welcoming and very personable. During the interview, she spoke about what was on her mind, she laughed a lot, and was outgoing.

Gwen: *"Adrian's father and I were together for nine and half a years. We were supposed to get married the year John was born but John is not his kid. I got mixed up with a guy I met off the internet...short three month relationship and I had a lot of fun. I choose to keep John and I told the father he did not have to help and he hasn't. He has been ordered to pay $292 for Child-Support as of March but he does not pay. I am on social assistance and so I work a few shifts a month and they take if off my cheque. So whatever I make, they just take off...maybe $300 a month. My mom was on welfare, so I don't want to be on welfare but John is too little right now and it does not make sense financially".*

Nadine: *"How would you describe your health?"*

Gwen: *"I went to my doctor. I was at the point where I wanted to hand back my kids to their fathers and just say 'I am done, I can't do this anymore'. I think I am depressed! I am overwhelmed, and I never get minute to myself. I love John but I am tired and the heat does not help. I am tired and he's tired and he sleeps in my room. My friends and I recognized the symptoms or at least that something was wrong with me. I was crying at the drop of a hat, I was angry...I did not feel like a good parent, second guessing myself.....I punched a hole in the wall.*

As Gwen and I talked on the side deck, one of her cousin's children interrupted by venturing outside naked. Gwen asked if he wanted to go "pee on potty", he nodded and she took him inside. I learned he did not make it to the bathroom. Gwen came back and apologized for the interruption which was interesting because I was the person interrupting her daily schedule.

Gwen continued to talk:

Gwen: *"Friends noticed, I was withdrawing, cartoons were making me cry....went to the doctor...it is not the first time, I told them I think I am depressed since I lived with postpartum with Alex. And having to do it on my own was harder. So, I told the doctor but before he would put me on medication, he wanted me to try counselling. I think that most doctors just give you the medication. Depression has been part of my life, I went to Maple Wood Adolescent Treatment Centre when I was younger so I have a history. I have been in and out of counselling".*

Nadine: "*How does your health affect your daily/weekly life"?*

Gwen: "*Some days I don't even want to get out of bed. I don't want to move, I just come downstairs and turn on the TV. And with children, you have to move even if you don't want too. And John is sooo needy but at least my ex will take Adrian...some days are good days and others are bad. It is really hard to stay at home with children all the time...it is easier to go to work then take care of children. This is something that is not recognized. My sanctity is my smoking".*

Nadine: "*What services would you like to access"?*

Gwen: "*No other services were offered outside of the counselling. We discussed some sort of respite and although there are places where you can go with you children, the idea is to have some time away. I just want to have a coffee by myself*".

Nadine: *What was your experience when accessing the service?*

Gwen: "*It took me two weeks to see a counsellor. She did phone right away but it takes a while to get in to see someone. Which was long since I was going crazy…I was told there was a wait list. I was going once every two weeks. She talked to me on the phone…she thought I was doing good compared to the last time I saw her. When I find myself feeling really low and I turn on the music and it pulls me out…I have to pick myself up and kick myself in the ass. I saw her on a good week…it depends on how the kids are…they affect me…and then Adrian comes home and tells me about the other house. And it hurts that my ex has moved on and his new girlfriend likes to show off that she is pregnant and basically say "ha ha, he's mine" and I feel like saying 'don't tell me that, I am the one that walked away' and 'I could have him back at any time'. I told her once…and she said no but I know I could have him back at any time*".

Nadine: "*How were you treated by the services*"?

Gwen: "*My counsellor is away. The lady Mandy is short term, this is the part I don't like, so then I have to be sent to someone else. The referral from the doctor means that social services pay for the services. So they need to see me as needing the service. All mothers need a place to go to get away from their children and see someone to talk to about the daily going on. Children are a lot of work. When I was pregnant with Alex at 24, I did not want to be pregnant…I called my mom but said I had to do it because she said she was not raising her grandchildren. She rarely watches my children but watches my brother's children. I watch or baby sit for everyone in my family. Even for my cousin*".

Nadine: "*Do you think being a woman affects your experience of services*"?

Gwen: "*I have two doctors in the same office. One of my doctor's tells me 'you're a mom', he is young and has kids so he understands. One doctor listens and the other does not. You chose to be a mom so this is your lot in life. The older generation of men seem to be harder on women, their wives did it so why can we not do it? I think you can be more victimized as a woman, by different organizations…..police, courts, your ex-partner. And then we accept things easier and people are more likely to abuse us and victimize us*".

Nadine: "*How does accessing Mental Health services make you feel*"

Gwen: "*It makes me feel like less than a mom since I am a mom and I should be able to deal with these things. Asking for help is hard because I should do everything perfect*".

Nadine: "*What would you change about the service*"?

Gwen: "*I would like the service to be longer than one hour. The hour seems a quick hi and then bye. And although the women I deal with is very sweet, she is always checking her watch. She needs to look at the clock…I just feel like asking 'do you have something better to be doing right* *now and if so I can leave'...it would be better if she just told me five minutes left. When she looks at it, it's like she is saying 'am I done yet'".*

"And I don't have babysitting...so I have to ask someone during the day, when lots of people work, to help out and watch my children. We don't have enough counselling or mental services in Prince George and being able to access promptly".

Gwen found cooperation with her doctor and was referred to a mental health counsellor. Although, Gwen likes her counsellor, she is disappointed that the appointments can only be booked once every two weeks because of large client wait lists. Gwen is part of a population of women who are not 'priority populations'. Even though many women living at the Phoenix Transition House have a history with depression, trauma, and addictions, they are overlooked, under-serviced, or even denied mental health services.

According to Davis (2006), mental disorders have a substantial impact on the quality of life of affected individuals, their families, loved ones and society because of health care costs, lost employment, and productivity. Sadly, mental health can interrupt an individual's life trajectory in early adulthood which is the case with Gwen, Nicole, and Tracy just when "education is being completed, careers being started, and families and significant attachments are being formed" (Davis 2006: 9). Therefore, listening to the stories of marginalized women living with depression and understanding the mental health practices they encounter questions the integrity of regionalization. It adds to an understanding of the relationship between regionalization, geography, and gender inequalities and mental health practice (Little 2002: 43).

Conclusion: Regionalized Health Care

According to Leatt 2004, "regionalization is still a structural change, the attainment of health goals depends on provincial commitments and mandates" (8) and it seems the provinces have wavered in their commitment to attaining health goals because they are not held accountable for them. Regionalization needs a clear mandate, provincial commitments and a participating public (Lewis and Kouri 2004). The "government must decide, finally, what regionalization should be, and then leave the regional health authorities to get on with the job, fully accountable for performance" (Leatt 2004:8). Furthermore, without clear objectives from the federal government, health organizations can take actions that benefit themselves (Ward and Bedford 2004: 56).

Women living with depression are affected by the vision of regionalization when it changes mental health access, costs, accessibility, utilization, and quality (see Aronson and Neysmith 1997; Armstrong *et al* 2002; Armstrong *et al* 2004; Cohen and Cohen 2004). There has been little momentum by regional health authorities to improve women's health or mental health access, and as demonstrated by Northern Health Website, there has been minimum participation of women's advocacy groups in mental health reports, and a lack of publicly addressed social issues such as violence, caregiver respite, and sexual abuse. While federal and provincial policy *do* affect mental health care, regionalization and health authorities ultimately dictate, how funding is directed towards mental health, based on localized ideologies and practices (Morrow 2007a: 368).

Therefore, it is important to examine spatial and regionalized ideologies and practices that legitimize and justify how mental health services and funding is directed. This is because practices make sense of the everyday world and can work to obscure contradictions while maintaining the ideas of the dominant group without an explanation of why the ideology exists. Negative representations of gender and mental health can normalize discriminatory actions and practices of the dominant group who, according to Lyon-Callo (2004), regulate and reform those that live outside and on the margins of society. The end result is realized and lived by women needing mental health services when health funding.

In the following chapter, I introduce Angie. While I watched Angie become further overwhelmed and consumed with the world around her, I was limited in my ability to offer help. Behar (1996) called the situation I experienced, the 'vulnerable observer' because while I threw a so-called life line to Angie, I was limited by my role and she was limited by the mental health services available. Angie's story illustrates how the landscape of mental health and its ideologies of inequality, space, and gender within government structures, acting through the experience of one woman. Angie's story undoubtedly 'breaks your heart' (Behar 1996).

Chapter 5: Angie's Story

What are the women's stories and experiences with mental health services in Prince George? Who are the seven women sharing their stories and why is it important to hear their voices?

Introduction

Angie*: "I would like to stop being so mad and depressed. Every drop in the sink is making madder and madder and I cannot live my life like this anymore ...and I feel overwhelmed. I want to know how to feel better".*

I met Angie at the Phoenix Transition House in March 2009. I was sitting with the residents at the kitchen table while they finished dinner. The doorbell rang and when I answered the door, Angie was standing there. I recognized her as a relatively new resident. She had long dirty blond hair, blue eyes, and a very skinny build. Her appearance was a touch of mischievous but balanced by a gentle and innocent demeanour (see Appendix D)[10]. Although, her birth name was Angela, she liked being called "Angie".

She entered the shelter looking distressed on that particular day. She followed me to the kitchen and then said really quietly and almost embarrassed, "I need something for my period".. I told Angie I would ask a staff member. I was given the keys to the storeroom and Angie accompanied me downstairs. She explained that she had just been at Sexual Assault Centre (SOS) and the counsellors were great. I gave Angie a package of liners concealed in a plastic bag. When we returned upstairs, I sat with Angie as she ate what was left-over from dinner. After dinner, she complained that the coffee was old. I suggested making fresh coffee. However, Angie

---

[10] Angie gave me permission to take her picture, create a sketch, and use the image in the research. The artist, Michael O'Toole, generously donated his time and skill in order to provide a 'face' to the audience. I am indebted to Michael for creating this gift for Angie. I promised to leave a copy of the drawing at the shelter for pick-up when my thesis was finished.

informed me that fresh coffee was not allowed after a certain time and she did not want to get into trouble.

In retrospect, I did not know that I would make a connection with Angie. However, sometimes there is a person, like Angie, who ‘tugs on your heartstrings’. During her stay at the shelter, Angie kept to herself and never had an altercation with residents or staff. I think it was easy to pass her over and deal with residents who are having more difficulties. No one noticed, except staff member Shirley that she was depressed, hearing voices, and living with post traumatic stress syndrome (PTSS).

In this chapter, Angie’s talks about her story and experience with community mental health support in Prince George. Angie’s story demonstrates the importance of the ‘determinants of health’ and the discursive practices that create a situation of limited access to mental health services. This chapter is about Angela’s struggle for survival and the real lived lives of the other women who participated in this research.

Angie: "The Quiet Mouse in the House"

When I interviewed Angie in May 2009, she had recently returned home to her husband and children. Angie met me at the Phoenix Transition Shelter on a Wednesday evening in order to participate in the interview. The interview took place in the downstairs office and this is where I started to learn about Angie’s story:

Nadine: "Where were you born"?

Angie: "In New Westminster, and lived everywhere, I have an older sister and younger brother…all step siblings…my mom and biological father were never married, an affair produced me. My mother lived common-law with my step-father, he was abusive. I don’t know if he abused others. I was 16 when I went to Court because he raped me….something that my grandmother pushed for but my mother never believed me. And the Courts told me it was a ‘love *affair' and 'I should find someone my own age- boyfriend'. He was 37...no one falls in love with a man that old...not in their right mind...I did not have a lawyer....I was abused...I was told it was nothing...GO Home!. My grandmother raised me but my mom had me but I was always at my grandmothers because I was not safe at home".*

Nadine: "How old were you when you met your first husband"?

Angie:" I was 21 and I had my first child by the time I was 24 and I left right after because of the mental and emotional abuse...not really physical...it was the words he used. I met my second partner, David[11]*, when I was 26 and I have been with him ever since."*

Nadine: "How long did you stay at the Phoenix Transition House?"

Angie: "From March 3rd...just over a month."

Nadine: "Why did you access the Phoenix"?

Angie: "I have 3 children, 34, and married in Prince George for three years. I have a 16 year girl living with me and she took advantage of the situation I gave her...and it caused me to actually melt down. I became suicidal and I did not want to deal with anything. A social worker was at my children's school and she told me to come here...she brought me here....I was here for support and benefiting in knowledge I did not know. I brought this 16 year old in, to have a roof over her head...she needed to go to school and find a job but she never supported herself for the last seven months. We put everything we had into her mouth. We were dishing out for her and that was not the deal when she got there. She was supposed to do twenty hours of babysitting but nothing was done. She got too comfortable with my husband and she got too comfortable with my kids.....taking advantage of me...laughing...and...I melted down...my husband told me to cool down and she could stay. ***I was the quiet mouse in the house.*** *"*

Nadine: "How do you feel about your husband having the children"?

Angie: "He's an awesome dad, feeds, baths, clothes them."

Nadine: "Are you attending any programs at the shelter"?

Angie: "Yes. The programs opened my eyes. The programs here are not available out there (in Prince George) or if they are available, no one knows where to go to get them. I attended the 16 Steps, Striving for Balance, Stitch and Bitch, umm...Grief and Loss, and Friday Morning Circle. We got to color and I never got to do that."

Nadine: "Do you have a physician"?

Angie: "I have a physician but I would not go to him because I do not like him, so I really don't have a physician. He did not support me when I separated from what you would call my first common-law husband Bob. I took Chris, my oldest child to Hope to get away from my husband and think about things. The relationship was terrible; he was crazy and had mental health problems. Lots of his family had schizophrenia ...Bob's dad had it, Bob's dad's dad had it and

---

[11] The names of Angie's children and common-law partners have been changed to provide anonymity.

the mother had it and both aunts had it....so Chris has a little of this in him...but we are dealing with it."

Nadine: "So you have mental health services for your son Chris"?

Angie: "Yes...my first visit there...I will tell you I was kind of annoyed because they told me it was normal boy behaviour...his misbehaving was normal...but it is not normal to kick your brother and sister for every little thing...this little boy has a lot of issues...you are trying to help your little boy...so I have not been back...my impression is that they are looking for the more needy kids that need help...but our case fall through the cracks. I have told them that his dad has mental health but they keep telling me that they don't show until their teens but that is crap, I have heard of little boys that are eight and nine with psychotic tendencies. My son has episodes...he has blackened my eyes, bruised my ribs...a very strong willed little boy and if it doesn't go his way...he'll let you know physically, I have been beat up by this kid and for them to say it is normal. So, they just leave him alone for the really needy kids."

Nadine: "Do you feel like you are fighting the same battle over and over"?

Angie: "Yes. Chris came out to Hope when I met my new husband, David, a year later. When we were in Hope, Bob called and wanted to see Chris. As soon as he got Chris, he went to welfare and said that I abandoned him, so my name got taken off and I had three years in Family Court trying to get my son back into my possession. We both had guardian ship and then two years ago he had the same opportunity, "I want Chris for a week" and what does he do? He took Chris to his ex girlfriend's houses parents' place and then moved to California, taking him to Disney land...I told my social worker and because I filed late so now I have to reapply and take it down to the courthouse and have it re-opened here."

Nadine: "So, you needed somewhere to get support and services"?

Angie: "Uh huh, I needed to know I am not crazy...ok I have social workers and home workers...but they are there because of Chris."

Nadine: "How old are the other children?

Angie: "One just turned six (Matthew) and the other five (Dawn) and social services are not interested in the others. Chris is the problem child, he has been conned, told to go out on the streets and ask for money (to help his daddy), brought to food banks, he is used as a meal ticket...as a pawn...basically..."

Nadine: "Where is Chris' father right now"?

Angie: "Pigeon Park (Located in East Vancouver)"

Nadine: "What do you think are the largest stressors in your life"?

Angie: "Quite a few... social services, the court services, my ex, my mother-in-law, my mother, and David...we have a very unhealthy relationship...he needs to work on his health issue...he something with his throat...he has not had surgery...so the scar tissue has not been *removed....he has a small hole to breathe through... Pulmonary Artery Obstruction....I take care of him, I take care of the kids...and the so-called nanny".*

Nadine: "What services have been offered to you"?

Angie: "I got into SOS (Sexual Assault Centre), Phoenix referred me. I was assaulted when I was thirteen years old and it continued until I was 16". The counsellors at SOS are awesome...down to earth. My counsellor is awesome, I can tell her how my day is going, there's no judgement and we talk about everything and anything...whatever I need...it is a one-shop stop".

Nadine: "Were you referred to any other programs"?

Angie: "Well, they did try and get me talking but I was all bound up inside for so long. I told them I was all fine and they did not have a clue. I have a lot to say but I did not know how to open up. For two years they had been part of our life (workers) but I was good at hiding that all was ok. When they were coming, I could open the curtain and pretend all was ok.

Nadine: "So, have you ever felt bad, sad, or unhappy for more than two weeks"?

Angie: "I went months, years. The whole family did not know...no one helped me... "

Nadine: "How does your mental health affect your daily/weekly life"?

Angie: "It bothered me to be depressed. I isolated myself. I always had the shades down and I did not like life. I did not like breathing, I did not like playing with my kids, I did not like the computer, I did not like the TV, I did not like reading...I was just a mess and I could not ask for help and the social workers did not pick up on it. I was hiding it, when they came, everything was bright. Sort of like closet depression. I hid it all from everyone."

Nadine: "What do you want now"?

Angie: "I want to go back to school. I quit school and I did not even go to prom....who doesn't go to prom...that is every little girl's dream. I want to finish school, I want to get my GED and my ECE and I want to open up another a Strong Start. They are small goals but they are my goals. I want to move out and be a social butterfly and not be afraid anymore even of making new friends."

Nadine: "Angie you are good at it, I remember you serving tea to the church ladies and you were you having a good time".

Angie: "I was!!!! Yeah that is who I am...it makes me feel good."

Nadine: "How long were you depressed"?

Angie: "Forever but especially since I had Dawn...I had post-partum. I had no time to heal. I had just had Mathew and I did not want to have two children so close together but it happened and I knew it would be a lot. It was hard. Then it was worse during my pregnancy because my hair was falling out and I was puking because I was under so much stress. David did not even try to understand what my head or body was going through. And when Chris was three that is when my ex came back and said 'oh he is three years old and I don't want him anymore" because he *had to go back to work so he found someone else to have kids with so he could stay at home and be a dad....I had Mathew, Dawn and Chris. I was overwhelmed and too tired. This Tuesday I am going into the doctor's with my social worker and we are going to discuss having me put on anti-depressants."*

Nadine: "Can you let me know what happens"?

After the interview, I walked to Tim Horton's with Angie to buy her a coffee and treats for her children. During our coffee, Angie informed me that, like Tracy, she lives with Cerebral Palsy. She self-medicates with marijuana. She lives in 'the hood' with her children, husband, and two dogs. The family lives below the poverty line and she finds it impossible to find decent housing, enough food for the children and animals, clothing, and other necessities. When we finished our coffees, I walked Angie to the corner of 15th and Victoria, hugged her, and said 'good-bye'.

Angie returned to the shelter a couple of weeks later as a resident again. She was there until August 2009 and during her stay she was always quiet, unsure, and tended to keep to herself.

Re-Constructing Women's Mental Health

Governments make mental health policy by drafting legislation and those legislators will be influenced by current ideologies, economics, practices and "particularly by public perception" (Davis 2006: 92). These ideologies conjure images or representations and demonstrate how the world works and how we, as people, should act and function in understanding a particular group (Said 1979). Federal and provincial ideologies affect everyone needing mental health services because they serve as a reality that legitimizes how people think and act in their social surroundings (Bailey and Gayle 2003) towards others and about themselves. Marginalized women can feel stigmatized by the idea of mental health and an ideology that 'they are simply not coping', as well as by the fact that mental health services are not available. We need to radically shift our ideologies about marginalized women, depression, the need for social services, and the commitment to improving the lives of women.

One way to "dislodge" science and inequality from its privileged position is to focus on these historical conditions of 'scientific production' and revise that production to meet the needs of women (Martin 1990: 72). Bourdieu 1977; Giddens 1979; Sahlins 1981; de Certeau 1984 (Ortner 1996) discuss power and inequality may be produced and reproduced, they can also be changed through practice. Therefore, if we understand inequality and practice, we can change "contradictory forms of power [including] race, ethnicity, class, and gender" (Ortner 1996: 3). Feminist movements challenge inequality and dominant paradigms while building a body of theory and practice to influence policy and at the same time respond to women's concerns, needs, and 'agency' (see Moore 198; Behar 1995; Cole 1995; Martin 1997; Harraway 2002; Morrow 2007a). Therefore, I thought it was important to ask Angie about her experiences with mental health and what practices she would like to see changed:

Nadine: "Do you think being a woman affects your experience of services"?

Angie: "Yes. We are supposed to have no problems, it is the man who has the problems because of work stress and we just stay and do the easy job of taking care of the kids. We are expected to suck it up, like 'suck it up buttercup'."

Nadine: "How does it make you feel when mental health services are provided"?

Angie: "It makes me feel that there is hope out there but you have to get the right hope, the right spot and the right people. I wish more services were available, even just listed on a bulletin board even in a grocery store I did get a resource book but it does not have everything in there, it does not have SOS in there and so it did not have what I needed."

Nadine: "What would you change about the service"?

Angie: "I want good people, to know where they are, and to advertise"

Nadine: "Do you think that Prince George offers enough mental health services"?

Angie: "No they do not but they should because we are the north. People come here from other areas, so why don't we have an equivalent number of doctors and services, if not more since we have to give services to other areas"?

Nadine: "What would you do to make services better"?

Angie: "Staff members need to be better equipped, for example, I came and asked for someone's number and no one had it. The staff also should not judge. They should just be there to support because when you are depressed it makes you want to shut down more."

Marginalized women living with depression, such as Angie, are simply trying to cope with daily activities. Self-advocacy and agency can be difficult to achieve when treatment, recovery, and resources are not available. Therefore, listening to and recording the voices of women experiencing depression is a form of advocacy and a chance to re-construct current mental health practices.

Themes of Fragmentation: Shared Stories of "Falling through the Gaps"

Throughout this thesis, I talk about marginalized women's mental access as limited and defined because of ideologies of inequality that are maintained in the structure of health care. The interviews with seven women confirm that their access to mental health services is prevented because of a lack of mental health promotion. Health determinants are not understood, there is a lack of available mental health services, and there is a lack of integrated services that meet the needs of women. The seven women I interviewed (Kim, Anne, Francis, Gwen, Nicole, Tracy, and Angie) are all marginalized by social and economic disparities. Three of the women were in their twenties, two in their thirties, one in her forties, and one in her fifties. All identified themselves as "white", except Nicole who identified herself as Aboriginal. Four of the women stated they were using the services at the Phoenix Transition House to deal with addictions and three wanted support in dealing with what they described as unhealthy relationships and lifestyles. Although these women were very different, a thread of commonality was their limited access to various and fragmented mental health services.

The landscape of mental health for marginalized women is fragmented and women like Anne, Kim, Tracy, Nicole and Angie are not heard, recognized, or provided services. Marginalized women are lost and forgotten in a system, that defines mental health promotion in *Best Practices 2002* but, through its non-committal approach to its own recommendations, provides no clear direction to mental health service. Currently, patients with co-occurring issues continue to be considered a 'poor fit' (Davis 2006) for mental health services. Service practices continue to ignore the specific needs of women and thus women are not receiving information about resources and treatment options. Just as Harraway (2003) argued that the descriptive insights of feminist ethnography are the only way to put women back into the stories, mental health services need to do the same. As Smith (2008a) confirmed, while we are defined and made through our landscape, we can also be excluded. It is a practice that allows marginalized women to '*fall through the gaps*'.

The interviewees' stories and the exclusion of their access to mental health services illustrate an overarching picture of how federal, provincial and regional mental health services are structured. Davis (2006) stated that people with mental health problems, specifically women with depression are not connecting with community services. Therefore, I used the women's words and interview responses to present a clearer picture of the effects of political complacency and service fragmentation. The pervasive eight themes from this research coincide with feminist writings that recommend the need for more collaborative and women-specific services. Yet, these themes continue to persist in the experiences of marginalized women and define their access to mental health services.

1. Diagnosed Depression

Four of the seven women were diagnosed by a physician with depression and two were taking prescribed medication specifically for the depression. Francis was the only woman who refused to take medication. While, Francis admitted to taking depression medication previously, she preferred to eliminate all drugs. However, she talked about being aware of the "ability to relapse and think dark thoughts". Although Kim and Nicole used the word "depressed" to describe their feelings, they were never formally diagnosed. Anne was the only woman to clearly say "no" she has never felt bad or sad for more than two weeks. She followed the response by stating that it is because "you realize there are people worse than you so there is no need to be there". The **diagnosis of depression** of only four women demonstrates that increased knowledge about the determinants of health and mental well-being is needed to increase the diagnosis and access to mental health services.

2. History Associated with Depression

I asked six of the women, who described feelings associated with depression, if they had past experiences with the same feelings. Five responded they had the same feelings in childhood and adolescence. Four of women discussed potential reasons for these feelings as abuse in their childhood homes. Three talked about being physically and sexually assaulted as children and one talked about verbal abuse. Gwen stated no abuse occurred while she was a child. She was only interviewee to receive mental health services as a resident in an institute in Vancouver, BC during her adolescence. Five women had a **history of depression** as a youth, yet only one had services at that time because women's mental health is feminized and symptoms associated with depression are often overlooked and normalized.

3. Dealing with Feelings Related to Depression

I asked the women if anyone, such as family or friends, noticed their feelings associated with depression. Six of the seven women talked about trying to hide how they felt from everyone. Four of the women talked about using illegal drugs and alcohol to hide their feelings. According to Francis, drugs and alcohol "masked" her feelings. Anne talked about using prescribed medication and alcohol while living in what she called "an abusive relationship", however, she never associated it with hiding feelings or coping, it was just a matter of fact. Kim was the only woman who never used any form of drug or alcohol. Angie admitted to smoking 'pot' for years but said it was for her Cerebral Palsy. Six women attempted to **hide the depression** because they were embarrassed by the associated stigmas and labels. These ideologies of self-shame are built and understood through the women's interaction with place (e.g. Prince George) and structures (e.g. health care)

4. Limited Services Accessed for Depression

While four of the women were formally diagnosed with depression, Gwen was the only one seeing a professional counsellor at Adult Mental Health. Angie had recently been put on medication by the Crisis Response Unit and was waiting to be assigned a counsellor from Adult Mental Health. However, she had received counselling for the Sexual Assault Centre (SOS). Two women were accessing an addictions counsellor during their eight weeks at the Nechako Day Program. Both women mentioned concerns about finding a new counsellor when the program finished. Kim visited a counsellor at the Native Healing Centre a few times, however, found it difficult to get an appointment and find care for her children during those times. Francis and Anne both talked about accessing addictions groups such as Alcoholics Anonymous for support. Anne also talked about using a priest for support. The **limited access** to varying services highlights that services are not integrated or working collaboratively.

5. Mental Health Service Experience

Six of the women talked about being appreciative with any counselling or support provided. The six also stated they would like more support, more frequent visits, more coordination among service providers, and more permanent long-term support. Anne was the only woman, while appreciative of groups and talking to a priest, did not want to put those two resources in the context of 'mental health' services. If six of the women want more support, then this demonstrates that women's access to mental health services is limited.

6. Perceived Barriers to Accessing Mental Health Services

Six of the seven women talked about not having a vehicle and the difficulty of transportation. One of the women talked about the stigma and labels she felt because of her past as "an addict and prostitute". Tracy also discussed the label of 'addict' and a physician's hesitations with prescribing medication unless 'clean' for a certain period of time. Angie felt no one listened. Anne talked about ageism and discrimination but referred these labels in relation to accessing housing and finding employment. While only one woman did not have a doctor, four of the women talked about a lack of cooperation with their physician. Only Gwen was happy with the support from her physician. Six women talked about **barriers** including transportation issues, child care, and money revealing that mental health services are not designed to promote easy access.

7. Personal Feelings Associated with Mental Health Services

All the women I interviewed, responded 'yes' to feeling overwhelmed recently. Although their reasons varied from addictions, children, housing, employment, finances, and relationships, they all talked about wanting help. However, Francis thought that she did not deserve help because of who she was and was shocked when support was provided. Angie and Kim used the words "not good enough" and "incompetent". Tracy talked about being a failure because she did not want to be like her family. Nicole also discussed feelings of failing associated with her children and parents. Gwen stated that she felt incompetent, as well, and not a good enough mother. Although Anne never associated her feelings to any issues of mental health, she did mention that she felt guilt about leaving her ex and not meeting the expectations of her adult children. All the women described **personal feelings** of being overwhelmed and many felt they were failures to their family and children. This ideology conforms to neolibralism's focus on 'blame the victim'.

8. Support from Family

Four of the women discussed a lack of support from family, one woman discussed a minimum level of support from family, and two of the women stated their parents provided support financially and with the care of grandchildren. The three women with support from their parents, talked about being grateful for the connection, for themselves and their children. These three women also talked positively about family and friends as social supports. While Francis told me she had no family support, she talked extensively about years of support from the staff at the Phoenix Transition House. She felt that they contributed to her overcoming issues related to mental health, addictions, stigmas, and poverty. If women are discussing a lack of support from family, then regionalized mental health care cannot best be achieved through 'community care' and 'home care'.

Conclusion: Angie's Story

As I mentioned, my fieldwork at the Phoenix Transition House finished at the end of August 2009. During that last month I spent more time with Angie. I accompanied her to the Emergency Room at the hospital for an eye infection, we went for coffee, and I met her after her mental health appointments.

In September, Angie and Tracy moved out together and into an apartment off of Queensway. She gave me her email and new address. On October 9th, two days before her birthday I dropped off a card. I was greeted by Tracy who explained both women had relapsed and while Tracy returned to the Phoenix for support, Angie had been missing for a week. That was the last time I had any form of contact with Angie or Tracy. Two months later, I heard from other residents that Tracy was trying to get into another addictions recovery program and Angie was on the streets, using drugs and in a bad place. Although Angie wrote down my work phone number and email on her emergency relapse plan, she did not contact me.

In November 2009, Kim informed me she could not afford her rent anymore so she returned to live with her ex-husband. We kept in touch through email but she said her ex-husband, now current common-law partner, was angry with my new place of work, the Northern John Howard Society. I was informed the phone and computer could not be used without his presence. I lost all contact with Kim by December 2009.

I understand that both Nicole and Anne are doing well. Gwen moved into another house with her children and since I had no forwarding address, we lost contact. However, while I was driving on 5th in spring of 2010, I saw her smiling and talking to her youngest son on the corner of Central. As for Francis, she emails infrequently with happy messages of her current travels of the United States.

As this chapter about the seven women's stories concludes, it represents a closure of the fieldwork and the research. However, it also represents a new vantage point and a new space to begin reflection. In the next and final chapter of this thesis, I reflect on the research and how my view of the mental health landscape, experienced by marginalized women has changed.

Chapter 6: Engaging and Supporting Women

FRIDAY, AUGUST 15th 2009- Participant Observation Notes (excerpt)

It was a beautiful summer day in Prince George. I sat outside on the patio of Books & Company having lunch and reading an Art magazine which I had just purchased. I was waiting to meet Angie, she had her first appointment with Crisis Response Unit (CRU) located across the street from the book store. When Angie did find me, she was wearing jeans, a blue sweatshirt with yellow GAP letters and had her shiny black purse. Her hair was pulled off her face and she had her teeth in. Angie sat down and looked at me exasperated; she said that she has been diagnosed with post traumatic stress syndrome relating to some experience with her mother. The therapists did not know the incident that triggered the PTSS and neither did Angie. I asked "so the voices are from PTSS" and Angie said "yes, that is what he says". She then pulled out two prescription pads with illegible writing. I could barely make out three individual prescriptions. One was for a sleeping aid and the other two I could not decipher. Angie was upset and stated she was confused about taking the medications after being clean for so long. We then discussed the anti-depressant and side effects. She was informed that the combination of medications could make her feel sick and drowsy. We both laughed because we understood the irony that to feel better mentally, you have to feel worse physically.

I bought Angie a coffee while she looked through my Art magazine. When I came back with her coffee, she told me she used to love drawing and needed to get back into drawing figures and people. She flipped through my magazine slowly and analyzed the pictures. We talked about the pictures and the beautiful images.

I remember August 15th 2009 for the warmth of the sun and my view of the long-line-up for coffee. This visit was one of my last with Angie and I was completely unaware that she would soon relapse, become homeless, and start using drugs other than marijuana.

I started this research with the vague feeling that current mental health support neglects the unique needs of women. From previous front-line experience, I felt that mental health support failed to recognize the distinct needs of women and that the services in Prince George were not provided in a timely or consistent manner. Consequently, women's well-being is jeopardized, thus encouraging an increasingly feminized landscape of mental health issues. I wanted to know why women like Angie, who have lived through sexual and physical abuse, disability, poverty, and trauma, were not offered the mental health counselling and support they required. Stuart *et al* (2004) notes that women who seek help for depression represent only a small proportion of depressed women or women in need. Research also indicates that depression in women is both under and over diagnosed as well as under, inappropriately, or over treated. Even though recommendations related to women and depression promote acknowledging the social, psychological, cultural, economic and biological factors, these have not been incorporated into either mental health recovery or prevention services (Perry *et al* 2006:18). Ultimately, the relationship between women, society, and mental health service delivery is yet another contributing factor to women's mental well-being. Therefore, I wanted my research to contribute to an understanding of how marginalized women experience regionalized mental health care in Prince George. Best expressed by Burstow (2005), I believe:

> We all have the responsibility to alter the social structures by which some people are oppressed, some are privileged, and all are dehumanized. What further complicates praxis is that, given the complexity of location, it is never the case that only one movement has bearing on people's situations (245).

It is important to remember that it took years before Angie was diagnosed with depression and PTSS because her behaviour was not outlandish, violent, or public. Ironically, and to her own detriment, she was quiet and complacent and thus went unnoticed. Angie's behaviours were normalized by the people around her as a consequence of her gender and situation. In June 2009, Angie started hearing voices and although she called the Crisis Response Unit in July, the earliest appointment was August 15th 2009. As a result, Angie was provided mental health services five months after she entered the shelter and upon her own request. The subtext is clear: Angie was not seen as a priority and she needed to become more mentally ill or display violent behaviour before services were made available to her. Unfortunately, there was no intervention for Angie before her mental health became more severe. Angie ultimately 'fell through the gaps' of the mental health care system because she was not provided with timely or consistent mental health care as a result of her circumstances.

My view of women's mental health in Prince George, especially for those who are marginalized, is that they will continue to face challenges in achieving mental well-being due to the current federal, provincial, and regional delivery of health care. Mental health support for marginalized women living with depression is limited because this group of women are not protected by federal national standards nor are they a priority for provincial and regional health agendas. Although the federal government is not constitutionally responsible for women's mental health care delivery, it made itself an important participant and leader of health care delivery with the *Health Care Act* and the *Charter of Rights and Freedoms*. However, in the current political and economic climate of neoliberal ideology, the federal government has distanced itself from the leadership of health care standards and decreased funding through the Canadian Social and Services Transfer in 1996. This neoliberal governance disadvantages marginalized women by decreasing social program funding, and creating increased access inequalities to social programs and health care.

The response of the provincial government to the decreased funding and federal neoliberal influence was *Patients First* and *Best Practices.* The province further decentralized health and mental health care into five regional health authorities. Yet, while the provincial government is constitutionally responsible for the delivery of health care, it has provided little leadership to health authorities or accountability for each region's health priorities. Health authorities were given the power to centralize services and implement their own agendas without full representation of sub-populations (for example those who are socially marginalized in the community). The system can easily overlook the specific populations it was designed to help. We need to recognize that social institutions and health care structures function as discourses of power, their particular vantage point, both generally and specifically, shapes the relationship and our understanding of women and mental health.

Currently, in Prince George, women are not being represented as a target population for mental health services. In fact, women are being disregarded because community organizations are focusing on men, who display more physical symptoms, and individuals with more obvious mental illness. Mental health structures in Prince George need to acknowledge that transforming ideologies must be accomplished through their own practices. When there is no guidance through federal national standards, decreased provincial accountability, and an advocacy ‘chill’, who is going to support the mental health needs of women who are already marginalized?

My purpose in examining mental health delivery and performing interviews was to demonstrate that the current mental health practices in Prince George do not account for the unique needs of women. There exists minimum feminist research that incorporates stories of marginalized women’s experience of mental health services. Therefore, I wanted to be part of a changing discourse that uses women’s stories in a discussion about how the delivery of federal, provincial, and regional health care is influenced by ideologies of gender, mental health, and place. This paper provides an avenue for the women directly impacted by the health structure, to provide feedback on their experiences and solutions, on how best the system could be improved to provide better support. I wanted the women to tell their story about how efficiency and efficacy promotes their mental health. By providing a space for stories, it also provided an opportunity for deconstructing the mental health structure and its impact on marginalized women. A feminist perspective demonstrated that heath care discriminates based on gender because it does not provide health care in a manner that distinguishes the specific needs of women. For example, many medical services are provided through extended medical care which puts marginalized women at a disadvantage because of their limited access. The seven women I interviewed also demonstrated that even with a diagnosis of depression, a history of associated feelings, or trauma, there was limited access to mental health supports.

While this research only scratches the surface of the issues challenging marginalized women's access to mental health care, it begins to shed light on a serious issue. Women are being impacted in a myriad of ways by our political, economic, and social structures and their mental well-being is compromised. The research provided the opportunity to engage specifically with women accessing services at the Phoenix Transition House. I was able to ask women how a mental health system could function better to support their needs more directly. It was also a creative endeavour that linked participant observation notes and interviews, ideologies of inequality, and health policy. My desire was for the audience to feel engaged with the interviewees and experience, with the women, the difficulties they encountered when accessing mental health services in Prince George. Too often, as a society, we are complacent in the needs of those who are marginalized and this ignores women's valuable contributions and participation in the mental health landscape. This research demonstrates that academically, there is room for marginalized women's voices, and that their stories need to be heard to advance policy changes. We need more feminist research that challenges mental health, as a structure, and provides opportunities to hear the stories of women. Patriarchal ideologies stigmatize women, especially women who live with various oppressors, and they normalize the resultant mental health issues faced by women by blaming gender. If we challenge ourselves, accepted mental health ideologies, and the consequences of resultant policy, there presents an opportunity to change and transform practices related to gender and mental health.

The voices of Angie, Kim, Anne, Francis, Tracy, Nicole, and Gwen provided real insight into mental health services in Prince George. All the women, except Anne, talked about wanting access to more mental health services, yet their gender-based circumstances continue to be neglected in the design of regionalized mental health services. The women who participated in this research demonstrated the impact of long waiting lists for traditional mental health care services, and that access to similar counselling services is unavailable or financially inaccessible. The provincial governments and the Northern Health need to listen to the voices of marginalized women and reconsider their desired outcomes for women's mental health. They need to adapt mental health care delivery to accommodate women's needs and provide a space for women to achieve mental well-being in a manner appropriate to their needs. This transformation includes acknowledging that women encounter daily social, economic, and political barriers that produce individual mental health responses that increase the likelihood of developing depression.

By participating in interviews, these seven women also challenged systemic inequality by demonstrating strength, endurance, humour, openness, and selflessness. This group of women re-negotiated their agency by recounting experiences and challenging practices that defined their access to mental health. Furthermore, the women impacted, strengthened, and expanded my vantage point by enriching it with the information I learned. Although it was disheartening to hear the women's stories and experiences of difficulties and barriers encountered by those who wanted better mental well-being. I was surprised and unprepared for the rewarding relationships

I formed throughout the research. This thesis was written with to share women's stories and provide personal examples of why mental health services need to contextualize women's health by acknowledging the intersection of gender, the social and economic positions of women, and their unique backgrounds that contribute to depression.

As a feminist researcher and a person who listened to the experiences of marginalized women, it is my responsibility to share my recommendations for improving the lives of women and their access to mental health services. Only through continual dialogue about the specific needs of women will the necessary social and structural changes occur.

First, I suggest women, researchers, and front-line workers start sharing stories about depression and limited access to mental health services. Through conversations, women can gain knowledge about determinants of health, confirm structured inequality in health care access, and be provided a space to hear about experiences with mental health and service access. I believe that by engaging in sharing stories about ideologies of inequality, gender, and mental health we can start new discourses that work to de-stigmatize and de-marginalize.

Second, I think we need to make information about mental health services, women-centered services, and advocacy services more readily available for women. I started this research thinking a booklet with a list of resources for depression was necessary, however, I think a one-page *'Mental Health Cheat Sheet'* that lists some key mental health and advocacy services is more beneficial. I also believe that promoting participation as a community member is important for developing a sense of belonging and connection to place. In one of my past positions as a front-line worker, I created a monthly events calendar detailing positive and fun activities in the community that were free or relatively inexpensive. I distributed the events calendar to numerous local organizations that worked with marginalized individuals. I recommend the "cheat sheet" resource list and events calendar because both items take minimum time and effort but offer choices that can have a big impact.

Third, I believe that the Northern Health Board in charge of delivering services needs to be held accountable for the implementation of regional health needs and provincially-led recommendations that support marginalized women. For example, *Best Practices 2002: Housing* recommends focusing on the housing and shelter needs of women experiencing violence and mental health. The report also discusses the training of shelter staff to meet the needs of women with mental health. Yet, these recommendations continue to be unaddressed. However, staff knowledge improves the recognition of mental health symptoms and treatment options being suggested. As well, providing safe housing for women improves their chance of achieving mental well-being. As a community, we can support women living with depression by attending the Northern Health Annual General Meetings and raise concerns about agendas that do not address the interconnectedness of women's issues regarding safety, housing, and mental health. We can also voice our concerns with the local member of Legislative Assembly and the British Columbia Ombudsperson.

Fourth and last, I suggest that stronger advocacy be used to confront complacency and the normalization of policy that perpetuates a feminized landscape of mental health. Individuals need to re-think their own approach to marginalized women by promoting anti-violence, pay equality, gender equality, and affordable safe housing. We can also practice agency and fight complacency by assisting marginalized women to navigate complaint processes with the providers of services such as: Northern Health, BC Housing, Ministry of Children and Family

Development, Ministry of Housing and Social Development. As well, there are also regional agencies that provide advocacy support for marginalized women, therefore, I recommend promoting contact with these agencies such as: The Representatives for Children and Youth, Prince George Native Court Worker's, The Phoenix Transition House, Prince George's member of the Legislative Assembly, and the British Columbia Ombudsperson.

As for myself, I will incorporate all my suggestion as I continue as a front-line worker, now better equipped with an understanding and knowledge base that allows me to challenge unequal practices. I will also be returning to the Phoenix Transition House as a volunteer in September 2011 where I will have the chance and the responsibility to practice these recommendations through my own actions.

Post Script: Final Notes

TUESDAY, JUNE 28th 2011-Personal Notes

It has been almost two years since I finished my fieldwork at the Phoenix Transition House. While I have been busy writing, raising two children, and working, there is not a day that goes by that I do not think about the women who I interviewed and the others who were living at the shelter. I could have talked more about the women I interviewed, about life stories shared, sad moments endured, and the giggles of funny incidents, alas, a thesis is only so long! Ironically, as I have talked about the problems of the researcher as an intruder in the lives of marginalized women, I now have the opportunity to say that I was impacted in a memorable way as well and it influenced my research and my writing.

Dialogue between Disciplines

In order to provide a richer understanding about the stories of marginalized women's mental health access, I needed to create a dialogue across the disciplines of Anthropology, Geography and Gender Studies. I used feminist anthropology and ethnography to write about marginalized women's experience with mental health care in Prince George because I was inspired by the work of Ruth Behar, Sally Cole, and Vincent Lyon-Callo, and my supervisor Dr Angèle Smith. These researchers create a space where people and their stories come to life and their personal experiences resonate throughout the writing. I wanted the audience to hear the voices and words of the women and I wanted the stories to be personal and to evoke a subjective emotion that might work to erode the strength of political discourses of inequality. Anthropology allowed me to bear witness and tell the stories of women and it provided me the platform to examine underlying assumptions based in prejudicial ideologies. Gender Studies expanded my understandings of gender inequality and approaches to developing rich interview notes and Geography (specifically medical geography) kept me focused on the power and practice of health care delivery from a federal to regional context. Together, the disciplines gave me a chance to explore myself and the women in relation to ideologies that reside in health care delivery.

I learned that when doing research about the lives of marginalized women accessing services at the Phoenix Transition House, I needed to use an extended time-frame, focus on the oppressions encountered by the women, and the influence of my role as researcher. Collaboratively, these disciplines (Anthropology, Gender Studies, and Geography) provided reasons to enter the shelter as an engaged researcher and accept and write about the litany of emotions, perceptions, and subjective feelings. Yet, it was Anthropology and my supervisor that directed my focus to the larger picture. The dialogues between my supervisor and myself created a valuable space about seven women's limited access to mental health services, which I could then use to challenge the larger structure of health care and its perpetuation of ideologies of practices, inequality, and gender.

The Larger Picture

THURSDAY JANUARY 1st 2009 Participant-Observation Notes (excerpt)

I began a conversation with Amber. We discussed the issues of distrust that many residents have towards people doing research. Amber told me a story about attending a group meeting where the women were dealing with drug addictions and prostitutes. The group was designed as a circle and each women spoke about her personal experiences. The last person to talk, declared she was a researcher and was studying the women and prostitution. I explained that my intention was not to focus on the women but the limiting structure of health care.

My role as researcher should be under scrutiny because ultimately, it is *my* interaction, *my* interpretation, and *my* writing that creates a space for women's voices to be heard. However, by using feminist research to increase the awareness of the barriers encountered by marginalized women like Kim, Anne, Francis, Gwen, Tracy, Nicole, and Angie who are disadvantaged by the structure of mental health care. I made myself accountable as a witness to the experiences of women. I also provided a space for those experiences to be heard. Therefore, I defined my agency.

Being a witness and understanding marginalized women's oppressions and the discourses of power started with recognizing my own practices of dominant ideologies of inequality. When I started this journey, I did not understand the pervasive ideologies that infiltrated and informed my own front-line worker practices. For example, in many of my past work experiences, I have been asked to challenge the needs and capacities of those marginalized rather than the practices implemented by management and the desires of the funding sources. Therefore, I needed to understand the connections and disconnections between marginalized women, the larger political discourse, and how I fit into these systems that perpetuate gender inequality and power imbalances. As a researcher, I needed my understanding of discourses to be challenged before I could really 'do' justice with women's narratives and feminist anthropology.

The metaphorical light bulb turned on during classroom discussions with my supervisor about a book written by Lyon-Callo (2004). As discussed by Kuhn (1970) and Bourdieu (1990), I had difficulties absorbing the new paradigms presented by my supervisor and I fought to maintain learned habituated practices. Eventually, I started to realize and confront my own complacency with neoliberal systems. I realized that I functioned in a system that gives the façade of unprejudicial access and equal opportunities to larger political, economic, and political structures. I continued to scrutinize my personal feelings and research through a process of journaling, feedback on my writing from my supervisor, frequent meetings with my supervisor, and documenting these discussions in a black book. Therefore, I extensively used the expertise of my supervisor to remain focused on the spatial and ideological marginalization of women in Prince George. I also used the work of feminists such as Judith Stacey, Donna Harraway, and Dorothy Smith ensured I stayed true to this course when I ventured off. The practice of being aware of personally perpetuating ideologies required guidance and constant engagement. I needed to be aware of how my printed words could confirm limited mental health access and act destructively by working to further sub-culture women. In ensuring the truth in writing, I needed to be cognizant that when I was re-telling a story, I was not talking about women in a way that "prevents them from speaking about themselves" (Moore 1988: 192). Therefore, by engaging in dialogues with my supervisor, I developed the skill of and commitment to discussing the voices of the women. Even when my intentions were well-meant, I always asked myself, "Is this the voice of the woman, or mine?"

In order for me to challenge inequality, my thesis needed to focus on how the seven women's stories are part of ideologies of inequality, gender, and mental health. Their voices provided a way to give back agency, power, and acceptance to anyone who is overlooked by neoliberal politics. This was also a way to demonstrate to an audience that while we all participate in the larger picture, we also have the opportunity to change our view and role. As my supervisor, Dr Angèle Smith, said "it is important for a researcher to examine from an insider perspective and then become the outsider". I needed to create a fluidness as I located myself in various positions (friend, researcher, feminist ethnographer, advocate, etc.) each informing the other to see how seven women's stories fit into federal, provincial and regional mental health care policy and service. At the same time, I also had to see and be witness to the unequal historical and present practices in social, economic, and political spheres that work to foster depression and marginalize women. It was important to use policy documents, secondary sources, women's advocacy groups, feminist anthropologists, and the women's words to see the interconnections between the narratives of the women and the structure of health care. Although women live with higher rates of depression and higher risks associated with depression, there still exists minimal representation of women in mental health care. Therefore, by using the guidance of my supervisor, engaging in dialogues with other disciplines, incorporating the work of researchers, understanding mental health policies, and incorporating the stories of marginalized women are truth, I can create a more complete picture that critiques the structure and ideologies associated with health care services.

The Process of Research

My thesis started as an exploration of how ideologies further marginalize women in the structure of health care. I wanted to understand how theories of inequality, gender, and mental health work to perpetuate and maintain discrepancies in access. Yet at the same time, I wanted to know why these ideologies perpetuate inequality in a way that is accepted and not examined. The focus on depression and women accessing the Phoenix Transition House developed from dialogues with my supervisor about: theories of subordination/domination (Foucault 2000; Bourdieu 2001), ideologies related to the power of representation (Bailey and Gayle 2002), and the historical misrepresentation of women in medicine (Scheibinger 1987; Martin 1997). I wanted to know if marginalized women living with depression (a mental health issue that in most cases is easily diagnosed and treated) are overlooked in the structure of health care. My supervisor and I decided I needed to use participant-observation and interviews to find out about the experiences of marginalized women and their access to mental health services in Prince George.

I examined federal, provincial, and regional health and mental health care efforts related to women in order to prepare for my fieldwork. I used primary sources from mental health research advocates who focus on women's mental health, mental health inadequacies in health care, and recommendations for improving women's well-being. These sources were the platform for writing about women's specific mental health needs, the effect of 'health determinants', and the changing political and economic climate of health care. Further, I studied primary sources related to health care systems themselves and I used secondary sources that characterized federal health care and specifically mental health care. These readings also helped me to understand the influence of neoliberal ideology and the introduction of the Canadian Health and Social Transfer (CHST). As a result, I was able to connect neoliberal ideology with the federal health care structure and decreased access to regional mental health services.

I wanted my participant-observation and interviews to challenge the neoliberal ideologies outlined in the government documents that present depression as the personal failings of marginalized women. I used my analysis of the recommendations made by advocacy group as a cross referencing point for my examination of current federal and provincial mental health policy, neoliberal ideology, and past medical paradigms related to women and mental health. The resources and theories confirmed that larger political, economic, and social structures marginalize women. Therefore, my reading of primary and secondary sources, informed my interaction and interviews with the women at the Phoenix Transition House because I understood their oppressions as structured into these larger discourses of power. I designed the interview questions with the help of my supervisor to explore if marginalized women's depression is related to structured oppressions, if their specific mental health needs are being heard, and if their access to mental health care and treatment is limited.

I entered the Phoenix Transition House excited about the opportunity to understand marginalized women's mental health experiences that are rarely documented. I also wanted to practice the skills I discussed with my supervisor and those written about by feminist ethnographers. Therefore, I needed my research to show a quality of observation, commitment, real concern, and contribution to women and social marginalization. I utilized months of participant-observation, electronic journaling, interviews, and documented dialogues with my supervisor in my black book to understand marginalization, women's mental health needs, and mental health access.

I used my participant-observation and interview notes to develop eight themes related to marginalized women's mental health experiences. The seven women's responses about access and suggestions for improving mental health coincided with recommendations made by mental health advocacy researchers. Yet, their stories provided the tangible and real-lived experiences. So, I used the experiences and themes to scrutinize federal, provincial and regional primary sources such as *Women, Mental Health and Mental Illness and Addiction in Canada: An Overview 2006, Patients First 2002, Best Practices 2002, Provincial Depression Strategy 2002,* and *Let's Talk About Addictions and Mental Health 2007.* I examined these documents to study the representation of women, marginalized women, mental health, and depression. I then returned to my participant-observation and interview notes to discuss how women's representation (or lack thereof) in mental health care documents affected and limited access to services. I learned from Lyon-Callo (2004) that society structures marginalization into political, economic, and social discourses without an acknowledgement or examination of its existence. This along with Dr Smith, our meetings, and my black book kept me focused on looking for health policy that acknowledges discrepancies in women's mental health care delivery. In my analysis, I found there to be little federal, provincial, or regional mental health effort directed to marginalized women. Furthermore, when I compared interviews with policies and recommendations to improve women's mental health, I was able to demonstrate that improvements are clearly not being practiced or implemented. I could then use these comparisons and concrete examples in my thesis to argue that society is complacent with marginalized women's mental health care because of the connection to ideologies of gender, mental health, and inequality that exist in the larger structure of health care.

When I discussed with my supervisor the prevailing theme that marginalized women's mental health is overlooked, 'Sharing Stories' was the result. The pervasive normalization and feminization of women's depression made it important to incorporate the stories of marginalized women. Therefore, throughout my thesis, I used the participant-observation excerpts and interview notes. I wanted the reader to focus on the stories of marginalized women such as Kim, Anne, Francis, Gwen, Tracy, Nicole and Angie, in order to hear about the material and discursive conditions that foster poor mental health. I wanted the reader to see that for marginalized women, depression is not a personal failing but society's social, economic, and political failing.

Bibliography

A New Era for Patient-Centered Health Care. British Columbia Ministry of Health Planning. Accessed March 20 http://www.health.gov.bc.ca/socsec/pdf/new_era_sustain.pdf.

Ad Hoc Working on Women, Mental Health, Mental Illness and Addictions
2006 Women, Mental Health and Mental Illness and Addiction in Canada: An Overview. May 8th

Allan, John
2005 Power. *In* A Companion to Political Geography. John Agnew, Katherine Mitchell, and Gerold Toal eds. Pp. 95-105. Malden: Blackwell Publishing.

Anderson, Dana
2004 Questioning the Motives of Habituated Action: Burke and Bourdieu on Practice. *In* Philosophy and Rhetoric Vol 37 No 3.

Anderson, Kay and Faye Gale, eds
1992 Inventing Places: Studies in Cultural Geography. Melbourne, Australia: Longman Cheshire.

Anderson, JM
2000 Gender, 'race, poverty, health and discourses of health reform in the context of globalization: A postcolonial feminist perspective in policy research. Nursing Inquiry 7:220-229.

Andrews, Gavin and Valorie Crooks
2009 Geographical Perspectives on Health Care: Ideas, Disciplines, Progress in Primary Health Care: People, Practice, Place. Valorie Crooks and Gavin Andrews, eds. Bodmin, Cornwall: MPG Books.

Armstrong, P, C Amaratunga, J Bernier, K Grant, A Pederson and K Wilson
2002 Exposing Privatization: Women and Health Care Reform in Canada. Aurora Ontario: Garamond Press.

Armstrong, P, K Grant, C Amaratunga, M Boscoe, A Pederson and K Wilson, eds
2004 Caring For/Caring About Women, Home Care and Unpaid Caregiving. Garamond Press, Aurora Press.

Armstrong, Pat and Hugh Armstrong
2004 Planning for Care In Changing Health Care in Canada. Tom McIntosh, Pierre-Gerlier Forest, and Gregory P Marchildon, eds. Toronto Buffalo: University of Toronto Press.
2008 About Health Care. Halifax: Fernwood Publishing.

Aronson, J and SM Neysmith
1997 The retreat of the state and long-term provision: Implications for frail elderly people, unpaid family carers and paid home care workers. *In* Studies in Political Economy 53 (summer) pp37-66.

Bailey, Gordon and Noga Gayle
2003 Ideology, Structuring Identities in Contemporary Life. Peterborough, Ontario: Broadview Press Ltd.
1993 Sociology: an introduction: from the classics to contemporary feminists. Toronto: Oxford University Press.

Banting, Keith and Robin Boadway
2004 Defining the Sharing Community: The Federal Role in Health Care in Money, politics and health care : reconstructing the federal-provincial partnership. Harvey Lazar and France St-Hilaire, eds. Pp.1-79. Montreal : Institute for Research on Public Policy.

Bashevkin, Sylvia
2002 Welfare Hot Button: Women, Work, and Social Policy Reform. Toronto: University of Toronto Press.

BC Ministry of Health
2002 Best Practices: Housing. Victoria: BC Ministry of Health.

BC Ministry of Health Living and Sport
2009 Model Core Program Paper: Mental Health Promotion and Mental Disorder Prevention. BC Health Authorities

BC Women's Hospital and Health Centre (2008) Building Bridges: Linking women abuse, substance abuse and mental ill health Vancouver BC Author.
BC Ministry of Health Services 2005/06 – 2007/08 SERVICE PLAN http://www.bcbudget.gov.bc.ca/2005/sp/hs/Message_and_Accountability_Statement_from_the_Minister_of_State_for_Mental_Health_and_Addiction_Services.htm accessed April 3rd 2011.

BC Backgrounder New Cabinet Ministers 2004) http://www2.news.gov.bc.ca/archive/2001-2005/2004OTP0068-000739-Attachment1.htm accessed April 1st 2011.

BC Mental Health and Addictions Services http://www.bcmhas.ca/NR/exeres/084C8F44-7998-4977-804B-F4FAB2F37188.htm accessed March 29th 2011.

Behar, Ruth
1995 Introduction: Out of Exile. *In* Women Writing Culture. Ruth Behar and Deborah Gordon, eds. Pp.1-33. Berkeley: University of California Press.
1996 The Vulnerable Observer, Anthropology that Breaks Your Heart. Boston: Beacon Press.

Bentley, Kia J
2005 Women, Mental Health, and the Psychiatric Enterprise: A Review, Health Social Work. 30 (1). 1-5.

Berger, Earl
2000 The Berger population health report. Toronto.

Bernard, H
1995 Research Methods in anthropology: Qualitative and quantitative approaches (2nd ed) California: Walnut Creek Press.

Bolaria, BS
1995 Social issues and contradictions in Canadian society (2nd ed). Toronto: Harcourt Brace and Company.

Bonisteel, Mandy and Green, Linda
2005 "Implications of the Shrinking Space for Feminist Anti-Violence Advocacy" Presented at the 2005 Canadian Social Welfare Policy Conference, Forging Social Futures, Fredericton, New Brunswick, Canada.

Bourdieu, Pierre
1991 Social theory for a changing society. Pierre Bourdieu and James S. Coleman, eds. New York : Westview Press.
2001 Structures, Habitus, and Practices. In Readings for a History of Anthropological Theory. Paul Erickson and Liam Murphy, eds. Pp. 533-543. Canada: Broadview Press

Bourdreau, Julie-Anne, Roger Keil, and Douglas Young
2009 Governing Urban Neoliberalism. Toronto: University of Toronto Press.

Boverman, I K, D M Boverman, F E Clarkson, P Rosenkrantz, and S R Vogel
1970 Sex role Stereotypes and clinical Judgements of Mental Health?. Journal of Consulting and Clinical Psychology, 34. 1-7.

Braën, André
2004 Health and the Distribution of Powers in The governance of health care in Canada.Tom McIntosh and Pierre-Gerlier Forest and Gregory P. Marchildon, eds. Imprint Toronto, Ontario: University of Toronto Press.

Browne, AJ
2001 The influence of liberal political ideology on nursing practice. Nursing Inquiry 8(2). Pp 118-129.

Burstow, Bonnie
2005 Feminist Antipsychiatry Praxis-Women and the Movement(s): A Canadian Perspective. In Women, Madness and the Law: a feminist reader. Wendy Chan, Dorothy Chunn and Robert Menzies, eds.Pp. 245-258. London: Glass House Press.

Burt, S
1995 The several worlds of policy analysis: Traditional approaches and feminist critiques. *In* Changing Methods: Feminist Transforming Practice. S Burt and L Code, eds. Pp 357-378 Peterborough, Ontario: Broadview Press.

Butler, Judith
1999 Performativity's social magic. *In* Bourdieu: A Critical Reader. R Shusterman, ed. Oxford Blackwell.
2007 Gender Troubles: Feminism and the Subversion of Identity.New York: Routledge Press.

Busfield, Joan
1994 The female malady? Men, Women and Madness in Nineteenth Century Britain. Sociology, 28 (1). 259-277.
2000 Introduction: Rethinking the Sociology of Mental Health. Sociology of Health & Illness, 22 (5). 1-12.

Canadian Mental Health Association
2005 Organizations laud Kirby Committee proposed new Canadian Mental Health Commission (November 25). Press Release.

Canadian Mental Health Association.
2006 Understanding Mental Illness. Available online at: http://www.cmha.ca/bins/content_page.asp?cid=3&lang=1

Canadian Standing Senate Committee on Social Affairs, Science and Technology.
2006 Out of the Shadows at Last: Transforming mental health, mental illness and addiction services in Canada. Ottawa: Government of Canada.

Capra, Fritjof
1996 The Web of Life. New York: Anchor Books.

Casebeer, Ann
2004 Regionalization Canadian Healthcare: The Good-The Bad-The Ugly. Peggy Leatte, ed. *In* HealthCare Papers, New Models for the New Health Care 5(1):88-96.

Casey, Edward
1993 Getting back into place: Toward a renewed understanding of the place-world. Bloomington: Indiana University Press.

Cohen M, and Cohen, M
2004 A Return to Wage Discrimination: Pay equity Losses Through Privatization in Health Care. Canadian Centre for Policy Alternatives. Vancouver.

Cole, Sally
1991 Women of the praia: work and lives in a Portuguese coastal community. Princeton: Princeton University Press.
1995 Taming the Shrew in Anthropology: Is Feminist Ethnography "New" Ethnography? *In* Ethnographic Feminisms: Essays in Anthropology. S Cole and L Philips, eds. Pp 185-205. Ottawa, Canada: Carleton University Press.

Conradson, David and Moon, Graham
2009 On the Street: Primary Health Care for Difficult to Reach Populations. *In* Primary Health Care: People, Practice, Place. Valorie Crooks and Gavin Andrews, eds. Pp 237-260. Bodmin, Cornwall: MPG Books.

Day, S, N McMullen and The Canadian Feminist Alliance for International Action.
2004 A Decade of Going Backwards: Canada in the Post-Beijing Era. A report prepared by S Day and N McMullen in response to UN Questionnaires on the Implementation of the Beijing Platform for Action 1995 and the Outcome of the Twenty-Third Special Session of the General Assembly (2000). Ottawa.

Davis, Jack
2004 Let Regionalization Continue to Evolve. Peggy Leatte, ed. *In* Health Care Papers, New Models for the New Health Care 5(1):50-55.

Davis, Simon
2006 Community Mental Health in Canada. Vancouver: UBC Press

Delaney, R, K Brownlee and M Zapf
1996 Issues in Northern Social Work Practice. Thunder Bay, Canada: Lakehead University.

Denton, Margaret, Steven Prus, and Vivienne Walters
2004 Gender differences in health: a Canadian study of the psychosocial, structural and behavioural determinants of Health Social Science & Medicine 58. Pp 2585–2600.

Dickinson, Harley
2004 Public Involvement in a Health Care Vision In Changing Health Care in Canada. Tom McIntosh, Pierre-Gerlier Forest, and Gregory P Marchildon, eds. Toronto Buffalo: University of Toronto Press.

Domosh, Mona and Joni Seager
2001 Putting Women in Place: Feminist geographers make sense of the world. New York: Guilford Press.

Dyck, I
2003 Feminism and Health Geography: Twin tracks or Divergent Agenda? *In* Gender, Place and Culture 10 no4 pp361-368.

Eagleton, Terry, ed
1994 Ideology. London; Longman.
2000 The idea of culture. Malden, Massachusetts: Blackwell.

Ehrenreich, Barbara and Deidre English
1978 For Her Own Good: 150 Years of Experts Advice to Women. New York: Anchor Press.

Erickson, Paul and Liam Murphy
2003 A History of Anthropological Theory. Canada: Broadview Press.

Foucault, Michael
1965 Madness and Civilization: A History of Insanity in the Age of Reason. New York: Pantheon Books.
1980 Power/Knowledge: selected interviews and other writings 1972-1977. Colin Gordon, ed. New York: Pantheon Books.
1984 The Foucault Reader. Paul Rabinow ed. New York: Pantheon Books
2000 Power/Michel Foucault. James Fabion, ed. New York: New Press.
2009 [1972] History of Madness. Johnathan Murphy and Jean Khalfa, trans. Jean Khalfa, ed. London: Routledge.

Fuller, C
1998 Caring for Profit: How Corporations are Taking over Canada's Health Care System. Ottawa: Canadian Centre for Policy Alternatives.

Gagnon, L and S Patton
2002 Major depression and its associated with long-term medical conditions. Canadian Journal of Psychiatry. 47 149-152.

Gesler, Wilbert and Robin Kearns
2002 Culture/Place/Health. London: Routledge.

Gibson-Graham
1994 "Stuffed if I know": Reflections on Post-modern Feminist Social Research. *In* Space, Gender, and Knowledge: Feminist Readings. L McDowell and J. Sharp, eds. Pp 124-146. Arnold, London (1997).

Giddens, Anthony
1979 Central Problems in Social Theory: action, structure, and contradiction in social analysis. Berkeley: University of California Press.

Glendhill, C
1997 Genre and gender. The case of the soap opera. In Representation: Cultural representations and signifying practices. S Hall, ed. London: Sage Publications.

Glouberman, Sholom and Brenda Zimmerman
2004 Complicated and Complex Systems: What Would Successful Reform of Medicare Look Like? In Changing Health Care in Canada. Tom McIntosh, Pierre-Gerlier Forest, and Gregory P Marchildon, eds. Pp. 3-21. Toronto Buffalo: University of Toronto Press,.

Goering, P, D Wasylenki and J Durbin
2000 Canada's mental health system. International Journal of Law and Psychiatry. 23(3—4):345-359.

Goldner, Elliot
2002 British Columbia's Provincial Depression Strategy Report. Ministry of Health Services.

Guide to the Mental Health Act
2005 Edition http://www.health.gov.bc.ca/mhd/mentalhealthact.html.

Gramsci, A
1972 [1971] Selections from the Prison. Quintin Hoare and Geoffrey Smith trans. New York: International Publishers..

Greden, J
2001 The Burden of recurrent depression: causes, consequences, and future prospects. Journal of Clinical Psychiatry 62 (Suppl 22) 5-9.

Hak, Gordon
1989 The Socialist and Labourist Impulse in Small-Town British Columbia: Port Alberni and Prince George, 1911-33. Canadian Historical Review 70 (4) 519-542.

Hamilton, JA and MF Jensvold
1995 Sex and gender as critical variables in feminist psychoparmacology research and pharmacology. *In* Women & Therapy 16: 9-30.

Hanlon, Neil
2009 Access and Utilization Reconsidered. *In* Primary Health Care: People, Practice, Place. Valorie Crooks and Gavin Andrews, eds.Pp. 43-57. Bodmin, Cornwall: MPG Books,.

Hanlon, Neil and Greg Halseth
2005 The graying of resource communities in northern British Columbia: implications for health care delivery in already-underserviced communities. The Canadian Geographer no 1 49: 1-24.

Hanlon, Neil, Mark Rosenberg and Rachel Clasby
2007 Offloading social care responsibilities: recent experiences of local voluntary organizations in remote urban centre in British Columbia, Canada. *In* Health and Social Care in the Community 15(4): 343-351.

Hanlon, Neil, Greg Halseth and David Snadden
2010 "We can see a future here": Place attachment, professional identity, and forms of capital mobilized to deliver medical education in an underserviced are. *In* Health & Place 16 pp 909-915.

Harroway, Donna
1991 'Gender' for a Marxist Dictionary: The sexual politics of a word. *In* Simians Cyborgs and Women. Donna Harroway, ed. New York Routledge.
2003 Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspectives (reprinted). *In* the Gender of Science. Janet Kourany, ed. Pp 361-371. Upper Saddle River NJ: Prentice Hall.

Harvey, David
1985 Consciousness and the Urban Experience. Baltimore: John Hopskins University Press.

Health Statistics Division
1998 National Population Health Survey Overview 1996/97 Cat no 82-567 Ottawa, Statistics Canada.

Healy, Theresa
2000 Past Perfect: Prince George history and how to find it. Prince George. Prince George Public Library (Papyrus Press).
2001 Expanding Boundaries: Historical Essays on Northern B.C's Rural Women. Lorna Townsend and Theresa Healy eds. Prince George: UNBC Print Services.

Healy, Theresa, Lynda Anderson, Barbara Heringer, Barbara Issac, and Ty Perry
2001 Out in the Cold: The Context of Lesbian Health in Northern British Columbia. British Columbia Centre for Excellence for Women's Health.

Hirsh, Eric and Michael O'Hanlon
1995 The Anthropology of Landscape: Perspectives on Place and Space. Oxford: Clarendon Press.

hooks, bell
1984 Feminist theory from margin to center. Boston: South End Press.

Hurley, Jeremiah
2004 Regionalization and the Allocation of Healthcare Resources to Meet Population Needs. Peggy Leatte ed. *In* Health Care Papers, New Models for the New Health Care 5(1):34-40.

Kuhn, Thomas
1970 The Structure of Scientific Revolutions. Chicago: The University of Chicago Press

Leatt, Peggy
2004 Notes from the Editor in Chief. Peggy Leatt, ed. *In* Health Care Papers, New Models for the New Health Care 5(1):4-12.

LeCompte, Margaret, and Jean Shensul
1999 Designing and Conducting Ethnographic Research. Altimira Press, New York.

Lefebvre, Henri
1979 Space: Social Product and Use Value. *In* Critical Sociology, European Perspectives. J Frieberg ed. New York: Irvington Publishers.
1991 The production of Space. Donald Nicholson-Smith trans. Cambridge: Blackwell.

Lerman, Hannah
1996 Pigeonholing women's misery: A history and critical analysis of the psychodiagnosis of women in the twentieth century. New York: Basic Books.

Levine, David
2004 Regionalization: An Opportunity for Improving Management. Peggy Leatt, ed. *In* Health Care Papers, New Models for the New Health Care 5(1):46-50.

Leipert, Beverly D and Linda Reutter
1998 Women's Health and Community Health Nursing Practices in Geographically Isolated Settings: A Canadian Perspective. Health Care for Women International, 9 (6) 575-588.
2005 Women's health in northern British Columbia: the role of geography and gender. Canadian Journal of Rural Medicine 10 (4) 241-254.

Leipert, Beverly
1999 Women's health and the practice of public health nurses in northern British Columbia. Public Health Nursing 16 280-9.

Let's Talk About Primary Health Care, Report on Community Consultation 2009
http://northernhealth.ca/Portals/0/About/Community_Accountability/documents/2009%20report%20on%20community%20consultation.pdf accessed April 1st 2011.

Lewis, Steven and Denise Kouri
2004 Regionalization: Making Sense of the Canadian Experience. Peggy Leatte, ed. *In* Health Care Papers, New Models for the New Health Care 5(1):12-34.

Little, Jo
2002 Gender and Rural Geography: Identity, Sexuality, and Power in the Countryside. London: Prentice Hall.

Lorber, Judith and Lisa Jean Moore
2002 Gender and the Social Construction of Illness. New York: Altamira Press.

Lyon-Callo, Vincent
2004 Inequality, Poverty, and Neoliberal Governance. Peterborough, Ontario: Broadview Press.

Mahar, Cheleen, Richard Harker, and Chris Wilkes
1990 The Basic Theoretical Position. In An Introduction to the Work of Pierre Bourdieu: The Practice of Theory. Richard Harker, Cheleen Mahar, and Chris Wilkes, eds. Pp 1-25. Hampshire UK: Macmillan Basingstroke.

Massey, Doreen
1994 Space, Place, and Gender. Minneapolis: University of Minnesota Press.

Martin, Emily
1990 Science and Women's Bodies: Forms of Anthropological Knowledge. In Body/Politics: Women and the Discourse of Science. M Jacobus, E Fox Keller, and S Shuttleworth, eds. Pp 69-82. Routledge, London.
1997 The Egg and the Sperm. In Situated Lives: Gender and Culture in Everyday Life. L. Lamphere, H. Ragone, and P. Zavella, eds. Pp 85-98. Routledge, London.

McIntosh, Tom
2004 Introduction. The governance of health care in Canada McIntosh, Tom, and Forest, Pierre-Gerlier and Marchildon, Gregory P, eds. Pp. 1-22. Ontario: University of Toronto Press.

Meade, Melinda and Robert Erickson
2000 Medical Geography. New York: The Guilford Press.

Meinig, D W
1979 The Beholding Eye. In The Interpretation of Ordinary Landscapes. DW Meinig, eds. Pp. 33-48. Oxford University Press.

Mental Health and Addiction
2005 http://www.health.gov.bc.ca/mhd/mentalhealthact.html.

Ministry of Health
2002 Best Practices for Mental Health and Addictions http://www.health.gov.bc.ca/mhd/best.html accessed April 1st 2011.

Moore, Henrietta
1988 Feminism and Anthropology. Cambridge: Polity Press.

Morrow, Marina and Monika Chappell
1999 Hearing Women's Voices: Mental Health Care for Women. British Columbia Centre of Excellence for Women's Health. Vancouver.

Morrow, Marina , Olena Hankivsky, and Colleen Varcoe
2007 Introduction: Beyond Gender Matters. *In* Women's Health in Canada Marina Morrow, Olena Hankivsky, and Colleen Varcoe, eds. Pp. 3-33.Toronto: University of Toronto Press.

Morrow, Marina

2003 Mainstreaming Women's Mental Health: Building a Canadian Strategy. BC Centre of Excellence for Women's Health.

2007a Creating Women-Centered Mental Health Policy. *In* Women's Health in Canada(Eds Marina Morrow, Olena Hankivsky, and Colleen Varcoe). 355-379. Toronto: University of Toronto Press.

2007b Our Bodies, Our Selves in Context: Reflections on the Women's Health Movement in Canada. *In* Women's Health in Canada Marina Morrow, Olena Hankivsky, and Colleen Varcoe). Pp. 33-64. Toronto: University of Toronto Press.

Nicki, Andrea

2001 The Abused Mind: Feminist Theory, Psychiatric Disability, and Trauma. Hypatia, 16 (4). 80-100.

Ortner, Sherry

1974 Is Female to Male, as Nature is to Culture. In Woman, Culture and Society, MZ Rosaldo and L Lamphere, eds. Pp 67-87. Stanford University Press, California.

1996 Making Gender: The Politics and Erotics of Culture. Beacon Press. Boston. Pp 1-20, 173-180.

Parry, Kim, Madeline Boscoe, Lissa Donner, Kelly Hegadoren, Abby Lippman, Donna Stewart, Janet Stoppard, and Cara Tannenbaum

2006 Women and Depression. *In* Women, Mental Health, Mental Illness and Addictions in Canada: an Overview 18-25 www.cwhn.ca.

Pierre, Nathalie, Nicole Pollard, and Patrick Fafard

2007 Health policies and trends for selected target groups in Canada [electronic resource] : an overview report / for the Canadian Association of Occupational Therapists (CAOT)

Pothier, Dianne

2007 But It's for Your Own Good. In Poverty: Rights, Social Citizenship, Legal Activism. Susan Boyd, Gwen Brodsky, and Shelagh Day, eds. Pp 40-57. Vancouver: UBC Press.

Provincial Health Services Authority

2010 PHSA Strategic Plan 2010-2013.

Razack, Sherene

2004 Race, space, and the law: unmapping a white settler society. Toronto: Between the Lines.

Riverview Redevelopment Project 2011

http://www.bcmhas.ca/AboutUs/News/Riverview_Redevelopment/default.htm accessed March 20th 2011.

Romanow, Roy and Gregory Marchildon

2004 History, Politics, and Transformational Change in Canadian Health Care: A Rejoinder. Canadian Psychology, 45 (3). 239-243.

Romanow, R
2002 Final report: Building on values—The future of health care in Canada http://www.hcsc.gc.ca/english/pdf/romanow/pdfs/HCC_Final_Report.

Rooney, J, D Lero, K Korabik, and DL Whitehead
2003 Self-Employed for Women: Policy Options that Promote Equality and Economic Opportunity. *In* Status of Women Canada. Ottawa.

Romans, Sarah and Lori Ross
2010 Gender and Depression in Mental Disorder in Canada. John Cairney and David Streiner, eds. Pp 259-285. London Ontario: University of Toronto Press.

Rose, Diana
1998 Television, madness and community care. Journal of Community and Applied Social Psychology, 8 (3). 213–228.

Said, Edward
1979 Orientalism. New York: Vintage.

Scheibinger, Londa
1987 Skeletons in the Closet: The First Illustrations of the Female Skeleton in Eighteenth-Century Anatomy. *In* The Making of the Modern Body: Sexuality and Society in the Nineteenth Century. C Gallagher and T Laquer, eds. Pp 42-82. Berkeley: University of California Press.

Schensul, Stephen, Jean Schensul, and Margaret LeCompte
1999 Essential Ethnographic Methods: Observations, Interviews, and Questionnaires. Walnut Creck, California: Altamira Press.

Select Standing Committee on Health Report
2002 Patients First 2002: The Path to Reform. The Legislative Assembly of British Columbia.

Simard, Martin and Carl Simard
2005 Toward a Culturalist City: A Planning Agenda for Peripheral Mid-size Cities. Canadian Journal of Urban Research 14 (1) 38-59.

Simmie, Scott and Julia Nunes
2001 The Last Taboo: A Survival Guide to Mental Health Care in Canada. McClelland and Postmodern Geographies: the reassertion of space in critical social theory. London; New York: Verso.

Smith, Angèle

2003 "Landscapes of Memory: Identity and Meaning in Place Lore of Ireland" in Landscape, Memory and History. Pam Stewart and Andrew Strathern, eds. Pluto Press, London. pp. 71-88.

2008a Landscapes of Clearance: Archaeological and Anthropological Perspectives in Landscapes of Clearance. Angèle Smith and Amy Gazin-Schwartz, eds. Pp 13-25. Left Coast Press, Walnet Creek California One World Series, Routledge, London.

2008b "The Irish Citizenship Referendum (2004): Motherhood and Belonging in Ireland" in Immigration and Citizenship in Europe and the United States: Anthropological Perspectives. Deborah Reed-Danahay and Caroline B. Brettell, eds. Pp. 60-77. Rutgers University Press.

2009 "A Negotiated Sharing of Space: Globalization, Borders, and Identity of African Asylum Seekers in Ireland" in Globalization and Transnational Migrations: Africa and Africans in the Contemporary Global System. Akanmu G. Adebayo and Olutayo Adesina, eds. Pp. 88-105. Newcastle upon Tyne: Cambridge Scholars Publishers.

Smith, Dorothy

1990 The conceptual practices of power: a feminist sociology of knowledge. Toronto: University Press.

Soja, Edward

1989 Postmodern Geographies the reassertion of space in critical social theory. New York: Verso

Stacey, Judith

1988 Can there be a Feminist Ethnography? In Space, Gender and Knowledge: Feminist Readings. L McDowell and J Sharp, eds. Pp. 115-123.Arnold London (1997)

Steward, DE, E Gucciardi, and SL Grace

2004 "Depression" from Women's Health Surveillance Report: A Multidimensional Look at the Health of Canadian Women. BMC Women's Health 4(suppl 1) S19.

Stewart, Pamela and Andrew Strathen, eds

2003 Landscape, Memory and History. London: Pluto Press.

Stoppard, JM and LM McMullen, eds

2003 Situating Sadness: Women and Depression in Social Context. New York: New York University Press.

Stuart, Heather

2010 Mental Disorders and Social Stigma: Three Moments in Canadian History in Mental Disorder in Canada. John Cairney and David Streiner, eds. Pp 304-330. London Ontario: University of Toronto Press.

Thein, Deborah and Neil Hanlon

2009 Unfolding dialogues about gender, care, and 'the north': An Introduction. *In* Gender, Place and Culture v16 no 2 pp155-162.

Tomblin, Steven
2004 Critical Insights for Researchers and Decision-Makers. Peggy Leatte ed. *In* Health Care Papers, New Models for the New Health Care 5(1): 60-63.

Vayda, Eugene and Raisa Deeber
1992 The Canadian Health Care System: A Developmental Overview in Canadian health care and the state [electronic resource] : a century of evolution . C. David Naylor, ed. Montreal, Que: McGill-Queen's University Press.

Visweswaran, Kamala
2003 Fictions of Femininst Ethnography. Minneapolis: University of Minesota Press.

Ward, Thomas and Lewis Bedford
2004 Continuum of Care Must be under Regional Control. Peggy Leatt ed. *In* Health Care Papers, New Models for the New Health Care 5(1): 55-60.

Weaver, Kevin
2006 The Regionalization of Health Care in British Columbia: Does Closer to Home Really Matter? MA dissertation, Department Political Science, Simon Fraser University.

Wiles, Janine and Mark Rosenberg
2009 The Role of Scale in Conceptualizing Primary Health Care Practice: Considering Social and Institutional Structures and Systems. *In* Primary Health Care: People, Practice, Place. Valorie Crooks and Gavin Andrews, eds. Bodmin, Cornwall: MPG Books.

Wilson, Kay and Beth Jackson
2006 Bringing Women and Gender into Healthy Canadians, A Federal Report on Health Indicators 2004. The National Coordinating Group on Health Care Reform and Women.

Wolf, Diane
1996 Feminist Dilemma in Fieldwork. Diane Wolf ed. Pp. 1-56. United States: Westview Press.

Women and Health Care Reform
2002 Women and Health Care Reform. The National Coordinating Group on Health Care Reform and Women, Victoria, British Columbia. http://www.womenandhealthcarereform.ca/publications/women-hcren.pdf accessed Sept 20th 2010.

Women's Health Bureau Minister's Advisory Council on Women's Health
1991 Women's Health in the Context of Regionalization: A Selection Of Issues. Ministry of Health and Ministry Responsible for Seniors.
2001 Provincial Profile on Women's Health: Updated Data on Selected Indicators on Women's Health in British Columbia. BC Ministry of Health and Ministry Responsible for Seniors.

Yalnizyan, A
2004 Canada's Commitment to Equity: A Gender Analysis of the Last 10 Federal Budgets 1994-2004. In Feminist Alliance for International Action. Ottawa: Cnaadian Feminist Alliance for International Action FAFIA. Available at http://www.fafia-afia.org/proj/gb/comeq.php
Young, Margot
2007a Introduction Margot Young, Susan Boyd, Gwen Brodsky and Shelagh Day eds. Pp.1-23. Poverty: Rights, Social Citizenship, Legal Activism.Vancouver: UBC Press.
2007b Why Rights Now? Law and Desperation. Margot Young, Susan Boyd, Gwen Brodsky and Shelagh Day eds. Pp.317-337. Poverty: Rights, Social Citizenship, Legal Activism.Vancouver: UBC Press.

Appendix A

Information Sheet

Researcher's name: Nadine English **E-mail:** englishn@unbc.ca

Sharing Experience: Northern Women's Mental Health Inequality

My Master's research focuses on the stories of northern women's mental health experiences. Specifically, I am interested in how women with depression in Prince George experience mental health services. Depression, although highlighted in the media and health care continues to affect women at an increasing rate. Yet, both women and depression continue to be marginalized in the health care system because of ideologies, inequalities, and practices. Although gender-based inequalities in the mental health system have been documented there has been a lack of feminist research about how women encounter and experience services because of these inequalities.

You have been asked to participate in this interview because of your experience, or even lack thereof, with mental health services. Your stories will add valuable information about how inequality, ideology, and Prince George's regionalized health care affect women's mental health experience.

You will be asked to participate in a forty-five minutes to an hour interview. However, this interview is completely voluntary, and the women have the right to withdraw from the interview at any point during the interview. If there are any questions that make the women uncomfortable answering, they have the right to dismiss the question. The interview will be recorded with an audiotape and transcribed. Only the researcher and my supervisor will have access to the audiotapes and the transcription.

If you do not want your name to be used, I will create a fictitious name and your anonymity is ensured; your name and consent form will be kept separately from the interview data. Nothing that could identify you will be published. The interviews are completely confidential and the interview data will be kept in a secure location at the home of Nadine English. The information will be stored in this secure place until the project is complete, at which time, the researcher will pull the tapes apart and erase the transcript data.

The purpose of this feminist ethnographic research is about recording the stories of women and understanding how social structures and practices have influenced their experience when needing mental health services. Examining women and depression in Prince George contributes to an understanding of how dominant understandings of gender inequalities and mental health ideologies are practiced and contribute to a geographical variation.

Any questions about the interview can be forwarded to me at englishn@unbc.ca or my supervisor, Dr. Angele Smith at smitha1@unbc.ca. If there are complaints about the project, please forward them to the UNBC Office of Research, (250) 960-5820 or by e-mail: officeofresearch@unbc.ca. I will ask you to sign two consent forms, one for yourself and one for my records. If you are interested in receiving a copy of the interview, please check the box on the consent form and I will forward a copy to the Phoenix Transition House or another address.

PARTICIPANT'S NAME________________ SIGNATURE_______________________

Consent Form

I understand that I have been asked to participate by Nadine English, a graduate student in the Interdisciplinary MA Program at the University of Northern British Columbia, in her Master's project. The purpose of the interviews and participant observation is to understand northern women's mental health experience. I have read and received a copy of the attached **information sheet**. By participating in this study, I understand the benefits and risks. I have had the opportunity to discuss and ask questions about this project with Nadine English. I understand that I have the right to not answer questions that make me uncomfortable or to withdraw from the interview at any point.

I give consent with the understanding that I can be either named or protected in the research and resulting thesis. If I choose to be protected, Nadine English will ensure confidentiality by assigning a fictitious name. The issue of confidentiality has been explained to me by Nadine English. At all times, consent forms and interview data from those interviewed will be kept separate to ensure confidentiality to those who desire anonymity. I understand that the information from the interviews will be shared with Nadine English's supervisor, Dr. Angele Smith and the University of Northern British Columbia. I understand and agree that the information I give to Nadine English on the date(s) ____________ will be treated in the following manner:

1. the interview will be audiotaped
2. the interview will be transcribed to make an interview script
3. this data will be kept in a secure location at the home of Nadine English
4. the data will be used only by Nadine English under the guidance of her academic supervisor Dr. Angele Smith, and only for her Master's thesis project
5. the researcher will pull the tapes apart and erase the transcript data after the Master's project is complete.

I hereby waive any claim against Nadine English, Dr. Angele Smith, the University of Northern British Columbia, and its Office of Research with respect to the use of the information, I have provided, as long as it is used in accordance with this agreement.

I understand that if I have any comments or concerns I can contact Nadine English at englishn@unbc.ca, Dr. Angele Smith at smitha1@unbc.ca, or UNBC Office of Research at (250) 960-5820. A copy of this agreement will be retained by all participants in the research.

RESEARCHER: ________________ SIGNATURE: ________________

DATE: ______________________

To be completed by participant

☐ I am interested in receiving a copy of my interview. Please send to: ____

☐ I want my identity to be kept unknown

☐ I consent to having my identity known and attached only to the project

☐ I consent to having my picture taken and attached only to the project. Any other persons in pictures must have also have individual consent.

NAME OF PARTICIPANT: ______________________

SIGNATURE OF PARTICIPANT: ___________________

DATE SIGNED: _______________________

Appendix B

Interview Questions

1. How long have you been staying at the Phoenix Transition House?

2. Why did you access the Phoenix?

3. Are you attending any programs at the shelter?

4. Has the shelter recommended any services outside of the shelter?

5. What do you think are the largest stressors in your life?

6. How would you describe your health?

7. Have you ever felt bad, sad, or unhappy for more than two weeks?

8. How does your health affect your daily/weekly life?

9. Can you please tell me about a typical day for you?

10. How would you like to feel about your health?

11. What services have you tried to access outside of the shelter?

12. What services would you like to access?

13. What was your experience when accessing the service?

14. How were you treated?

15. Was the service respectful?

16. Do you think being a woman affects your experience of services?

17. Did the service provide what you wanted?

18. How does accessing Mental Health services make you feel?

19. What would you change about the service?

20. Have you ever accessed Mental Health services outside of Prince George?

21. Do you think that Prince George offers enough Mental Health services?

22. Would you change the location of the Mental Health service?

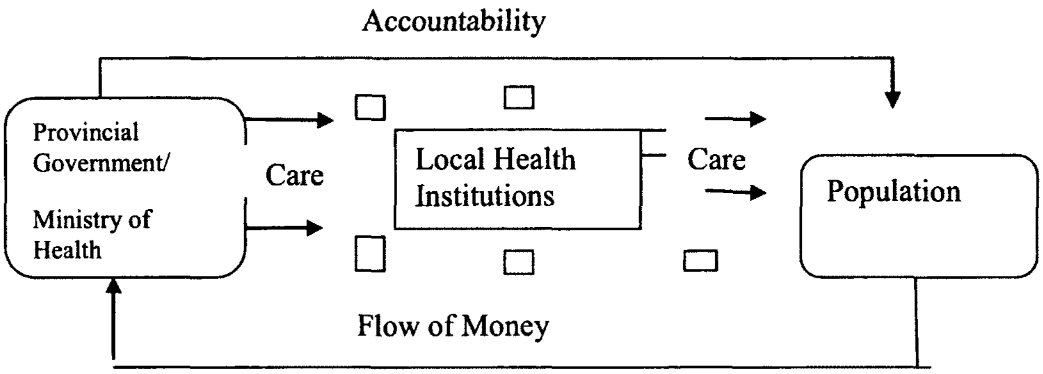
23. What would you do to make services better?

24. How would you help other women in a similar situation to yourself?

25. What will make you feel better about your health?

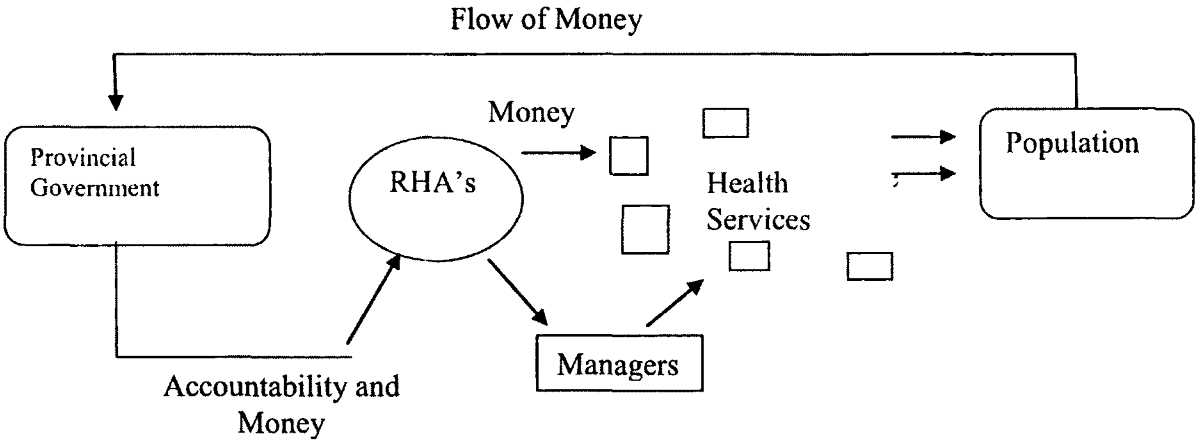
Appendix C

Figure 1: Pre-Regionalization



Source: Adapted from Weaver (2006: 20)

Figure 2: Regionalization and Accountability



Source: Adapted from Weaver (2006: 21)

Appendix D