THROUGH OUR LENS: EXPERIENCES OF ADULT MENTAL HEALTH SERVICE CONSUMERS IN THE ARROW LAKES REGION OF BRITISH COLUMBIA

by

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ABSTRACT

In efforts to address and understand health and social inequities linked to rural residency contemporary health policies and discussions are becoming increasingly invested in including rural and remote health consumers' experiences in policy decisions (Bodor, 2009; Dyck & Hardy, 2013; Government of British Columbia, 2015; Ryan-Nicholls & Haggarty, 2007).

This exploratory, text and image based qualitative research examined the experiences of six adult mental health service consumers living in the Arrow Lakes region, with the intent of creating a foundation for structural, consumer-driven shifts in health care policy and community mental health literacy, while simultaneously working to bridge the gap in literature on mental health in the Arrow Lakes.

The findings from this project demonstrate the resiliency of six adults managing mental health in the Arrow Lakes through explorations of supports and challenges to maintaining wellness and visions for reform and developments in health and social services.

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CHAPTER ONE: INTRODUCTION

The geographic region of the Arrow Lakes has limited representation within academic literature. Further, the experiences of adult residents who have accessed mental health services living in the Arrow Lakes region are also not represented within existing academic literature. The lack of representation in the Arrow Lakes region is a narrative upheld in many rural and remote communities across British Columbia. Contemporary health policies and discussions, such as the *Rural Health Services in BC: Policy Framework to Provide A System of Quality Care*, are becoming increasingly invested in including experiences of health consumers in rural and remote locations in policy decisions (Government of British Columbia, 2015). This interest is – in part – attributable to the reality that individuals living in rural communities tend to have poorer socioeconomic statuses, more barriers to accessing health care services, and inequitable health outcomes in comparison to their urban counterparts (Bodor, 2009; Dyck & Hardy, 2013; Government of British Columbia, 2015; Ryan-Nicholls & Haggarty, 2007).

This research explored the experiences of adult mental health service consumers living in the Arrow Lakes region of British Columbia through an exploratory, text and image-based qualitative framework. By exploring the experiences of the participants, this research worked to empower participants, while producing literature related to the intersections of rural residency and mental health in the Arrow Lakes region. The purpose of this research was to develop an understanding of the experiences of adult mental health service consumers living in the Arrow Lakes region while creating an opportunity for structural, consumer-driven shifts in health care policy and positive developments in community consciousness regarding mental health.

Health authorities have the responsibility to work collaboratively with communities to develop healthy behaviours and safe health care services (Government of British Columbia,

2015). Building off of this responsibility, this research has the potential to influence policy change related to mental health care within the Interior Health Authority's rural, small rural, and rural remote communities. The findings from this project will be disseminated through a community art installation with a focus on reducing stigma and raising community consciousness in the Arrow Lakes region.

Organization of Thesis

This thesis consists of five chapters. Chapter One provides an introduction to the research – including the research question, definitions of the key concepts utilized in this thesis, and my positioning as the researcher. Chapter Two provides a literature review of: the rural and remote realities of mental health presented in international, Canadian, and British Columbian literature; the developments in mental health policy and practice in Canada; the role of federal, provincial and municipal government in mental health; the effectiveness of the creative-arts in the field of mental health at the micro, mezzo and macro levels of practice; and informal and formal mental health services. Chapter Three summarizes the research methodology and methods; standpoint theory; exploratory, text and image-based qualitative research; and data collection, analysis and management. Chapter Four presents the research findings yielded by this inquiry, including: informal supports of mental health in the Arrow Lakes region, formal supports of mental health in the Arrow Lakes region, community culture as a challenge to maintaining mental wellness, gaps/lack in services available, barriers to accessing existing services, cost of living/financial burden in the Arrow Lakes region, work place discrimination/stigma, and visions for mental health in the Arrow Lakes region. Finally, Chapter Five provides a discussion of the research findings, the recommendations presented from this inquiry, and the conclusion. Participants' knowledge and visual data is presented using pseudonyms, which were chosen at the first

interview to respect confidentiality and support anonymity. Images produced by the individuals involved in this project are placed throughout this thesis report to bring forward a visual representation of participants' experiences of mental health in the Arrow Lakes region.

Me, In The Research

My interests in the experiences of mental health in the Arrow Lakes region largely emerge from my lived experience as an able-bodied, heterosexual, cis-woman of European and Indigenous dissent that grew up in a middle-class home in the rural, remote community of Fauquier, British Columbia. Fauquier is an unincorporated, resource-based community of 118 residents located on the shores of the Columbia River – the traditional territory of the Sinixt First Nation – in the Interior of British Columbia (Statistics Canada, 2017). Public and social services, such as RCMP, healthcare, and education, are available to the residents of Fauquier in Nakusp, British Columbia. Nakusp is 47 kilometers, or a 42-minute drive in good conditions, from Fauquier – with the opportunity for public transportation between the communities once per week. If the services of a regional hospital – including inpatient mental health services – are required residents of the Arrow Lakes must attend the Trail Regional Hospital, which is 228 kilometers, or two hours and 52 minutes on good roads, from Fauquier.

As a result of Fauquier's rural, remote context, I grew up in a space that functioned on the basis of informal, community-driven systems of support. For instance, the formation of parent ride-shares to ensure children had opportunities to participate in extra-curricular activities; the extensive amount of community volunteerism to create opportunity for local recreation; and the development of local, informally recognized governance structures to advocate on behalf of the community at the regional level. Despite the wealth of informal support systems present in Fauquier, the need for formal supports related to mental healthcare became evident to me as I

witnessed my family's experiences with mental health adversity. Characterizing these experiences were significant distances travelled to receive psychiatric care, lack of formal support services for family caregivers, lack of tertiary care, and lack of mental health promotion programs available in community. However, amidst the navigation of these barriers, the resilience of rural, remote individuals on the pursuit of mental health was indisputable.

In recognition of the brilliant resiliency of the community members of Fauquier, despite the barriers found in rural, remote life, I became inspired to explore the experiences of adult mental health service consumers in the Arrow Lakes region, with the intent of demonstrating the ways in which healthcare providers can work in collaboration with consumers to create equitable health outcomes in all geographic contexts.

Figure 1. Artist: Kiara McLean. This image captures a piece of the Arrow Lakes valley overlooking the Needles/Fauquier Ferry crossing.

Research Question

The central research question being explored was, "What are the experiences of adult mental health services consumers living in the Arrow Lakes region of British Columbia?"

Key Terms

Experiences are defined in this research as practical, personal and lived encounters of events and/or facts.

Adults, as defined in British Columbia's Age of Majority Act of 1970, are individuals that are 19 years of age and older.

As defined by Barker (2014), *mental health* can be understood as "the relative state of emotional well-being, freedom from incapacitating conflicts, and the consistent ability to make and carry out rational decisions and cope with environmental stresses and internal pressures" (p. 266). From this understanding, mental health exists along a continuum ranging from mental health to mental illness.

Mental health services can be understood as social or clinical programming designed to deliver effective interventions for mental health and promote mental health management (World Health Organization [WHO], 2003).

Building off of the operationalized terms 'mental health' and 'mental health services', a *mental health service consumer* is as an adult who has accessed mental health services to manage their mental health needs.

The *Arrow Lakes region* is located within the central Kootenay region of British Columbia, Canada. For this research, this region includes the following communities: Nakusp, Arrow Park, Burton, Fauquier, and Edgewood.

Adapted from the Government of British Columbia's (2002) definition, the term *rural remote* refers to communities with populations fewer than 10,000, which are also "80-400km or about one to four hours transport in good weather from a major regional hospital" (p. 8).

Formal Mental Health Services can be understood as clinical, community and social mental health programming delivered by health and allied professionals (WHO, 2003). Examples of formal mental health services include community-based rehabilitation, therapeutic and residential services, home help and support services, and community-based services for special populations (WHO, 2003).

Informal Mental Health Services in the context of this research refers to mental health services and programs delivered by local community members, paraprofessionals, and other community-based resources (WHO, 2003). Commonly these are low-barrier services as they exist outside of the professional realm and are more readily available in community (WHO, 2003).

CHAPTER TWO: LITERATURE REVIEW

Individuals living in rural and/or remote contexts across the world experience barriers to equitable healthcare (Fitzpatrick, Perkins, Luland, Brown & Corvan, 2017; Handley et al., 2014; Kelly et al., 2010; Morling & Boxall, 2014; Procter & Ferguson, 2014; Robinson et al., 2012; Ryan-Nicholls & Haggarty, 2007; Singh, 2017). In this chapter, I provide an overview of the rural and/or remote realities of mental health showcased in international, Canadian, and British Columbian literature. At the international level, Australian, American, and Scottish literature comprised the majority of rural, remote mental health research. In this section I also present literature on: the developments in mental health policy and practice in Canada; the role of federal, provincial and municipal government in mental health; the effectiveness of the creative-arts in the field of mental health at the micro, mezzo and macro levels of practice, which are defined below; and informal and formal mental health services.

Developments in Mental Health Policy and Practice in Canada

1800s

In the Canadian context, state investments in mental health began with the opening of the first mental health institution in New Brunswick, Canada in 1836 (Glancy & Regehr, 2010). Prior to this development, individuals living with adverse conditions of mental health were viewed as the responsibility of the family or were imprisoned (Glancy & Regehr, 2010). Following the introduction of mental health institutions, periodically referred to as ‘lunatic asylums,’ people with adverse mental health conditions were institutionalized with the treatment approach being informed by expectations of chronicity (Glancy & Regehr, 2010; Nelson, 2012). This period of mental health treatment is referred to as ‘institutional consensus’ (Nelson, 2012). Citing Foucault, Nelson (2012) argued that institutional consensus was – in part – developed by

governmental authorities to confine people who did not fit into the fast-emerging capitalist market and agenda in Canada.

Despite the establishment of custodial mental health treatment centers, provincial and federal legislation did not emerge until 1871 with the introduction of Ontario's Act *Respecting Asylums for the Insane* (Glancy & Regehr, 2010). This document introduced the evolving idea of 'consent to treatment' by placing the power to dictate treatment in the hands of the lieutenant governor, medical professionals, and the mayor (Glancy & Regehr, 2010).

In the late 1800s concern arose regarding the treatment of patients in 'asylums' across the nation as public investment in human rights gained support (Glancy & Regehr, 2010; Nelson, 2012). The *Royal Commission Report on Asylums for the Insane*, published in 1894, revealed oppressive conditions of cruelty in custodial treatment facilities in British Columbia (Glancy & Regehr, 2010). Despite increased awareness of the conditions of 'asylums,' reform in the treatment of mental health did not begin until the mid 1900s.

1900s

Custodial treatment of mental health continued until the mid-1900s (Glancy & Regehr, 2010; Nelson, 2012). However, terminology began to shift at the beginning of the century as 'asylums' became 'hospitals' (Glancy & Regehr, 2010). For instance, the BC Asylum became 'the Hospital for the Mind' (Glancy & Regehr, 2010). Involuntary treatment continued to be common practice in these institutions until the 1960s when provinces and territories began to develop policy clearly stating treatment cannot be administered without consent (Glancy & Regehr, 2010).

The pharmaceutical industry began to gain recognition in the treatment of mental health disorders in the 1950s with the birth of psychoactive drug treatments, predominantly

phenothiazines and lithium (Glancy & Regehr, 2010; Nelson, 2012). In part, pharmaceutical developments aided in the transition to 'deinstitutionalization' in the 1960s (Glancy & Regehr, 2010; Nelson, 2012). Other drivers of this reform included the establishment of welfare programming, which minimally supported individuals living in community, and an increased political investment in cutting expenditures (Nelson, 2012).

Deinstitutionalization's primary focus was to prevent hospital re-admissions; therefore, mental health aftercare focused on pharmacotherapy, not social reintegration and recovery (Nelson, 2012). Many discharged individuals were housed in psychiatric ghettos – low quality housing – or faced homelessness (Glancy & Regehr, 2010; Nelson, 2012). As a response to this inequity, consumer-led self-help movements began to form to fill gaps in services for people living in community with adverse conditions of mental health (Nelson, 2012). An example of a consumer-led self-help group that developed during the era of deinstitutionalization is the Mental Patients Association, which began in Vancouver, BC and worked on advocacy and respite housing (Nelson, 2012).

The *Medical Care Act*, published in 1966, was a federal policy impacting the provision of mental health care across Canada (Glancy & Regehr, 2010). This act dictated the quality and standard of federally funded health services in the provinces and territories (Glancy & Regehr, 2010). By 1972, all provinces and territories had established legislation governing health care services (Glancy & Regehr, 2010). Within this framework, mental health consists of psychiatric hospitals, psychiatric units in general hospitals, reimbursement programs for medical professionals working in mental health, and community mental health programming (Glancy & Regehr, 2010).

In 1967, the *Mental Health Act* was published by the federal government and outlined the treatment of mental health conditions across the nation (Glancy & Regehr, 2010). The act was revised in 1978 following revisions to the *Canadian Charter of Rights and Freedoms* (Glancy & Regehr, 2010). These revisions primarily focused on the definition of the term 'safety,' which was concerned with potential serious bodily harm to self or others or imminent and serious impairment due to lack of competence to care for self (Glancy & Regehr, 2010). Later revisions in 1984 and 1987 focused on the topic of involuntary admissions (Glancy & Regehr, 2010). Changes included the duration of the initial admission period, which went from five days to three, and the demand for the charge physician and treating physician to complete admission forms and contact legal council on behalf of the patient following involuntary admission (Glancy & Regehr, 2010).

Nearing the end of the 1900s, mental health treatment shifted into the stage of community mental health (Nelson, 2012). Between 1980 and 1998, British Columbia's provincial spending on community mental health programming increased from eight million to 113 million (Nelson, 2012). Parallel to these provincial developments, the federal government opened the Mental Health Promotion Unit (MHPU), which operates under the Public Health Agency (Nelson, 2012).

2000s

Building off of the policy developments in the late 1990s, important documents began to emerge in the early 2000s (Glancy & Regehr, 2010; Nelson, 2012). The *Kirby Report* of 2002 called for collaboration among stakeholders to reduce the lack of health services, misdistribution of services, and jurisdictional competition (Glancy & Regehr, 2010). The *Kirby Report* recommended that stakeholders focus on the development of adequate human resources,

appropriate public funding, and systemic reform in the delivery and funding of public health care (Glancy & Regehr, 2010). In congruence with this federal document, provincial authorities published mental health literature with similar calls to action and reform (Glancy & Regehr, 2010). For example, Ontario's report published in 2002, *The Time is Now: Themes and Recommendations for Mental Health Reform in Ontario,* called for consumer-driven mental health planning, increase in equity and access, accountability and research, and increased services (Mental Health Task Force, 2002).

Kirby and Keon's (2006) report *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addictions Services in Canada* was published as the first national report on mental health (Glancy & Regehr, 2010). This report influenced the Mental Health Commission of Canada's 2007 public initiatives to address mental health in Canada; these included: developing a national mental health strategy, implementing a 10 year anti-stigma campaign, and building a national knowledge exchange centre (Glancy & Regehr, 2010).

In the provincial context of British Columbia, *Healthy People Healthy Minds: A Ten-Year Plan to Address Mental Health and Substance Use in BC* was published in 2010 with three goals (Ministry of Health, 2010). These goals include improving mental health, improving quality and accessibility of services, and reducing economic costs to public and private sectors related to mental health and substance use problems (Ministry of Health, 2010).

The Mental Health Promotion Unit followed through on one of the three initiatives identified in 2007 by publishing *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* in 2012. This is the first national strategy addressing mental health in Canada (Glancy & Regehr, 2012). Subsequently, in the recent past, the federal government has released context-specific legislation to address mental health, including the 2015 *Mental Health*

Action Plan for Federal Offenders and the 2016 *Federal Public Service Workplace Mental Health Strategy* (Government of Canada, 2015; Government of Canada, 2016).

The Mental Health Commission of Canada (2017) published the most recent national legislature related to mental health which is a strategic plan developed to guide advancements up to 2022. The focal areas for contemporary advancements – in the scope of this document – include leadership, partnership and capacity building; promotion and advancement of the mental health strategy for Canada; and knowledge mobilization (Mental Health Commission of Canada, 2017).

Role of the Federal, Provincial and Local Governments in Mental Health Care in Canada

The federal and provincial governments have distinct responsibilities related to the funding and provision of mental health programming under the *Constitution Act* of 1867 (Butler & Phillips, 2013). Despite the current interpretations of responsibility and jurisdiction, the *Constitution Act* does not assign specific responsibility for health, or mental health, to either level of governance (Butler & Phillips, 2013). With jurisdictional power pertaining to community-based services, such as policing, housing, and aspects of public health, municipal and local governance structures exist as an alternative support of community wellness and mental health (Bish & Clemens, 2008; Government of British Columbia, 2018a; Government of British Columbia, 2018b).

Federal Government

The federal governments' primary authority and jurisdiction is related to policy guidelines for provincial health care, funding, research, certain intersections of mental health and criminal law, and the provision of mental health programming for certain demographics (Butler & Phillips, 2013).

The federal government provides guidelines regarding the administration of health care in provinces and territories (Butler & Phillips, 2013). The most prominent piece of legislation related to this authority is the *Canada Health Act*, which outlines the criterion that must be met by provinces/territories health services to receive federal support (Butler & Phillips, 2013). Under this legislation, delegated provincial and territorial health authorities receive funding from the federal government to administer health care services – including mental health care – to Canadians (Butler & Phillips, 2013).

Under the *Constitution Act* the federal government has spending power, which allows Parliament to fiscally support initiatives that concern all Canadians (Butler & Phillips, 2013). This federal authority has supported initiatives such as the Mental Health Commission of Canada, Mental Health Promotion Unit of the Public Health Agency of Canada, and numerous research projects related to mental health (Butler & Phillips, 2013). Despite these initiatives, mental health advocates Bartram (2017) and Lough (2015) highlight the continued underfunding of mental health services in Canada. As discussed by Lough (2015) mental illness constitutes "more than 15% of the disease burden in Canada," yet mental health services receive 7% of the total federal health funding (p. 465).

The federal governments authority over criminal law under the *Constitution Act* affords the federal government power to legislate in mental health-related areas, such as determining fitness to stand trail under the *Criminal Code* and the mental health treatment of young people convicted of certain offences under the *Youth Criminal Justice Act* (Butler & Phillips, 2013).

Finally, the federal government is responsible for developing and providing mental health services to First Nations peoples on reserve and Inuit communities; federal offenders in custody; Canadian Forces; veterans; Royal Canadian Mounted Police; some classes of resettled refugees;

and federal public service employees (Butler & Phillips, 2013). The federal departments providing these services vary and the services available are not universal to all peoples receiving federal mental health programming (Butler & Phillips, 2013).

In the recent past an absence of targeted federal support in mental health care has placed significant strain onto provincial and territorial budgets to address the gaps in funding for adequate mental health services (Bartram, 2017). In 2017, the federal budget outlined the allocation of five billion dollars to be distributed to provincial and territorial governments, over a ten-year span, with the aim of improving access to mental health services (Bartram, 2017). Bartram (2017) suggests that the federal government develops a clear outline, which is inclusive of data collection to ensure efficacy of spending, to make certain that the budgeted funding is equitably distributed at the population level. These objectives must further investigate the needs of rural Canadian communities in relation to accessing mental health care (Lough, 2015). Lough (2015) suggests that rural accessibility could be enhanced through tele-psychiatry and increased access to evidence-based therapies. Further, Lough (2015) highlights the need for increased federal investment in alternative approaches to mental health promotion, including housing, employment and income.

Provincial/Territorial Government

Provincial and territorial governments are responsible for the establishment, maintenance and management of hospitals under the *Constitution Act* (Butler & Phillips, 2013). As previously mentioned, specific delineations of responsibility were not determined in the *Constitution Act*, and therefore have been left open to interpretation (Butler & Phillips, 2013). This interpretation has resulted in the provincial/territorial governments' responsibility for establishing, maintaining, and managing health care delivery and services (Butler & Phillips, 2013).

Under the *Constitution Act*, the provincial and territorial governments are awarded authority over civil rights in the province (Butler & Phillips, 2013). In relation to mental health care, this is translated to commercial and contractual transactions related to service provision (Butler & Phillips, 2013).

Local Government in British Columbia

British Columbian local governance structures are premised upon two provincial acts, the *Local Government Act* and the *Community Charter* (Government of British Columbia, 2018a; Government of British Columbia, 2018b). These acts outline a legal framework for the development and sustenance of local governance, including regional districts and municipalities, which work to represent the needs of individual communities (Government of British Columbia, 2018b).

The *Local Government Act* awards local government the opportunity to respond and adapt to the changing needs of the communities that they serve (Government of British Columbia, 2018b). Included in local governments' jurisdictional power, under its health protection authority within the *Local Government Act*, is the ability to regulate conditions that are understood to promote or preserve public health (Government of British Columbia, 2018b). Further, under the *Public Health Act*, as discussed by Bish and Clemens (2008), local government action is required if community health hazards are identified. This obligation to promote and preserve public health is further accentuated by local government involvement in housing and human services (Bish & Clemens, 2008).

Similarly, the *Community Charter* lays a foundation for the sustenance and creation of local governments across British Columbia, while outlining the typical services provided by local government (Government of British Columbia, 2018a). As outlined in the *Community*

Charter, local government is typically responsible for transit, community programs, policing, recreation and street lighting (Government of British Columbia, 2018a). Under the *Community Charter*, a council may, through the implementation of bylaws, impose requirements to protect and enhance the wellbeing of the community it serves and to promote public health (Government of British Columbia, 2018a).

When the conceptualizations of 'needs of communities' and 'health protection' are framed as alternative promoters of community mental health it becomes evident that local governance has a significant role to play in the promotion and continuation of community mental health (Bish & Clemens, 2008; Government of British Columbia, 2018b). To exemplify this point, I turn to the existing literature on rural and remote mental health. Existing literature on rural and remote mental health notes lack of transportation and proximity to mental health care and related social programming as barriers to adequate community mental healthcare (Fitzpatrick, Perkins, Luland, Brown & Corvan, 2017; Handley et al., 2014; Kelly et al., 2010; Morling & Boxall, 2014; Procter & Ferguson, 2014; Robinson et al., 2012; Ryan-Nicholls & Haggarty, 2007; Singh, 2017). As previously outlined in this section, local governments are typically responsible for providing and advocating for localized services, including social programming and public transit (Government of British Columbia, 2018a; Government of British Columbia, 2018b). Under this jurisdiction, local governance structures, including regional districts, have the authority and obligation to establish services, which support mentally healthy communities as a modality of promoting and protecting public health (Bish & Clemens, 2008; Government of British Columbia, 2018a; Government of British Columbia, 2018b).

Medicine Hat, a community in Alberta, Canada, acts as an exemplar of the role that local governance can play in the promotion of conditions that support equitable mental health through

their elimination of homelessness (CBC Radio, 2015; Lawrynuik, 2017). In collaboration with the provincial and federal government, the city of Medicine Hat successfully mobilized and implemented a housing-first strategy to address the needs of community members facing housing insecurity (CBC Radio, 2015; Lawrynuik, 2017). While Alberta exists within a different provincial political context than British Columbia, this example offers insight and hope on the role that local government can play in mental health.

International Conversations of Rural and/or Remote Mental Health

Australia

Australia's scholarly conversations of rural and remote mental health focus on exploring and addressing healthcare accessibility issues, differences between urban and rural mental health, barriers faced by service consumers and their families, and the feasibility of stakeholder-centered healthcare reform (Fitzpatrick, Perkins, Luland, Brown & Corvan, 2017; Handley et al., 2014; Kelly et al., 2010; Morling & Boxall, 2014; Procter & Ferguson, 2014).

Attitudinal barriers to accessing mental health services have been linked to experiences of stigma, discrimination and the norms and values in service consumers' communities (Fitzpatrick et al., 2012; Handley et al., 2014). As discussed by Handley et al. (2014), rural residents commonly demonstrate values of self-reliance, and subsequently have a preference for self-management. Handley et al. (2014) query these common values as a potential factor of the lower display of help-seeking behaviors demonstrated in rural and/or remote Australian communities.

Physical and structural barriers to accessing mental health services in the Australian context have received significant attention from health researchers (Fitzpatrick et al., 2017; Handley et al., 2014; Kelly et al., 2010; Morling & Boxall, 2014; Procter & Ferguson, 2014). These barriers have been identified in the literature as proximity to services, fiscal burden of

travel, lack of transportation, lack of choice in healthcare services, lack of community support services, and lack of specialized mental health services (Fitzpatrick et al., 2017; Handley et al., 2014; Kelly et al., 2010; Morling & Boxall, 2014; Procter & Ferguson, 2014). Despite the equal prevalence of mental illness in rural and urban settings, Morling and Boxall (2014) highlight the inequity in mental health outcomes for rural residents. Morling and Boxall (2014) attribute this inequity in mental health outcomes to the complexity of structural barriers to accessing services as a rural, remote Australian. In addition to these structural barriers, Morling and Boxall's (2014) research suggests that rural and/or remote Australians experience higher environmental risks of adverse mental health, including poorer health outcomes, smoking, high-risk drinking, illicit substance use, heightened exposure to natural disasters, and substandard housing.

While Australian research has addressed the variety of barriers to accessing mental healthcare, it has also developed recommendations for systemic reform (Fitzpatrick et al., 2017; Handley et al., 2014; Kelly et al., 2010; Morling & Boxall, 2014; Procter & Ferguson, 2014). Recommendations provided address topics for further inquiry, concrete calls to action and consumer-driven agendas (Fitzpatrick et al., 2017; Handley et al., 2014; Kelly et al., 2010; Morling & Boxall, 2014; Procter & Ferguson, 2014). As discussed by Morling and Boxall (2014), Procter and Ferguson (2014) and Handley et al. (2014), future research must investigate attitudinal, physical/structural, and time-commitment barriers to accessing mental health care as separate categorical experiences held by service consumers and their families in efforts of achieving equitable mental health outcomes for rural and remote service consumers. Fitzpatrick et al.'s (2017) research with healthcare workers calls for systemic reform, stating that a less-hierarchal 'place based' system of mental health care must be developed to effectively address the healthcare needs of rural and remote mental health consumers. Fitzpatrick et al. (2017)

recommend that service consumers and frontline workers drive this healthcare reform, rather than organizational power holders.

United States of America

Rural and remote realities presented by American researchers Robinson et al. (2012), Singh (2017), and Bocker, Glasser, Nielsen, and Weidenbacher-Hoper (2012) highlight a similar narrative to Australia, as issues of accessibility and other barriers emerge. Robinson et al.'s (2012) research explored the experiences of mental health service consumers, and their families, who live in rural communities and found that issues of mental health, and required treatment, were commonly met by stigma in rural contexts. This stigma resulted in feelings of shame, which subsequently had a negative impact on individuals help-seeking behaviors (Robinson et al., 2012). Furthermore, as a result of internalized stigma and lack of community resources, participants noted that in their experiences as rural residents, mental health needs were commonly left unaddressed (Robinson et al., 2012). Participants disclosed that proposed solutions for addressing the lack of services in their rural communities were inadequate, stating that law enforcement had been introduced as a solution to mental health needs at the community level, further reinforcing community stigma (Robinson et al., 2012). Accessibility of mental health services was also identified as a primary barrier to adequate treatment, specifically relating to fiscal burdens of missed work and travel expenses, and time burdens of travelling to urban centers (Robinson et al., 2012).

Robinson et al.'s (2012) research highlights the importance of incorporating consumer-driven perspectives in policy decisions by presenting a section on rural mental health service consumers' proposed solutions to healthcare inequity. These solutions include: increased advocacy, emphasis on community education, development of support groups, development of

an itinerary of community and online resources, increased state funding for existing community resources, increased number of mental healthcare providers, support of alternative access to specialized mental health care, and increased collaboration in healthcare (Robinson et al., 2012).

Similar to Robinson et al.'s (2012) research, Singh (2017) notes that the most common barriers related to timely mental health treatment in rural America are cost of services, perceived stigma, confidentiality concerns, shortage of mental healthcare providers, and lack of transportation. The experience of these barriers leads to delays in help seeking, which Singh (2017) links to higher rates of hospitalizations and emergency room usage, higher treatment costs, and negative health outcomes. Singh (2017) proposes that future mental health developments focus on creating rural curriculum for mental health care providers, advancing telemedicine, and implementing collaborative care plans for rural residents.

Bocker et al.'s (2012) research explored the experiences of rural older adults' mental health, with a focus on depression. The prominent barriers discussed by participants were related to structural and attitudinal attributes related to rural residency (Bocker et al., 2012). Bocker et al. (2012) noted primary barriers identified in the data, including denial and/or fear of depression, lack of perceived seriousness of the condition, insufficient amount of time spent with mental healthcare providers, and proximity to services. Bocker et al. (2012) recommend that future reform in the field of rural, American mental health focus on the development of interdisciplinary mental healthcare teams, adequate training and recruitment strategies for prospective rural practitioners, and policy to address financial and administrative barriers (Bocker et al., 2012).

Deen and Bridges' (2011) research exploring mental health literacy yielded findings congruent with those of Robinson et al. (2012), Singh (2017), and Bocker et al.'s (2012) research

on rural American mental health. Deen and Bridges (2011) discussed barriers to equitable mental health care in rural geographies, including proximity to services and lack of mental health specialists. As discussed by Deen and Bridges (2011) rural populations commonly present with lower perceived need for, and utilization of, formal mental health services in comparison to their urban counterparts. In place of these formal mental health services, Deen and Bridges (2011) found that participants expressed an increased dependence on informal networks of mental health care, such as religious communities, in their rural context.

Scotland

Scotland's existing research exploring the rural, remote realities of communities located in geographically isolated contexts reveals attitudinal, structural, and gender-related diversity in experiences of mental health and related care (Levin & Leyland, 2005; Parr & Philo, 2003). The diversity in experiences of mental health exemplified across Scotland's rural and remote geographies influences the ways in which individuals interact with healthcare services, as well as the ways in which communities navigate both formal and informal care work (Levin & Leyland, 2005; Parr & Philo, 2003). In congruence with research originating in the United States of America and Australia, barriers to equitable mental health outcomes appear in the intersections of rural, remote residency and mental health care needs in Scotland (Levin & Leyland, 2005; Parr & Philo, 2003).

Parr and Philo's (2003) research with formal and informal care workers and mental health service consumers explored the role of caregiving in rural and remote contexts. Parr and Philo (2003) argue that 'care,' specifically at the intersections of rural residency and mental health, must be understood as "more than just a medical interaction" (p. 472). Complexities related to the provision of formal and informal mental health care in rural geographies are

characterized by concerns related to lack of anonymity, community gossip networks, fear of stigma, social proximity to services, and the [in]visibility of care workers (Parr & Philo, 2003). Parr and Philo (2003) conceptualized the collection of these concerns as a "geography of fear" (p. 484). This 'geography of fear' presented in the rural, remote Scottish communities included in Parr and Philo's (2003) research is based on the common concern that if mental health care, and subsequently the care providers, were more widely acknowledged and known in community, that there would be adverse community reactions. In summary, Parr and Philo (2003) concluded that rural communities do not inherently possess and present an emotional openness to the administration of localized mental health care. Parr and Philo (2003) recommended that further investigation into the gendered differences in caring, and care needs, is required in the context of rural, remote mental health in Scotland.

Adjacent to Parr and Philo's (2003) research, Levin and Leyland (2005) investigated the inequalities between urban and rural populations in relation to rates, demographics, and modalities of suicide. While suicide is not a mental health condition, this research highlights the rural versus urban inequities related to conditions of health and subsequent healthcare needs and management (Levin & Leyland, 2005). Suicide is the leading cause of death among young men in Scotland; Levin and Leyland's (2005) research revealed that young men are at significantly higher risk of completing suicide in rural, remote geographies in comparison to their urban and rural-accessible counterparts. Furthermore, men in rural geographies were found to be more likely to utilize non-domestic gas, firearms, and explosives as methods of suicide (Levin & Leyland, 2005). Levin and Leyland's (2005) research also discussed dominant realities represented in international literature on the intersections of mental health and rural residency. These realities included the inaccessibility of social services related to substance abuse

management, exaggerated local cultures of self-reliance, community stigma towards mental health, and physical isolation from social and support networks (Levin & Leyland, 2005). Attributable, in part, to these realities, Levin and Leyland (2005) discussed the reliance on informal – namely familial – care workers in the management of mental health in rural, remote Scotland. Levin and Leyland's (2005) research proposed that in efforts to address the inequities related to death by suicide in rural geographies, healthcare policymakers and other stakeholders must begin to create strategies that reflect the needs of targeted demographics based on socioeconomic and health needs related to age, gender, and ethnicity.

Canadian Conversations of Rural and/or Remote Mental Health

In Canadian literature, rural and/or remote realities of mental health are inclusive of structural and attitudinal barriers to accessing mental healthcare, as well as environmental risk factors (Bodor, 2009; Dyck & Hardy, 2013; Goodwin, MacNaughton-Doucet & Allan, 2016; Panazzola & Leipert, 2013; Ryan-Nicholls & Haggarty, 2007). Identified barriers to accessing mental healthcare in Canada include proximity of services, accessibility, provider shortages and lack of mental healthcare consumer involvement in decision-making processes (Bodor, 2009; Dyck & Hardy, 2013; Panazzola & Leipert, 2013; Ryan-Nicholls & Haggarty, 2007). Ryan-Nicholls and Haggarty (2007) identified additional systemic barriers to effective rural and remote Canadian mental health care in their research. These systemic barriers included paternalistic attitudes in Canadian healthcare provision and organizational reliance on urban models of healthcare (Ryan-Nicholls & Haggarty, 2007). Ryan-Nicholls and Haggarty (2007) noted that the persistence of these systemic barriers would continue to create barriers for rural and remote communities in their strides to obtain equal health status with their urban counterparts.

Despite the recognized need for place-based developments in rural and remote Canadian mental healthcare, these communities are often the last to receive service (Bodor, 2009). With an increasing realization that it is unlikely the needs of rural and remote mental health consumers will be met through mainstream services, recommendations for systemic reform are emerging (Ryan-Nicholls & Haggarty, 2007). Recommendations for reform presented in the literature include: advancements in telemedicine and alternative access to specialized mental health care, implementing interprofessional mental health teams, increased mental health promotion and educational programming, inclusion of mental healthcare consumers and their families in policy and programming decisions, development of local community resources, and the development of rural curriculum for mental healthcare providers (Dyck & Hardy, 2013; Goodwin, MacNaughton-Doucet & Allan, 2016; Panazzola & Leipert, 2013; Ryan-Nicholls & Haggarty, 2007).

British Columbian Conversations of Rural and/or Remote Mental Health

In British Columbia, research of rural and remote realities of mental health has focused on the impacts of regionalization, barriers to accessing services, and the influence of community values on help seeking behaviors (Caxaj & Gill, 2017; Coen, Oliffe, Johnson & Kelly, 2013; Morrow, Hemingway, Grant & Jamer, 2012).

Dobrowolsky (2009) states that the regionalization of healthcare services, as a neo-liberal task, works to shift the responsibilities of healthcare to communities – referred to as a small-government approach – without providing said communities with the resources to take up these responsibilities in ways that promote healthcare equity. Regionalization in British Columbia has resulted in the decentralization of mental health care services from one large psychiatric hospital, to a community care model, demanding self-sufficiency within local healthcare structures in

respects to caring for individuals with adverse conditions of mental health on both the inpatient and outpatient level (Morrow et al., 2012). Morrow et al. (2012) highlight the lack of literature outlining rural and remote communities capacities to deal with the demands of regionalization.

Fleet, Plant, Ness and Moola's (2013) article provides a case example of funding cuts associated with regionalization in Nelson, British Columbia. Regionalization, as discussed by Fleet et al. (2013), has profound impacts on the accessibility of healthcare services in rural areas. In the city of Nelson the shift to the regionalized model of care resulted in the closing of three health units, one of which was the inpatient mental health unit (Fleet et al., 2013). To access these services now, residents must attend the regional hospital in Trail, British Columbia, which is 71 kilometers away from Nelson (Fleet et al., 2013). Between the years 2006 and 2009, following the elimination of the mental health inpatient unit in Nelson between 1,110 and 1,600 inter-facility ground or air transfers were required per year and mental health inpatient services was one of the top four emergencies requiring transfer (Fleet et al., 2013). Building off of the barriers introduced by the structural impacts of regionalization, Caxaj and Gill's (2017) research presents limited mental health specialists, decreased anonymity, increased risk of mental illness stigma, economic disparity, and travel as barriers to accessing mental health services in the rural British Columbian context.

Coen, Oliffe, Johnson and Kelly's (2013) research on men's depression in Prince George, British Columbia explored community values of mental health. Coen et al. (2013) present the concept of the 'rural paradox' in this research, noting that rural places are commonly believed to be favorable for mental health promotion given their informal support networks, though in reality rural contexts have the potential to erode privacy and confidentiality while perpetuating stigma that moves people with mental illnesses to the margins. Coen et al.'s (2013) research also found

that open discussion and disclosure of mental illness was commonly framed as inappropriate and threatening to the male participants' social locations, and thus, mental health was displaced from public domains.

Summary

Rural, remote residents in a diversity of geographical settings experience barriers to equitable mental healthcare (Fitzpatrick et al., 2017; Handley et al., 2014; Kelly et al., 2010; Morling & Boxall, 2014; Procter & Ferguson, 2014; Robinson et al., 2012; Ryan-Nicholls & Haggarty, 2007; Singh, 2017). Despite the commonalities amidst existing literature on rural, remote mental health the relevance of place-based, community explorations of stakeholders' perspectives is acknowledged as a necessary step towards achieving equitable reform in the provision of rural, remote health services (Bodor, 2009; Robinson et al., 2012; Ryan-Nicholls & Haggarty, 2007).

Visual Arts in Creative Art Therapy

Visual arts as therapeutic modalities for supporting and maintaining mental wellness have been recognized for their non-invasive, creative approaches to self-exploration and the processing of traumatic content (Boyd, 2015; Levine & Levine, 2019; O'Connor, 2011; Withrow, 2004). This section outlines the benefits of incorporating colour therapy, non-representational art, and visual art in therapeutic spaces.

Colour Therapy

Colour therapy upholds the holistic, non-invasive healing potentials of colours as tactful resources for overcoming a broad range of health disparities (O'Connor, 2011). The potential of colour as a therapeutic resource is based upon the broad range of cognitive, physiological, behavioral, spiritual and emotional responses to, and associations with, colour (O'Connor, 2011;

Withrow, 2004). O'Connor (2011) suggests that the use of colour in visualizations is the most effective, noting that the use of colour therapy in other applications is fundamentally symbolic. The symbolic properties of colour associations and meanings are commonly introduced in conjunction with a range of psychological responses including affect and judgments (Gil & Le Bigot, 2014; O'Connor, 2011; Withrow, 2004). These reactions – or feelings – evoked by colours have been termed "colour emotions" (Ou, Luo, Woodcock & Wright, 2004, p. 232). Colour emotions are culturally influenced, as exemplified by the differences between British and Chinese participants emotional associations with colours in Ou et al.'s (2004) research.

Colour therapy, when used in creative arts therapy, offers enrichment to the creative process held within therapeutic spaces (Withrow, 2004). This enrichment is fostered through colours' unique ability to allow for the non-verbal exploration and expression of emotions that may be challenging to verbalize, such as hate and guilt (Withrow, 2004). Subsequently, service consumers in different emotional states commonly choose to interact with different colours, creating opportunity for the art therapist to explore the service consumers' symbolic investment in the colours utilized during the creative process (O'Connor, 2011; Withrow, 2004). When service consumers realize that all colours and emotions have a place and a value within the creative process, authentic healing and exploration of the inner-self can begin (Withrow, 2004).

Non-Representational Art

Non-representational art is a form of art that does not work to depict – or represent – beings, figures, or places from the natural world, but rather offers symbolic meaning to the creator and the spectator through the interpretation of line, form, and colour (Gersh-Nesic, 2017). When art is valued beyond its ability to represent reality, the scope of art and creative practice is broadened (Boyd, 2015).

In application to art therapy, non-representational art can relieve service consumers' anxiety about the ability to produce a product – or 'good' representational art – and rather works to shift the focus to the profoundly transformative powers presented within the creative process (Boyd, 2015; Levine & Levine, 1999). Withrow (2004) highlights non-representational arts' potential to act as a medium for the communication of peoples' unconscious minds, suggesting that this communication offers distinct opportunity for personal growth and awareness within the safety of the therapeutic relationship.

Visual Art

The use of visual arts in therapeutic interventions offers service consumers potential for self-discovery, personal development, and an increased quality of life (Rogers, 2011; Warren, 2003; Withrow, 2004). Visual arts also offer service consumers the potential for future, independent healing (Warren, 2003). This potential is established through service consumer's exposure, experience, and knowledge of materials and creative processes – effectively empowering service consumers to take with them, wherever they go, skills to navigate future turmoil (Warren, 2003).

Different modalities of visual arts are available to be explored in therapeutic relationships, including painting, drawing, clay work, and collage (Warren, 2003). The creative process associated with these artistic explorations must be respected as emotional encounters by the arts facilitator (Warren, 2003). Warren (2003) urges arts facilitators to be mindful of the raw and uncensored presentation of human emotion manifested in the creative process, suggesting that facilitators avoid placing value and judgments onto service consumers finished products. The inclusion of different arts modalities, such as music, in combination with visual arts can aid the creative process (Warren, 2003).

At the end of a visual arts therapy session, Warren (2003) recommends that arts facilitators actively create space for service consumers to discuss their experiences of the creative process. Additionally, it is recommended that arts facilitators allow service consumers to explore the symbolism presented in their finished products – for instance, exploring the interpreted meaning of the colour theme and line form (Warren, 2003).

It is integral that the therapeutic use of arts is tailored to fit the needs of the service consumers, whether that be an individual, group, or community (Warren, 2003). Setting service consumers up for creative success can include a variety of adaptations to modalities (Warren, 2003). Warren (2003) discusses adaptations made in work with peoples with diverse fine motor skills; for example, suggesting that applying Velcro to the end of the brush and giving the service consumer a Velcro bracelet can work to reduce this physical barrier to participation. Furthermore, when personalizing art interventions, facilitators and therapists must assess the service consumer's openness to the creative arts process (Warren, 2003). Warren (2003) suggests introducing primary modalities – such as drawing and colouring – at the beginning of the working relationships to develop rapport and empower the client to explore the creative process from a place of relative familiarity. However, it is important to have resources readily available to meet the service consumers creative needs as they arise to ensure their experience is not restricted (Warren, 2003).

Creative Arts in Mental Health

The creative arts offer profound opportunity for healing, self-exploration and empowerment with a diverse range of populations (Levine & Levine, 1999; O'Connor, 2011; Rogers, 2011; Withrow, 2004). This section will highlight the relevance of creative art therapies

and their roles as alternative mental health interventions at the micro, mezzo and macro levels of practice.

For the purpose of this section of the proposal the terms micro, mezzo, and macro are defined as:

Micro: the social worker, or clinician, engages with individuals and families to solve problems (Social Work Licensure Map, 2017).

Mezzo: the social worker, or clinician, services a small to medium sized group, such as a school, neighborhood, or other local stakeholders (Social Work Licensure Map, 2017).

Macro: the social worker intervenes in large structures of oppression to advocate for, and elicit, social change (Social Work Licensure Map, 2017). Macro social work empowers service consumers at the micro and mezzo levels by involving them, or their narratives, in systemic change (Social Work Licensure Map, 2017).

Micro Applications

A central aim of art therapy is to improve and maintain mental health and emotional wellbeing through the creative exploration of individuals' lived experiences and subconscious minds (Farokhi, 2011). This exploration must occur in compassionate spaces, characterized by mutuality, trust, understanding, and recognition – all of which are integral for mental health recovery (Crawford, Lewis, Brown & Manning, 2013). When used as an alternative health intervention with people experiencing negative symptoms of mental health, art therapy offers three positive contributions including positive self-growth, relief from negative symptoms, and cognitive development (Caddy, Crawford & Page, 2012; Papagiannaki & Shinebourne, 2016).

Positive self-growth fostered within arts-based therapeutic relationships can have significant impacts on service consumer's life trajectories (Caddy et al., 2012; Papagiannaki &

Shinebourne, 2016). By utilizing creative arts based interventions in clinical mental health settings the cycles of boredom, lack of purpose, and low motivation can be surpassed, allowing service consumers to build on their abilities and talents while being supported to explore and reflect on their mental health (Rowley & Comisari, 2016). Caddy et al.'s (2012) research found that participating in creative arts positively correlated with increased self-esteem, self-efficacy, self-worth, empowerment, satisfaction, confidence and achievement in people living with mental health concerns. Furthermore, Caddy et al. (2012) concluded that participating in creative arts contributed to heightened intrinsic motivation and therefore has the potential to contribute to increased levels of activity. These positive personal advancements commonly result from the enjoyment of the creative process and the satisfaction of creating something comforting and tactile (Rogers, 2011).

Creative arts have the potential to provide relief from negative symptoms of mental health issues (Caddy et al., 2012). The creative process can create a focused experience that mimics the dissociation presented in meditation, offering space for distraction and relief from worry, rumination, and negative thinking (Caddy et al., 2012; Levine & Levine, 1999; Rowley & Comisari, 2016). Additionally, Caddy et al. (2012) highlight that the creative process can offer a means for structuring time and facilitating purpose in the lives of service consumers.

The creative process has also been proven to contribute to cognitive development (Caddy et al., 2012). The physical 'doing' of creative activity elicits a complex interaction of mind and body processing, which can stimulate the growth of new neural networks in the cerebral cortex (Caddy et al., 2012). During these processes, both sides of the brain are engaged; the tactile requirements of the creative process activate and energize the mind, while the implementation of

imagination accesses the right brain function, and in turn, can work to surpass rigid thinking patterns (Caddy et al., 2012).

Depression and creative arts interventions. Depression can be understood as a mental health condition, persisting for two weeks or more, which is characterized by overwhelming feelings of sadness, isolation, and despair (Bressert, 2017). This depressed mood significantly impacts the individual's social, occupational, emotional, and educational functioning (Bressert, 2017). Other depressive symptoms include: diminished interest and pleasure in activities, weight loss or weight gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue, feelings of worthlessness, suicidal ideation, and cognitive fugue (Bressert, 2017).

In solidarity with literature pertaining to the general benefits of creative arts therapy in the treatment of mental health, Blomdahl, Gunnarsson, Guregard and Bjorklund's (2013) literature review found eight common therapeutic benefits to using arts-based approaches in the treatment of depression. These benefits are: self-exploration, self-expression, communication, understanding and exploration, integration, symbolic thinking, creativity, and sensory stimulation (Blomdahl et al., 2013). By identifying the multiple therapeutic benefits of arts-based approaches in the treatment of depression, therapists can make informed decisions about what modalities to employ to elicit the most beneficial intervention for service consumers (Blomdahl et al., 2013). In summary, the use of therapeutic arts creates the opportunity to examine and explore presenting depressive symptoms, and their implications, in a playful, safe manner (Blomdahl et al., 2013).

Thyme, Sundin, Stahlberg, Lindstrom, Eklof and Wiberg's (2007) research with 39 women with depression found that the use of art psychotherapy reduced the prevalence of depressive symptoms. These positive results were still observable three months later at the

research follow up sessions (Thyme et al., 2007). This research demonstrated the effectiveness of psychodynamic art therapy with women who are diagnosed with depression or are experiencing depressive symptoms (Thyme et al., 2007).

Arts based interventions have been proven to provide positive relief for certain demographics experiencing depression (Blomdahl et al., 2013; Thyme et al., 2007). With the identification of the eight therapeutic benefits presented in the current literature, therapists have the opportunity to create meaningful, personalized art interventions for individuals experiencing symptoms of depression – creating the opportunity for healing and empowerment within therapeutic relationships (Blomdahl et al., 2013).

Borderline personality disorder and creative arts interventions. Borderline personality disorders (BPD) are characterized by a mixture of unstable, stress-induced symptoms and stable personality characteristics (Oldham, 2012). Specific symptoms include: fear of abandonment, difficult interpersonal relationships, uncertainty about self-image or identity, impulsive behavior, self-injurious behavior, emotional changeability, feelings of emptiness, difficulty controlling anger, and disconnectedness (Oldham, 2012). As per the *Diagnostic and Statistical Manual of Mental Disorders – 5*, five of the aforementioned symptoms must be present to justify the diagnosis of BPD (Oldham, 2012).

Eastwood (2012) conducted a case study on a feminist art therapy group with 11 female participants with BPD at an in-patient health facility. Eastwood's (2012) research concluded that the art making process gives women the opportunity to deconstruct and dilute the power constraints in their lives while working towards tangible transformation. Eastwood (2012) highlights the importance of an egalitarian relationship between the art therapist and participants to ensure a feeling of collaboration can be fostered. Eastwood (2012) noted positive shifts in

identity, the value of art as a safe space, and the importance of symbolic communication in the art making process.

Franks and Whitaker (2007) conducted a pilot study exploring the benefits of group psychodynamic art therapy with five individuals with personality disorders. This study focused on mentalization, which is the capacity to perceive and understand ones' self and others in terms of mental states (Franks &Whitaker, 2007). This focus was achieved through an investigation of the roles of images produced within the art therapy groups (Franks & Whitaker, 2007). The research concluded that those who had participated in the art therapy group had decreased symptoms and distress related to their personality disorder, and reported overall improved social functioning (Franks & Whitaker, 2007). Similarly, Springham, Findlay, Woods, and Harris' (2012) research with six participants diagnosed with BPD concluded that using art therapy to increase mentalization capacity enhanced service consumers' distress tolerance, emotional expression, and sense of self-identity.

In solidarity with Frank and Whitaker's (2007) and Springham et al.'s (2012) findings pertaining to increased social functioning, Huckvale and Learmonth's (2009) research concluded that art therapy, in combination with dialectical behavior therapy, works to improve emotional regulation, self-acceptance, and reflective capabilities in individuals with BPD. Participants reported that the psychodynamic art therapy resulted in positive growth in the following areas: personal relationships, daily interactions, managing conflict, decreased experiences of paranoia in public, reduced self-injurious behaviors, and increased ability to manage intense emotions (Huckvale & Learmonth, 2009).

The use of arts-based interventions with people experiencing BPD – and other personality disorders – has proven to positively impact individuals' social functioning, emotional regulation,

and perceptions of self (Eastwood, 2012; Franks & Whitaker, 2007; Huckvale & Learmonth, 2009; Springham et. al., 2012).

Schizophrenia and creative arts interventions. Schizophrenia is a mental disorder characterized by disturbances in perception, thought, and behavior (Tandon et al., 2013). Hallucinations, delusions, disorganized speech, and catatonic behaviors are symptomatic of these disturbances (Tandon et al., 2013). As a result of these symptoms, deterioration in everyday functioning is commonly observed in the lives of people experiencing schizophrenia (Tandon et al., 2013).

Hanevik, Hestad, Lien, Teglbjaerg and Danbolt's (2013) research explored the experiences of five women with psychotic illnesses in an expressive arts therapy group. The group utilized various artistic modalities, including music and painting (Hanevik et al., 2013). In conclusion the participants reported experiencing positive changes as a result of their participation in creative arts (Hanevik et al., 2013). These changes included the increased ability to manage: psychotic experiences and behaviors, feelings of being valued, coping skills, and problem solving skills (Hanevik et al., 2013). Hanevik et al. (2013) concluded that the experience of artistic exploration might contribute to participants' understandings of their diagnoses, and in turn, offer opportunity to better control their psychosis.

Similar benefits of creative arts modalities in the treatment of schizophrenia were reported in Killick's (1996) case study. Killick's (1996) research found that the use of art therapy helped the participant to manage symptoms of their psychosis through the development of positive coping skills. Furthermore, Killick (1996) reports the use of symbolic imagery as a medium for increased communication between the participant and the therapist – and in turn, more therapeutic benefit.

In solidarity with Killick's (1996) findings, Noronha's (2013) case report highlighted the effectiveness of art as a medium for allowing non-communicative service consumers to communicate in therapeutic settings. In this case report, the participant – who was diagnosed with schizophrenia – was able to create concrete goals using imagery and creative arts, allowing for positive growth and exploration of past trauma (Noronha, 2013).

Emerging literature recognizes the effectiveness of arts based interventions in the therapeutic treatment and management of schizophrenia (Hanevik et al., 2013; Killick, 1996; Noronha, 2013). Positive benefits of employing arts modalities in the treatment of schizophrenia include: increased ability to manage psychotic experiences and behaviors, feelings of being valued, coping skills, problem solving skills, and a medium for increased verbal exchange (Hanevik et al., 2013; Killick, 1996; Noronha, 2013).

Mezzo and Macro Applications

The creative arts offer a medium from which societal norms and perceptions of mental illness – and other marginalized intersections of identity – can be explored at the community and national level (Koh & Shrimpton, 2014; Quinn, Shulman, Knifton & Byrne, 2011; Ryan et al., 2015). This societal exploration of mental health and illness has commonly been promoted through exhibitions of creative arts modalities (Koh & Shrimpton, 2014; Quinn et al., 2011; Ryan et al., 2015). These exhibitions – when properly curated and organized – work to reflect the diverse range of personal experiences of mental illness, while presenting the artists as accomplished and valuable, effectively empowering and affirming individuals' healing journeys (Koh & Shrimpton, 2014). The community presentations of these exhibitions has been linked to: decreases in stigma, increases in community mental health literacy, increases in overall community mental health, and increased community mobilization related to advocating for

equitable health care (Koh & Shrimpton, 2014; Quinn et al., 2011; Ryan et al., 2015). These community level shifts work to create safe environments for future work pertaining to community mental health promotion and social inclusion (Quinn et al., 2011).

The positive impacts of creative art installments on communities' conceptualizations of mental health and illness have significant impacts on the mental wellness of individuals living with mental health concerns (Koh & Shrimpton, 2014; Quinn et al., 2011; Ryan et al., 2015). For example, as highlighted in Quinn et al.'s (2011) research, increased community mental health literacy and decreased stigma contributes to the reduction of barriers to obtaining housing, employment, education, and healthcare for individuals with experiences of mental illness.

At the macro level, creative arts have a meaningful reputation for their ability to create non-judgmental spaces for the exploration of social developments related to mental health care and promotion (Ryan et al., 2015). Ryan et al.'s (2015) research works to highlight the effectiveness of arts based explorations in the developments of new policy and programming. In recognition of arts' ability to create environments in which painful and difficult experiences can be communicated, Ryan et al. (2015) utilized arts as an exploratory tool with service consumers to uphold their voices in a national health-initiative development campaign. The final exhibition from this project offered insight – from the perspectives of service consumers – into what sustainable art and mental health initiatives should look like (Ryan et al., 2015).

Summary

Creative art therapies create opportunity for alternative explorations of the experiences of mental health through micro, mezzo, and macro interventions (Caddy et al., 2012; Papagiannaki & Shinebourne, 2016). At the micro level, these alternative mental health practices work to promote positive self-growth, relief from negative symptoms, and cognitive development (Caddy

et al., 2012; Papagiannaki & Shinebourne, 2016). Mezzo and macro level applications of arts-based approaches to mental health work to promote mental health literacy in communities, which works to diminish stigma and promote community mental health (Koh & Shrimpton, 2014; Quinn et al., 2011; Ryan et al., 2015).

Formal and Informal Mental Health Services

The wellness of individuals with adverse conditions of mental health can be promoted and supported by both formal and informal mental health services, with collaborative approaches to care presenting the best opportunity for the management of complex mental health needs in community (Cummings & Kropf, 2009; O'Neill, George & Sebok, 2013; Sav et al., 2015; WHO, 2003; Winters, Cudney, Sullivan & Thuesen, 2006). This section of the literature review will discuss the differences between formal mental health services and informal mental health services.

Formal Mental Health Services

Formal mental health services can be understood as professionally led social and clinical services that provide support – in some capacity – to individuals living with adverse conditions of mental health (WHO, 2003). Examples of formal mental health services include community-based rehabilitation programs, mobile crisis teams, therapeutic and residential supervised services and hospital diversion programs (WHO, 2003). Formal helping professionals play integral roles in promoting and supporting the wellness of community members (O'Neill, George & Sebok, 2013). Resource rich communities often offer a diversity of formal mental health services to adults with adverse conditions of mental health, maximizing the opportunity for community re-integration and health management (WHO, 2003). High quality systems of

community mental health require significant funding and access to trainer personnel – presenting a barrier to provision in a diversity of geographic settings (WHO, 2003).

In Cummings and Kropf's (2009) research with older adults with mental illness the value of formal and informal supports were explored. Cummings and Kropf (2009) found that formal sources of support were sought after and utilized during episodes of psychiatric distress, for physical health needs, and when dangerous behavior related needs were presented.

Informal Mental Health Services

Informal mental health services play a key role in the maintenance and promotion of mental health in rural communities (Cummings & Kropf, 2009; Sav et al., 2015; Winters et al., 2006). Paraprofessionals, caring community members, and community-based resources typically deliver informal mental health services (WHO, 2003). Informal services have been found to present fewer access barriers as they are provided in the community context (WHO, 2003). Rural residents often utilize informal mental health services as tactics for the self-management of chronic illnesses (Sav et al., 2015; Winters et al., 2006). Informal mental health services identified in existing literature include: community connections, family care giving, traditional healers and place-based natural resources presented in rural, remote geographies (Chen & Greenberg, 2004; Cummings & MacNeil, 2008; Neil, 2013; Sav et al., 2015; WHO, 2003; Winters et al., 2006).

In exploration of the prevalence of self-management of mental illness in Australia, Olsen, Butterworth and Leach's (2018) research found that of their sample, "half of all adults who met the criteria for an affective or anxiety disorder in the last 12 months reported using non-practitioner led support services and/or self-management strategies for their mental health problem" (p. 823). Similarly, Say et al.'s (2015) work noted the unique ways in which rural

residents self-management plans are dictated by place-based resources. Say et al. (2015) found that geographic isolation – in part – contributes to the presentation of more creative approaches to meeting mental healthcare needs with available resources; for instance, a participant noted the value of 'bush-walking' as a replacement for fitness facilities.

In Winters et al.'s (2006) research with women managing chronic illness in a rural context, the intersections of rural residency and health management was explored. In consideration of the physical and structural barriers to accessing formalized health services Winters et al. (2006) found that rural residents commonly utilize self-management techniques for chronic illness, incorporating localized resources in said management plans. Women in Winters et al.'s (2006) project valued the beauty of nature, open space, clean air, the presence of wildlife, land for domestic animals, and community as rural resources supporting wellness. Additionally, women voiced their sense of satisfaction and fulfillment gained through being involved in community events and organizations in volunteer capacities (Winters et al., 2006). Winters et al. (2006) noted that the 'uniquely rural' atmospheres explored in this project were created by a combination of social, cultural and economic determinants.

Summary

Formal and informal mental health services present opportunity for successful mental health management in community settings (Cummings & Kropf, 2009; O'Neill et al., 2013; Sav et al., 2015; WHO, 2003; Winters et al., 2006). As presented in the literature, preference for self-management of mental health is prevalent in rural contexts (Sav et al., 2015; Winters et al., 2006). The preference for self-management has been associated with access barriers related to utilizing formal services in rural settings (Sav et al., 2015; Winters et al., 2006).

Gaps in the Literature: Arrow Lakes Region

Existing literature showcases the significant barriers to accessing mental health services in rural and/or remote communities (Dyck & Hardy, 2013; Fitzpatrick et al., 2017; Goodwin, MacNaughton-Doucet & Allan, 2016; Handley et al., 2014; Kelly et al., 2010; Morling & Boxall, 2014; Panazzola & Leipert, 2013; Procter & Ferguson, 2014; Robinson et al., 2012; Ryan-Nicholls & Haggarty, 2007). Although these barriers are categorized in similar ways across the literature, regional contexts influence the ways in which barriers are presented and navigated by mental health service consumers; this influence of regional contexts is showcased in Morrow et al.'s (2012) research exploring the ways in which psychogeriatric care in northern British Columbia has been complicated by the impacts of regionalization. In acknowledgement of the importance of regional context and regional perspectives on mental health, the Arrow Lakes' regional lack of representation within existing literature works to dissociate diverse experiences of mental health and illness from national conceptualizations, contributing to the maintenance of cohorts of socioeconomic and health disadvantage disproportionally located in rural and remote geographies (Coen et al., 2013; Government of British Columbia, 2015).

My exploratory, text and image-based, qualitative research with adult mental health service consumers works to address the Arrow Lakes regions' lack of representation in existing literature, while presenting the opportunity for community-based stigma reduction, increased mental health literacy, and participant empowerment through the arts-based component of this research (Koh & Shrimpton, 2014; Quinn et al., 2011; Ryan et al., 2015). Furthermore, by revealing the experiences and needs of mental health care consumers this research offers the potential to influence mental health policy in ways that contribute to more equitable health outcomes for rural and remote service consumers in the Arrow Lakes region through the

development of a place-based model of mental healthcare (Fitzpatrick et al., 2017; Robison et al., 2012; Ryan-Nicholls & Haggarty, 2007).

CHAPTER THREE: METHODOLOGY AND METHODS

Theoretical Informant: Standpoint Theory

Standpoint theory originated as a feminist research methodology, committed to valuing women's experiences, needs, and struggles from their perspectives or their standpoints (Harding, 2009; Intemann, 2010; Rouse, 2009). In contemporary applications, standpoint theory is utilized in social projects with a diversity of oppressed demographics (Harding, 2009). Standpoint theory is concerned with including excluded voices in social projects and subsequently producing information relevant to the researched population (Harding, 2009; Rouse, 2009). Furthermore, standpoint theory works to create space for oppressed groups to vocalize and demonstrate the ways in which privileged institutions and populations have maintained, and implemented, harmful, disadvantageous social conditions (Harding, 2009; Intemann, 2010). In the context of rural and/or remote mental health, these disadvantageous social conditions have included community stigma and the inadequacy of urban-based healthcare models in rural healthcare settings, both of which have contributed to inequitable mental health outcomes for rural, remote residents (Dyck & Hardy, 2013; Ryan-Nicholls & Haggarty, 2007).

Standpoint research centralizes the perspectives of the oppressed groups participating in research by using their standpoints as a framework from which structural power imbalances are analyzed (Harding, 2009; Rouse, 2009). Standpoint research does not seek to be value-neutral, but rather aims to produce "accurate, comprehensive, rationally justifiable, and politically useful knowledge" for the oppressed group (Harding, 2009, p. 195).

From these understandings and the recognition that this research aims to empower mental health service consumers, elicit policy change, and improve community understandings of the

diversity of mental health, standpoint theory provided a fitting methodological foundation for this inquiry.

Methodology: Exploratory, Text and Image-Based Qualitative Research

My research with adult mental health service consumers in the Arrow Lakes region utilized a qualitative methodology, specifically engaging an exploratory, text and image-based qualitative lens. Qualitative research focuses on exploring meaning, context, and process within a flexible research structure (Becker, Bryman & Ferguson, 2012). The central aim of qualitative research is to gain familiarity with, and achieve new insights on, a specified phenomenon through the exploration of individuals' personally constructed worldviews – or in the context of this research, from their standpoints – commonly resulting in rich, documentations demonstrating the diversity of the human experience (Becker et al., 2012; Kothari, 2005; Morgan & Drury, 2003). To achieve the outlined aims of inquiry, the qualitative research process "involves emerging questions and procedures, data typically collected in the participants setting, data analysis inductively building from particulars to general themes, and the researcher making interpretations of the meaning of the data" (Creswell, 2014, p. 4).

In the context of this qualitative inquiry, the phenomena being explored were the experiences of adult mental health service consumers in the Arrow Lakes region. These phenomena were explored using three instruments – demographic questionnaires, qualitative interviews and creative arts – which will be further discussed in the data collection section of this thesis. Prior to this inquiry, the Arrow Lakes region did not have representation in existing literature on the topic of mental health, and therefore, this research was exploratory.

Qualitative interviews work to produce rich understandings of the experiences and realities of participants (Creswell & Poth, 2018; Marlow, 2011). The value of experiences and

standpoints upheld in this method of data collection creates an opportunity for participants to share current, historical, and hypothetical understandings with the researcher (Creswell, 2014). As further discussed in the 'Data Collection' section of this thesis, semi-structured interviews were utilized as one of three data collection methods in this project. The use of semi-structured interviews in this research allowed me, the researcher, to guide the line of questioning, while creating space for flexibility to ensure maximum participant collaboration and disclosure (Creswell, 2014; Dicicco-Bloom & Crabtree, 2006).

Image-based qualitative research has largely been used to explore phenomena that are difficult for participants to discuss and to gain insight into participants' lived experiences (Mason, 2005; Matthews, 2012; Prosser, 1998). Matthews (2012) outlines the potential for image-based research to align with social work's ethical framework of social justice as it creates opportunity for people belonging to historically excluded demographics to contribute to social research. Furthermore, image-based qualitative research presents the opportunity for researchers to engage with participants on their functional level, thus reducing the power imbalance in the researcher-participant relationship (Matthews, 2012).

Matthews (2012) and Clark (2013) highlight that the use of integrated research approaches, including image-based data, offer a way to explore the complexity and diversity of the human experience. Matthews (2012) holds that the incorporation of image-based methods in qualitative research contributes to the richness of the final product, stating that the purpose of visual methods is to elicit and record raw representations of real situations, which are inclusive of factual and subjective information.

Cooper (2010) notes that researchers incorporating arts into their research design must consider their proficiency with the artistic instrument being utilized for inquiry, just as they

would with other traditional skills associated with qualitative inquiry. In the case of this research, the arts-informed instruments used were photography, painting and creative writing. As the researcher, I have both formal, and informal, training in visual arts. Although my experiences with visual arts have not directly been utilized in research settings prior to this inquiry, my comfort with artistic mediums lent to the success of the image-based component of this qualitative inquiry.

Clark's (2013) article outlines ethical issues that may arise when conducting visual research. These issues include: informed consent, anonymity and confidentiality, and the process of determining ownership of the visual data (Clark, 2013). Expanding on the topic of informed consent, Clark (2013) notes that the issue is further complicated in visual research, as the issues of storage, ownership, analysis, and display of images must be accounted for and negotiated with participants. Further, it is the duty of the researcher to ensure that participants understand the importance of gaining consent from people they may feature in their images (Clark, 2013). On this topic, Clark (2013) cautioned that this responsibility placed on the participant might result in a 'dehumanized' representation of the phenomenon, as participants may choose to photograph empty landscapes.

The ethical issue of anonymity and confidentiality in visual research is difficult because efforts to manage participant anonymity can undermine the purpose of collecting visual images, as the representation of the phenomenon may be devoid of significant characters due to censoring (Clark, 2014). Clark (2014) suggests that researchers communicate restrictions on anonymity and risks associated with the production of images with participants at the beginning of the project. Furthermore, Clark (2013) recommends that researchers explicitly discuss ownership and intentions for the visual data with participants at the beginning of the researcher-

participant relationship in efforts to reduce the potential for ethical issues related to displays including the images.

In attempts to mitigate the risks related to anonymity and confidentiality in the visual data, I discussed – specifically – the ways in which photography and art can breach confidentiality and privacy via identifiable subjects. Participants were made aware of these risks at the first face-to-face interview during the consent discussion and were again reminded at the exchange of the visual data. Furthermore, participants signed a second consent form at their second interview, which outlined the privacy risks associated with the community art exhibit and explored their desired approach to having art displayed with the option of anonymous display, display under their chosen pseudonym, and display under their real name. As the art exhibit will be a public event, participants were cautioned to be mindful of how they interacted with their arts pieces as identifying their contributions could result in a breech their anonymity and confidentiality as a contributor to the research project.

Recruitment and Sampling

Criterion sampling was utilized to recruit participants, meaning that all community members that fit participation criteria had the opportunity to participate (Marlow, 2011). I chose this recruitment technique on account of the small populations of the communities included in this study. Community members who fit the following criteria were eligible to participate: nineteen years of age or older, mental health service consumer, and resident of the Arrow Lakes region for 12 or more months. Six individuals were recruited to participate in this research. As discussed by Guest, Bunce and Johnson (2006), the inclusion of six to twelve participants supports the concept of data saturation. Data saturation, in the context of qualitative research, is achieved when no new information or themes are observed in the data, enough information is

available to replicate the research, and the opportunity for further coding is not feasible (Fusch & Ness, 2015; Guest, Bunce & Johnson, 2006, p. 59).

Participants were recruited using: community partnerships with social agencies, word of mouth, and recruitment posters (see Appendix B). The primary recruitment partnership was with Arrow and Slocan Lakes Community Services as this is the prominent non-profit social services agency in the Arrow Lakes region. Additionally, community social media forums, such as 'Nakusp Communicator,' 'What the Fauquier is Going On' and 'Edgewood, BC,' were utilized via the online posting of the recruitment poster (Appendix B).

In recognition of the small populations of the communities in the Arrow Lakes region, 'word of mouth' was a successful method for recruiting participants due to the natural social networks in these communities. By placing recruitment posters in community settings, information began to circulate among the communities. To protect participants' confidentiality during the recruitment period, all communication occurred at the individual level via in-person contact, phone calls and/or e-mail.

Potential participants received copies of the interview guide (Appendix B) and a brief description of the arts-based component of the project during the recruitment phase. In providing potential participants the information pertaining to both forms of data collection during the recruitment phase, informed consent was potentially enhanced, as participants had insight into the foundation of the interview questions and creative demands prior to their agreement to contribute to the research project. Further, allowing the participant's access to the interview guide – and subsequent creative prompts – supported thorough responses during data collection, creating opportunity for an in-depth exploration of the lived experiences of adult mental health service consumers in the Arrow Lakes region. Exemplifying the benefits of sharing the interview

guide prior to the interview was the three participants' who wrote notes in the safe environments of their homes for review and discussion during the interview, allowing more in-depth explorations of their introductory answers to the interview questions.

The six individuals who contributed to this research lived in the communities of Nakusp, Burton, Fauquier and Edgewood, with self-identified ethnicities of 'mixed-blood' (Métis), Caucasian, Canadian and German. The ages of participants ranged from 19 to 80 years or older. The exact ages of participants was not explored in the demographic questionnaire. Four of the participants identified as women, one identified as male, and one chose to not specify their gender. The levels of education reported among the sample included 'less than high school,' 'high-school diploma,' 'post-secondary diploma/certificate,' and 'masters degree – post graduate diploma.' Participants' reported conditions of mental health included: depression, general anxiety disorder, 'schizo', 'stressed but coping', 'great', major depression disorder, attention deficit disorder, trauma, and 'f**cked up beyond all repair.'

Data Collection

Three instruments were utilized for data collection – a demographic questionnaire, qualitative interviews and qualitative images. The incorporation of multiple instruments during collection created different sources of data, allowing for the development of a rich, comprehensive understanding of the experiences of adult mental health service consumers in the Arrow Lakes region (Carter, Bryant-Lukosius, DiCenso, Blythe & Neville, 2014). The use of different sources of data to establish understandings of phenomena in qualitative research is referred to as triangulation (Carter et al., 2014). In this research, data source triangulation worked to strengthen the validity of the study while creating the potential for a broader understanding of

the experiences of mental health service consumers in the Arrow Lakes region (Carter et al., 2014).

Demographic Questionnaire

Questionnaires are utilized in research to collect data from individuals about their experiences and/or perceptions in social contexts (Auriat & Siniscalco, 2005). Questionnaires can be utilized in solitude, or in conjunction with other methods of data collection such as interviews (Auriat & Siniscalco, 2005). In this research, the questionnaire focused on exploring demographic characteristics of the participants, including age, gender, ethnicity, term of residency in the Arrow Lakes region, education level, income, and community of residency. The data generated from the demographic questionnaire contributed to a rich discussion regarding implications for social work practice, as well as recommendations for future research, as the sample featured individuals from different social locations, which resulted in differing lived experiences and different recommendations for improvements and introductions of mental health supports in their communities.

The questionnaire was administered at the beginning of the first in-person qualitative interview. By conducting the questionnaire in-person, potential limitations related to literacy were minimized (Marlow, 2011).

Semi-Structured Qualitative Interviews

Qualitative interviews, as discussed by Creswell and Poth (2018) and Marlow (2011), work to collect information from participants in efforts of gaining an understanding of the meaning of their experiences and their lived realities. With this focus on participants' experiences, interviews allow participants to share historical information (Creswell, 2014). On account of this inquiry's interest in experiences, understanding the historical, present, and future

contextual settings within which participants' experiences have been developed was an important component of the research. The form of qualitative interviews that were utilized in this study was semi-structured. Semi-structured qualitative interviews afford the researcher opportunity to guide the line of questioning, while allowing space for flexibility to ensure maximum participant collaboration and disclosure (Creswell, 2014; Dicicco-Bloom & Crabtree, 2006). Typically, semi-structured interviews are conducted with participants from a sample that is "fairly homogenous and share critical similarities related to the research question" (Dicicco-Bloom & Crabtree, 2006, p. 317). The critical similarities in the context of this research were confirmed through the participation criteria, which was discussed with potential participants prior to recruitment.

Six adult mental health service consumers completed the first interview. Of the six individuals involved in this project, three completed the second interview, two submitted their visual data without completing the second interview, and the sixth individual chose to only participate in the first interview. The first interview began with a demographic questionnaire (Appendix E). Following this questionnaire, the interviews investigated what supports participants' mental wellness, what challenges participants' mental wellness, and participants' visions for developing communities that support and promote mental health (see Appendix D). As a method of member-checking the data, follow-up interviews were scheduled to interpret visual data with participants – which will be discussed further below – and ensure the accuracy of their transcripts from the previous interview. Member checking is a technique used for validating, verifying, and assessing the accuracy of the products of research, while working to minimize the potential for researcher bias (Birt, Scott, Cavers, Campbell & Walter, 2016). Five of the six participants reviewed the transcripts and codes created from their interview prior to the

completion of data analysis. The incorporation of member checking in this research design worked to support the rigor and credibility of the results, while honoring the participants' rights to accurate representation (Birt et al., 2016).

Limitations of utilizing qualitative interviews stem from the researcher-participant relationship (Creswell, 2014). Creswell (2014) notes that the presence of the researcher can bias information disclosed in the interview. Additionally, participants are not equally articulated and/or perceptive, and therefore different qualities of data will arise from each interview (Creswell, 2014). In acknowledgment of these limitations, interviews were conducted with multiple participants and qualitative visual data was also collected, creating a more inclusive understanding of the experiences of adult mental health service consumers the Arrow Lakes region.

Sigstad's (2014) research explored the limitations of qualitative interviews with individuals with mild intellectual disabilities. One of the identified limitations was the complexity of language used in interviews (Sigstad, 2014). To address this limitation, Sigstad (2014) recommended that researchers actively seek to understand the social contexts of the participants before developing the interview guide in efforts to proceed from the participants' ability level. Further, Sigstad (2014) noted that the use of semi-structured interviews allows the researcher to address specific topics, while providing participants the opportunity to deepen the discussion by disclosing themes relevant to their experiences.

Although Sigstad's (2014) research was conducted with individuals with mild intellectual disabilities, I believe the identified limitations – and subsequent recommendations – of qualitative interviews had significance in my research with adult mental health service consumers. To implement Sigstad's (2014) recommendations in my research, I conducted a

thorough literature review prior to beginning data collection, which provided me with a contextual understanding of the social realities presented in other rural, remote communities. Secondly, in solidarity with Sigstad's (2014) research, semi-structured interviews were utilized to allow space for participants to discuss topics relevant to their lived experiences as mental health service consumers in the Arrow Lakes region. Questions presented in the interviews investigated what supports mental wellness, what challenges mental wellness, and participants' visions for developing communities that support and promote mental health (see appendix C). By conducting the interviews in person, I was able to adapt language as needed and clarify questions presented by participants to diminish the risk of language and literacy related challenges.

Qualitative Visual Materials

The qualitative visual materials submitted in this research were photographs. The photographs captured scenes from participants' realities and one photograph was of a painting. The use of an image-based method worked to align this research with social work values of equity and social justice as it works to reduce barriers to participation through offering an additional venue for participants' self-expression and disclosure (Matthews, 2012). Further, as discussed by Creswell (2014), the use of visual materials within qualitative research creates opportunity for unobtrusive data collection. Creswell (2014) and Matthews (2012) highlight visual qualitative data's ability to share participants' realities, from their perspectives. Additionally, the use of visual material as a form of data is a creative way to capture the attention of the audience reviewing the research (Creswell, 2014).

As identified by Creswell (2014) and Harper (1998), interpretation of visual-data is the primary limitation of this instrument. Additionally, Creswell (2014) notes that accessibility barriers pose a potential limitation to the use of visual-images in data collection. As previously

noted, interpretation of the visual data took place at the second in-person interview where participants wrote, or discussed, the descriptions of their visual data. One participant submitted their images and completed their member-check electronically, one participant submitted their film camera but did not complete a second interview to discuss images, and one participant chose to not create visual data or member-check. The purpose of the second interview was two-fold: to create space for participants to interpret their visual materials, reducing the risk of misinterpretation in data analysis; and to provide an opportunity for participants to member check their transcripts from the first interview.

To address the issue of accessibility identified by Creswell (2014), I provided participants with disposable cameras and/or art supplies at the initial interview. In recognition of the perceived difficulty of engaging in visual arts creation, I had the arts supplies out during the first interview and provided participants the opportunity for a brief demonstration of ways in which the supplies could be used. Further, participants were offered the option to create their visual data during the second interview, during which I could facilitate the creative process.

Harper (1998) raises two primary ethical concerns associated with the use of image-based qualitative data – specifically photographs. These concerns include the perception that photographic images are inherently 'true,' and the invasive nature of photographic data (Harper, 1998). Furthermore, Pink (2001) argues that it is impossible to create visual-data without interference, and thus, reflexivity and recognition of the context in which the images are created is crucial in the research process. Harper (1998) recommends that to control for negative outcomes associated with these ethical issues, the researcher must overtly acknowledge the social and technical constructs from which the photographic images were derived. In the case of this research, the photographic images were created using the prompts, "What helps to maintain

your mental wellness?," "What challenges your mental wellness?," and "What does a community that promotes mental health look like?" In acknowledgement of these predetermined creative drivers, the context in which the images in this research were created was serving the social purpose of representing adult mental health service consumers' experiences in the Arrow Lakes region. The ethical concern of the invasive nature of photographic data collection, as identified by Harper (1998), was addressed during the consent conversation with participants. Participants were made aware that although their names will not be attached to images, the potential for them to be identified based on what they choose to photograph is a potential risk to their privacy, which I could not control. To further address the ethical concerns raised by Harper (1998) a second consent form was created and completed which specifically outlined the potential privacy risks associated with the community art exhibit. Participants completed this form when visual data was collected.

Photographs created for this project are used throughout this thesis featuring the artists' pseudonyms and descriptions of their creative pieces where possible. Based upon the artists' descriptions, and the subsequent data analysis, images are presented in relationship to the themes they supported; for instance, *Figure 2: Artist: Amy. "A Tight Family"* is placed under the sub-heading 'Community as Belonging' because Amy discussed the importance of found family and community in her description of the visual data item. Three participants chose to use the film cameras provided at the first interview; three chose to utilize their own devices to create images. Five of the adults involved in this project – the artists – created a total of 47 images. Of the 47 submitted images, only one will be excluded from the art exhibit due to the feature of a non-consenting individual in the image. One participant chose to not create visual material for this thesis. Two participants submitted three images, one submitted two images, one submitted 27

images, and one submitted 12 images. In consideration of the formatting of this thesis, a minimum of two images from each artist is presented. While not all of the 47 images are featured in this report, all images will be displayed in the community art exhibit as a part of the dissemination of the findings from this project.

Ethical Considerations

Potential privacy risks were presented in this project due to the population sizes of the communities in the Arrow Lakes region, the inclusion of visual data, and the dissemination of results through a community art exhibit. Further, reflecting on systems and events that challenge mental wellness carried the potential to trigger discomfort, grief, and a variety of other emotional response; these potential responses were recognized as psychological/emotional risks of this research.

In efforts of reducing the associated privacy risks, all data collection took place in rented community spaces. I arrived to the scheduled interviews 30 minutes prior to the beginning and left 30 minutes following the completion of the interviews to avoid the identification of the participants. In efforts to protect participants' anonymity, I disclosed that if we were to see each other in community, I would not initiate contact. Participants chose pseudonyms to represent their research contributions in efforts of promoting anonymity and confidentiality throughout the project. All contact with participants occurred in-person or via phone-calls and/or email. In the recruitment phase, potential participants did contact me via Facebook messenger, as the recruitment poster was posted on virtual bulletins. In response to these inquiries the following prompt was used, "for further information about your potential participation, please contact me, Kiara McLean, at 250.265.1832 or mclean3@unbc.ca." This prompt worked to redirect communications to secure spaces, such as phone-calls.

In consideration of the inclusion of photographic data in this research, I reflected upon Clark's (2013) ethical discussion regarding the potential of individuals who are not participants in the research project being featured in images created by participants. In this research, this risk was addressed during the consent conversation with participants. Participants were informed that if their images contain identifying features of non-consenting individuals, the images would not be used in the final report or the art exhibit.

As per the TCPS-2, in certain research contexts participants' may want to be credited for their contributions by being named. In recognition of this TCPS-2 statement and the positive impacts that having art in public settings can have on individuals' senses of accomplishment and self-worth, participants were given the opportunity to submit their pieces under their research pseudonyms, anonymously, or with their names. At the second interview, participants determined their preferred art-credit titles. I clarified that at the art exhibit I would not be able to protect their privacy if they choose to disclose to community members that they created art pieces, and participated in the research, regardless of how they chose to display their art.

To aid in the mitigation of the psychological/emotional risks presented in this research, a risk management plan was implemented. Prior to data collection, participants were made aware of the voluntary nature of their participation and were reminded of this at the second interview (see Appendix A). Participants received a list of emotional support services available in community (see Appendix A). As a registered social worker I have the core competencies needed to assess signs of emotional distress. When participants became distressed, I stopped or redirected questioning to their voluntary status in the project. Additionally, if participants became distressed during the interview I included a second reference to the list of mental health supports included in their consent package at the end of the interview.

Data Analysis

Thematic analysis was utilized during the data analysis phase. As discussed by Braun and Clarke (2006) and Vaismoradi, Turunen, and Bondas (2013), thematic analysis is a technique used for identifying, analyzing and reporting themes that emerge across data. In thematic analysis the reporting of themes is often a rich, detailed and complex account of the data (Braun & Clarke, 2006). Braun and Clarke (2006) argue that thematic analysis is a prime method for examining differing perspectives as it showcases similarities and differences within the data. In recognition of the focus on identifying and comparing themes across data, thematic analysis proved beneficial in my research, as it was utilized to analyze both visual and textual material for reoccurring patterns of meaning that arose from participants' disclosures. Further, Vaismoradi, Turunen and Bondas (2013), Braun and Clarke (2006) and Nowell, Norris, White and Moules (2017) note that on account of thematic analysis' theoretical flexibility, it presents an accessible, foundation-level form of qualitative analysis, making it an ideal method for novice-researchers, such as myself.

Data was analyzed using an inductive, data-driven approach, meaning that the identified themes are strongly linked to the data itself (Braun & Clarke, 2006). This analysis focused on the semantic content presented in the data – exploring the explicit meanings of the data without seeking meaning beyond what the participant disclosed (Braun & Clarke, 2006). This was chosen in consideration of the theoretical informant of this research, standpoint theory, which works to centralize the researched populations' knowledge, wisdom and experiences as the framework from which social inequities are explored and analyzed (Harding, 2009; Rouse, 2009). In the analysis of images, participants' descriptions of the images were referenced as the semantic content. These descriptions were created at the second qualitative interview or

submitted following the creation of the images. Of the five participants who submitted visual data, only three chose to complete descriptions.

Nowell et al. (2017) state that thematic analysis has limited representation within existing literature, and subsequently researchers may feel unsure of how to conduct thematic analysis. As a novice researcher I chose to follow Braun and Clarke's (2006) six-phase guide to performing thematic analysis to ensure rigor and credibility. The six-phases in this guide are: familiarizing self with data; initial coding; searching for themes; reviewing themes; defining and naming themes; and producing the final report (Braun & Clarke, 2006).

In phase one of Braun and Clarke's (2006) approach it is integral to familiarize ones self with the data. To familiarize myself with the data I listened to all audio-recordings prior to beginning verbatim transcription, which allowed me to reflect on the content of the data, as well as the non-verbal context of disclosures, such as tone and tempo. I transcribed the audio-recordings, which worked to further support me in familiarizing myself with the data. Once converted to text format, I read through the verbatim transcriptions while simultaneously listening to the audio recording to ensure congruence. During the second read of the data, in solidarity with Braun and Clarke's (2006) advice, I immersed myself by actively reading the transcripts searching for emerging meaning and patterns while simultaneously creating a list of codes, such as 'family/friends as support' and 'nature.'

In phase two, data sets were first manually coded in isolation, meaning that each interview was analyzed as an individual data item prior to being analyzed across the data set for collective meaning and patterns. This worked to ensure the codes were data-driven; meaning that codes – and subsequent themes – emerged naturally from the research participants' disclosures (Braun & Clarke, 2006). Working systematically, data items were coded using a colour-map,

working to visually organize data extracts into their codes, for instance all ‘work’ data extracts were manually highlighted yellow. Codes were then organized using tables. The coded tables were used to compare and analyze codes across the data set, resulting in a collated list of codes and data extracts (Braun and Clarke, 2006).

Phase three of analysis was completed using poster boards and printed data extracts. Each participant was assigned a coloured font, for instance Amy’s data was printed in green font, to ensure specific standpoints were still represented and upheld within the analysis. All related codes were organized into labeled envelopes, such as ‘leaves for care,’ to systematically organize data extracts into potential themes. Envelopes contents were then examined in relation to each other and candidate themes and sub-themes titles were created, marking the end of this phase (Braun & Clarke, 2006).

Candidate themes and sub-themes were reviewed as hard-copy mind maps created on poster board. Many theme’s collapsed into one another, for instance ‘community as belonging’ was moved into the theme of ‘informal supports of mental health.’ Once this process was completed, candidate themes were organized using tables. In creating these tables, I re-read the transcripts that presented the data extracts to ensure the context in which the data extracts were presented and analyzed were reflective of the overall data item. Data extracts remained in their assigned font colours in this table in an attempt to continue to demonstrate the differing standpoints amidst participants’ disclosures and experiences.

In phase five candidate themes and sub-themes were read individually to ensure internal homogeneity and re-read to ensure external homogeneity across the data (Braun & Clarke, 2006). This resulted in the refining of candidate themes to ensure they were concise, consistent and reflective of their overall titles, descriptions, and data.

Building off of Guba and Lincoln's (1989) work, Nowell et al. (2017) present credibility, transferability, confirmability, audit trails, and reflexivity as pillars in establishing trustworthiness in qualitative research. Trustworthiness works to persuade research-consumers that the information is worthy of consideration and attention (Nowell et al., 2017). In efforts to ensure these pillars of trustworthiness were present in my research, I incorporated: member checking; review via the supervision of my thesis committee; and a detailed audit-trail, in the form of a journal, documenting the decisions made during the research process (Nowell et al., 2017).

Limitations of this Research

This project had a number of limitations. Perhaps most important is the size of the sample. With participation criterion including three factors – resident of the Arrow Lakes region for 12 or more months, adult (19+) and mental health service consumer – the total sample recruited was six. A project with a broader regional focus – for instance, the Central Kootenay Region – may yield a larger sample. Further, only three of the five participants who submitted visual data provided descriptions of their submitted images, limiting the analysis of the visual data collected for this project. I acknowledge that the timeline applied to this project may have limited the number of potential participants involved. Recruitment lasted for five months and was completed when the identified minimum number of participants were involved.

Additionally, my positionality as the researcher may have acted as a barrier to participation for residents of the Arrow Lakes region, perceived privacy and/or confidentiality risks might have been associated with my status as a resident of the Arrow Lakes region. As this project employed a qualitative design, the findings from this project are not generalizable to the larger population of adult mental health service consumers in the Arrow Lakes region, but rather

only represent the experiences – and subsequent recommendations – of the six adults involved in this project (Atieno, 2009).

Dissemination of Results

The completed thesis will be shared with participants via the delivery method determined at the first interview, either through mail or electronically. As discussed in the Information and Consent Letter (see Appendix C) appropriate stakeholders, including Interior Health and Arrow and Slocan Lakes Community Services, will receive copies of this thesis – as well as the thesis defense presentation – in efforts of promoting and contributing to structural change in mental healthcare provision in the Arrow Lakes region.

Images produced for this project will be featured in a community art installation, exploring stigma and community mental health literacy. This art installation will create the potential for critical dialogue, mental health education, and awareness, while celebrating the participants as artists. All participants who submitted visual data consented to having their art showcased. Utilizing an art exhibit as a form of dissemination aligns with one of standpoint theory's central tenants of valuing the researched population as the experts, as it will present raw depictions of the experiences of adult mental health service consumers in the form of images and creative writing, minimizing my bias as the researcher in the presentation of disclosures (Harding, 2009; Rouse, 2009).

Data Management

The data management plan employed in this research was developed from the guides: Research Data Management, and TCPS Research Ethics Policy (Government of Canada, 2018; University of Northern British Columbia, n.d.).

Data Management Plan

1. All information related to this research was obtained through face-to-face interviews and visual images. Interview information was recorded as audio-files and transcribed as word documents. Visual material was collected as hardcopy and digital images. Data was coded to remove identifying information and was, and continues to be, stored in a locked filing cabinet at my residence. The code list is secured in a locked filing cabinet in my residence. Consent forms are stored in the secure office of my thesis supervisor, Professor Dawn Hemingway, in the School of Social Work at UNBC. Information collected was used for research purposes only, with the potential of further analysis and publication, and in the thesis report.
2. Data collected from interviews is stored on a USB flash drive, which is encrypted using Apples' File Vault (recommended by UNBC's IT Security Sharepoint site – http://our.unbc.ca).
3. Interview transcription took place at my residence. As per UNBC's IT Security Sharepoint recommendation, Sync was utilized to share data with thesis supervisor, Professor Dawn Hemingway. Research participants had the opportunity to review transcriptions, as a form of member checking, at their second interview.
4. All data is securely stored in a locked filing cabinet at my residence.
5. Participants were made aware of the purposes of this research and the intent for the data during the consent conversation(s), including the ways in which data would be safeguarded.
6. Collected data was accessible for research purposes until the final thesis report was approved. Data will be stored for five years following the completion of the thesis

report with the potential of being used for further analysis and publication. Data will be destroyed five years following the completion of the thesis report.

CHAPTER FOUR: RESEARCH FINDINGS

Chapter four presents the findings from the qualitative interviews and images created by Alien, Kitty, Josie, Amy, Skye and Francis-Evans exploring their experiences as adult mental health service consumers. The purpose of this research was to develop an understanding of the experiences of adult mental health service consumers living in the Arrow Lakes region while creating an opportunity for structural, consumer-driven shifts in health care policy and positive developments in community consciousness regarding mental health. The questions and creative prompts posed to the individuals who contributed their knowledge to this project worked to produce an introductory understanding and narrative of mental health in the Arrow Lakes region.

As a result of this inquiry, Alien, Kitty, Josie, Amy, Skye and Francis-Evans divulged information pertaining to their unique experiences at the intersections of rural residency and mental health. The data collected on these intersections presented eight themes including 'informal supports of mental health in the Arrow Lakes region', 'formal supports of mental health in the Arrow Lakes region', 'community culture as a challenge to maintaining mental wellness', 'gaps/lack in service available', 'barrier to accessing existing services', 'cost of living/financial burden in the Arrow Lakes region', 'work place discrimination/stigma', and 'visions for mental health in the Arrow Lakes region'. Multiple themes required further division into sub-themes, as exemplified by Table 1 below.

Table 1: *Thematic Overview*

Theme(s):	Sub-theme(s):	Sub-theme(s): Tier 2:
Informal Supports of MH in ALR	Community	➢ Community as a Support Network ➢ Community as Belonging ➢ Volunteerism/Giving Back ➢ Small Town Pace/Culture
	Nature	
	Family/Friends as a Support Network	

	Animals/Pets	
	Work	
Formal Supports of MH in Arrow Lakes Region	Interior Health Authority Services Psychiatry Community Services Out of Town Services Public Transportation Alternative Wellness Opportunities	
Community Culture as a Challenge to Maintaining Mental Wellness	Stigma/Lack of MH Literacy Conservative/Traditional Values Small/Close-Knit Communities	
Gaps/Lack in Services Available	Long Wait Periods for Service and Availability of Services Leave Community for Care Lack in Services Available	
Barriers to Accessing Existing Services	Lack of Promotion and Advertisement of Existing Services Proximity to Services Lack of Choice in Service Providers Anonymity and Confidentiality Concerns	
Cost of Living and Financial Burden(s) in Arrow Lakes Region		
Work Place Discrimination and Stigma		
Visions for Mental Health in Arrow Lakes Region	Education/Awareness	➢ Community-based mental health education ➢ Youth mental health education
	Reform/Reimaginings in MH Care Services	➢ Streamlined Process/Service Hub ➢ Increased Promotion/Advertisement of Existing Services ➢ Mandatory Continued Professional Development
	New/Increased Services	➢ Outreach ➢ Clinical ➢ Psychiatry ➢ Transportation
	Community Based Changes	➢ General Wellness Supports

		➢ MH Peer Advocacy Group
	Inclusion of Service Consumers in Mental Health Program/Policy Development	

Informal Supports of Mental Health in the Arrow Lakes Region

During analysis, informal support of mental health in the Arrow Lakes region emerged as a theme supported by all six participants. Five informal supports were discussed in-depth, which contributed to the creation of the sub-themes identified as community, nature, family/friends as a support network, animals/pets, and work. The theme "informal supports of mental health in the Arrow Lakes region" demonstrates the importance of individual resiliency and resourcefulness in developing and sustaining wellness plans in the rural communities of the Arrow Lakes region, with a focus on the ways in which informal, place-based networks of caring work to fill gaps presented in formal support networks.

Community

All participants framed community as a form of support working to promote and maintain their mental wellness. The ways in which community was articulated and communicated across the data include: community as a support network, community as belonging, volunteerism/giving back, and small/town pace and culture. These sub-themes present the different variations of the ways in which community has been a meaningful component in the lives of Alien, Kitty, Josie, Skye, Amy and Francis-Evans, as will be further discussed below.

Community as a support network.

Community was discussed for its supportive capacity by all six participants. In creating the framework of 'community as a support network,' participants discussed the ways in which their communities worked in teaching capacities, promoted resiliency, supported resourcefulness,

and stepped into care giver roles – with the overarching understanding that community is a space of support with expectations of accountability, helping, and reciprocity. As summarized by Francis-Evans, "*everyone is a teacher, as it says, it takes a village."*

Two participants presented the availability of community members in the roles of teachers and educational resources as supportive components of their mental wellness. Alien reflected on the food-security techniques he learned through community teachers as a method for self-sustenance, "*I learned how to can, and I learned how to hunt, and… I like fishing anyways, but I learned how to can… I learned how to live off the land, I'm learning about gardening… don't even have a green thumb, so I'm learning.*" Through learning these techniques, Alien identified that he "*gets through a little bit"* as these acquired skills work to subsidize his grocery costs.

The role that community plays as a support network was discussed as an informal mental health support through the ways in which community members take on the roles of caregivers in the Arrow Lakes region. Whether it is through alternative supports of mental health, such as ride shares, or literal health services, such as suicide prevention and intervention, the community plays an integral role in promoting wellness in the Arrow Lakes region. As an example of this role of community members, Josie discussed a time when she was the caregiver for a friend experiencing suicidal ideation, "*I actually had someone really close to me who was suicidal, like really suicidal, and I made all the phone calls and all the things… nothing happened… I took that person and I looked after them… and took them out of town because it was life or death… I've realized that it's community that we need, not these hotlines."* In a more generalized statement, Kitty discussed the ways in which community needs and inquiries are often answered via natural networks, such as friendships and families, *"you usually ask questions if you have to*

ask questions… my friend, I just talked to her… question on when the dump is open… she didn't know, I explained to her that… I know, who the fellow is."

Building off of the roles of care giving explained by participants, the concept of community accountability to wellness was discussed. As presented in Amy's disclosure of her time spent in the Arrow Lakes region, some community members take on the responsibility – and are accountable – to not only the wellness of themselves and their families, but also to the wellness of their neighborhood; "*You walk and chat to people and make sure the neighbors are healthy, that your house is… inside and outside of yourself… it's so much more community-based here… you can't be happy if your neighbor is in hell or distress that doesn't compute here."*

Community as belonging.

Figure 2. Artist: Amy. "*A Tight Family – everyone defines family differently. Also, everyone's needs are different. We were fortunate enough to find a fertile environment in which to build our family, based on shared values, and thrive*."

Community as a space of belonging was a theme represented in four of the six interviews. Predominantly, this was presented in disclosures related to feeling wanted and needed in community, feeling safe through community connections, multi-generational interactions, opportunity for community involvement, and non-familial relationships.

Through community involvement and non-familial relationships, participants disclosed developing a sense of belonging fostered through the perceptions of being needed and wanted by their communities. For instance, Alien reflected on the ways in which his work on a local agricultural plot created a sense of pride and purpose in his life, *"I'm near a farm… they always call me down to help out…I'm needed, I'm wanted."* Further, participants described the relationships they developed and maintained in their communities as facets of belonging and wellness, as exemplified by Amy's statement, "*we're lucky enough to have enough people to live with and to make community with that we can hang out in our comfort zone and where we are who we are and we do what we do*."

Participants highlighted the social connections fostered – in part – by the population sizes of their communities in the Arrow Lakes region. As described by Josie, "*well it's a close community… so I'm really close to my neighbors and I often know people quite intimately within the community*."

All participants framed this sense of community belonging, and the subsequent relationships formed, as supports of mental wellness. In reflection upon the role of community in supporting her mental wellness Kitty stated, "*it helps when you get a phone call, a nice phone call from a friend… and it helps the trauma*." Similarly, Josie referenced the pride she feels as a result of her relationships with members of her community, "*I love my community and I really*

pride myself on getting along with 99% of the people around me… you don't get that in the city, so that's a hidden gem."

Volunteerism/giving back.

Three of the six individuals who contributed their knowledge to this project framed volunteerism and giving back as an informal support of their mental wellness. In these discussions, volunteerism and giving back were identified as mental health supports as the act can boost self-esteem, help participants to connect with community, and create opportunity for participants to help others. As summarized by Amy, "*it's a mood lifter… it sounds bizarre but ultimately volunteering is a selfish activity. Like you're helping everybody but you're helping yourself, too, to be happy, to be fulfilled, to be involved, to have a network."*

All participants who discussed volunteerism and giving back described a personal and moral obligation to helping others – commonly based in their experiences of feeling a lack of services. In exemplification of this concept, Skye disclosed, *"I find that I'm trying to be the person that I needed as a child and support kids… we take 10 minutes at the end of class kind of deal to be like, okay how are we all doing, are we finding that we're frustrated… I'm not just judging you on your physical… I want to know how your mental health is too."*

Small town pace/culture.

Figure 3. Artist: Josie

Four of the six participants spoke to the value of the small-town pace and culture of the Arrow Lakes region as an informal support of their mental health. The small-town pace and culture was discussed for its slower pace, community focus, and connection to nature and natural resources. Kitty summarized the community culture as a "*nice, quiet… country place*," while Josie presented it as "*kind of small – like the schools, the town, the people, everything is not giant… there's a slow pace here*." Participants voiced their feelings of balance and appreciation for the small-town pace and culture of the Arrow Lakes region. Amy found that in contrast to her previous urban residency, she feels "*more balanced and relaxed, and as a result… more healthy in mind and body*" due to her connections with nature and opportunity to return to "*the basics*" of

life. Similarly, Josie discussed her appreciation for the Arrow Lakes region culture and small town pace in reflection upon her experiences in urban communities in the Okanagan, "*when you go to the city, I get honked at all the time… everybody is just trying to get to where they're going… I think that's really a reward of living here*." Skye expressed her increased appreciation for "*slowing down, taking time, not wanting that busy hustle*" upon her return to the Arrow Lakes region from an urban setting, noting that she felt she had to "*learn that appreciation*" for her community's culture through exposure to other communities.

Figure 4. Artist: Skye. Skye disclosed that she selected this image as a representation of her gratitude and appreciation for the Arrow Lakes region and her community culture, noting that her opportunity to travel abroad validated her feelings of connection and belonging to the Arrow Lakes region.

Nature

Figure 5. Artist: Alien. Alien used the carving featured above in his series of images to represent his self. He noted the missing arm on the carved figure as a representation of his disability. The carving – and his pseudonym – was chosen to depict the ways in which he feels 'alienated' and discriminated against in society as a person with a disability. In summary of his visual data Alien stated, "*my name is Alien, people often don't pay attention to me, they look the other way as if I don't exist*."

Figure 6. Artist: Skye. "*Support and Peace of Nature*" - Skye stated that this image was created as a representation of the accessibility and power of nature as a mental health support.

Alien, Kitty, Amy, Josie, Skye and Francis-Evans all voiced their involvement with, appreciation for, and reliance on nature, and natural resources, as a support of their mental wellness. Nature was discussed for its ability to increase mood and offer space for self-care practices.

Participants praised the accessibility of and proximity to this mental health support provided through residency in the Arrow Lakes region. Skye voiced her appreciation for the opportunity to be "*completely surrounded by natural environment that is like 3 minutes*" out of her home. Similarly, Josie noted that within "*four minutes*" she is at "*the lake with the most beautiful views in all directions*."

Nature as a space for self-care was a concept developed through the disclosures of all participants. Alien reflected on the value of access to nature in his life, noting that, "*it makes [him] feel human"* when he spends time "*where there is trees*." Further, Alien expressed a strong connection to the natural world around him, stating that he "*love[s] walking in the woods*" and commonly spends time meditating in these spaces. Skye also discussed nature as a space for meditation, and other-self care practices such as exercise and art, noting that it has been rewarding to have access to a space that is "*calm and… peaceful*" to focus on her wellness. Similarly, Kitty voiced her experiences with the natural world as a support of her mental health, disclosing, *"[nature] helps the trauma*" by making her "*feel more relaxed*." Amy discussed the "*stillness of nature*" as a "*healing component*," which has helped to manage her anxiety.

Building off of the concept of self-care, participants specified nature's ability to act as a positive mood influencer. Francis-Evans noted that nature, specifically being in the wild, provides him with "*joy… everlasting*," as it works as a space of connection to "*the central force*

of the planet." Comparable to Francis-Evans' disclosure, Alien noted the "*lift*" that "*watching the wildlife, the bears and the bald-headed eagles*" provides him.

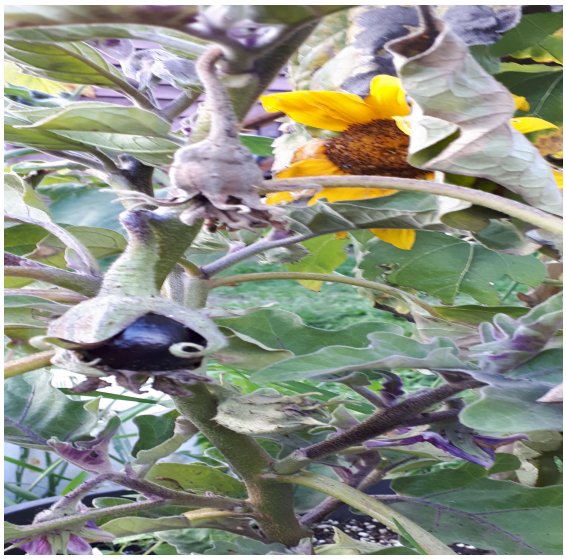

Figure 7. Artist: Amy. Amy tied this image into a revelation she experienced while observing the "*fertility of nature,"* which supported her "*overall mental well-being*" as she realized "*the physical presentation, artificial stuff like clothes and makeup, and other things that can be acquired but are not part of one's basic person, were clearly less important*." Amy identified with the life of the sunflower and eggplant as she experienced her pregnancy, stating, "*the same thing I saw with a healthy, naturally occurring sunflower pollinized by bees in our backyard, or the cute little egg plant that grew out of a cute little purple flower, in the pot, gifted to us by a friend, is exactly as simple and beautiful as it was to be pregnant and have a child of my own… the correlation with Mother Nature is very strong, with an emphasis on back to basics*."

Figure 8. Artist: Kitty.

Family/Friends as a Support Network

Figure 9. Artist: Amy. "*These Boots Are Made for Walking and That's Just What They Do (500 Miles) – This picture unites the concepts of family, nature, and fitness for overall mental well-being; the idea here is we love walking on the beautiful trails surrounding us, and ever since acquiring a sidekick, I've been more excited about our future adventures and opportunities to explore and build the world*."

All participants discussed the safety, security, resourcefulness and continuity of the care provided by partners, family members and friends as a primary support of their mental health in the Arrow Lakes region.

Two participants specifically referenced their partners as supports of their mental wellness. Josie recognized her partner as her "*biggest support system*," disclosing that during "*really dark episodes*" she has learned to be vulnerable and communicate her needs to her partner. Furthermore, Josie discussed the importance of her partners' help in a family setting when "*things are getting speedy*," noting that he now inquires about ways to help and takes on tasks to promote her mental wellness. Amy also identified her partner as her "*biggest support*," noting that he is "*really a stabilizer*" for her.

Participants referenced family and friends, in broader terms, in different supportive capacities. Skye identified her family and friends as her "*biggest support*," with a focus on the role that her parents play in supporting her mental health and health related needs, stating "*they've really helped me along in getting me to the places that I've needed to go whether it was physically or emotionally*." Francis-Evans discussed the support of a family friend in his younger years, stating "*I wouldn't be here if it wasn't for her, I'd be dead, in prison, or on skid row in that order… she is the definition of a teacher*." Alien voiced the importance of his "*good friends*" in helping him to secure housing and gain employment opportunities, disclosing that he has "*got friends out here that give [him] the opportunity*" to succeed. Kitty identified her reliance on informal supports, such as family and friends, as a challenge she experiences while living in the Arrow Lakes region, disclosing that she does not feel a comparable level of support from professionals.

Animals/Pets

Figure 10. Artist: Josie

Figure 11. Artist: Alien. Alien noted of the images featuring his dog, "*I have someone to care for… it makes me feel human*."

Figure 12. Artist: Kitty

Five participants acknowledged their pets, and wild animals, as supports of their mental health. Participants praised animals/pets for their ability to: create meaning in life, promote feelings of calmness, motivate caring, and provide companionship. Josie disclosed that her animals "*saved her life*" because she would not allow herself to "*not feed or care for them properly*." Building off of this sense of commitment and accountability, Josie stated that her animals support her in "*get[ing] to the next place*" when she "*cannot get out of bed*" as she will "*go outside and fill the fresh waters,*" which she identified as a strategy for her to surpass barriers imposed by her mental health. Similarly, Francis-Evans shared that his dog was his "*best friend*" and that he could "*tell her anything*," creating solace and providing companionship in his life.

Work

Work was framed as an informal support of mental wellness because of its ability to boost positive mood, create value, and provide environments of support and connection. Three participants discussed these aspects of their professional lives. Amy noted that she found "*joy and value*" in her professional roles, and Alien stated that work makes him "*feel human*" as he is "*needed*" and "*wanted*" for his contributions. Supporting these positive feelings was a narrative of success and increased self-esteem, as captured in Alien's reflection upon his work life, "*I know I got disabilities like my foot and my hand and stuff… but at least I'm able to do something*." Josie voiced her success with maintaining her employment and the positive, honest relationship she has developed with her supervisor, stating that she "*had to trust… someone that was a superior and… show vulnerability*." Josie noted the empathy her supervisor met the disclosure of her mental health needs with, stating, "*a good part about healing and being your*

best is when someone knows… that that's who you are and… they actually do understand, they have a connection, they do empathize with what I live with."

Formal Supports of Mental Health in the Arrow Lakes Region

Formal supports of mental health, in the context of this research, can be understood as professional services – in the public and/or private sector(s) – accessible in the communities of the Arrow Lakes region that work to support mental wellness. In the lives of the six contributors to this project, formal services identified as supportive of mental health included: health authority services, psychiatry, community support services, out of town services, public transportation, and alternative wellness opportunities. These identified services formed the sub-themes discussed in this section.

Interior Health Authority Services

Three participants discussed the Interior Health Authority's (IHA) services as positive supports of their mental wellness. The specific services discussed included counseling, adult mental health caseworkers, psychiatric services, and Terra Pondera – the mental health clubhouse in Nakusp.

Two participants discussed utilizing IHA services for managing crisis situations, such as Kitty noting the role of psychiatric services during her "*breakdown*." While two discussed using community care services through IHA for mental health management including counseling and mental health case management services. Skye expressed her appreciation for her caseworkers introduction of "*cognitive behavioral therapy and… different techniques*" as a method for managing her mental health needs.

Psychiatry

Two participants identified psychiatrists as supports of their mental health maintenance. Josie disclosed that as a result of her doctor, she has been able to identify environmental triggers, such as transition periods, that challenge her mental wellness and subsequently she can now work to manage these situations in effective ways. Josie shared that she works with a psychiatrist out of community. Skye mentioned that it is "*super nice*" to have "*psychiatrists that come… every two weeks*" to Nakusp.

Community Based Services

The importance of community based services in the maintenance and promotion of mental wellness were discussed by four of the six research contributors. Services highlighted in these discussions included: the food bank, the public library, art therapy, crisis lines, and marriage counseling. Kitty and Alien identified the food bank as an integral service in community, noting that it is a "*good service*" that helps to subsidize the cost of living and stretch monthly budgets.

Out of Town Services

Two participants verified that they choose to access mental health services outside of community. Reasons for these decisions were identified as lack of choice in service providers in the Arrow Lakes region and confidentiality/anonymity concerns; these topics will be further discussed in the section discussing barriers to accessing existing services in community.

Amy chooses to access services in her former urban community. In reflection upon her decision to seek mental health supports out of the Arrow Lakes region Amy stated, "*I feel like it's an open relationship… some needs are met at home and some needs are going to be met elsewhere and we just all agree to disagree*." Amy expressed gratitude for having the

opportunity and resources to leave community for care, disclosing, "*thankfully I have [URBAN COMMUNITY] and I have my professional and personal network there, I have all that there… in [URBAN COMMUNITY] when you show up and say 'hey' and you ask that question, they'll answer that question*."

Josie accesses mental health services, including psychiatry, "*support groups*," and "*group programs*," in the Okanagan. However, Josie disclosed that due to the proximity of these resources she does not attend regularly, and since the resources are "*not really available here*" she has found other methods to maintain her "*mental health wellbeing*."

Public Transportation

Two research contributors identified public transportation as a form of support. Both the "*community bus*" and the "*medical bus*" were discussed as essential services connecting the rural communities of the Arrow Lakes region, and the residents, with health related, and general, services.

Alien and Kitty both discussed the affordability of the community and medical buses as a positive aspect of these resources. Further, Kitty noted that "*the buses are connecting pretty good*" and subsequently have supported her in keeping up with her prescriptions, attending medical appointments, and connecting with family in other communities such as Castlegar, Salmo and Trail.

Alternative Wellness Opportunities

The sub-theme of 'alternative wellness opportunities' was created to capture the broader formal supports that were identified by two participants. Josie acknowledged the value of "*body work*" in the maintenance of her mental wellness, specifying her incorporation of "*yoga*," "*meditation*," "*registered massage therapy*," and "*acupuncture*" in her mental wellness plan.

Francis-Evans identified "*church*" as a space of support, frequently referencing his Christian values as informants of his worldview and social interactions.

Community Culture as a Challenge to Maintaining Mental Wellness

Community culture as a challenge to maintaining mental wellness in the Arrow Lakes region was identified by four of the six contributors to this research. This theme outlines the ways in which community understandings, truths, and cultural beliefs pose challenges to maintaining wellness as an adult living with adverse conditions of mental health. The challenges discussed in relation to community culture were further categorized into three sub-themes including: stigma/lack of mental health literacy, conservative/traditional values, and small/close-knit community networks.

Stigma/Lack of Mental Health Literacy

Three participants discussed their experiences of stigma and low levels of mental health literacy in their communities, which have contributed to social exclusion and feelings of shame and isolation. Skye conceptualized the lack of understanding, communication, and literacy related to mental health as "*small town stigma*." In reflection upon her teen years in the Arrow Lakes region, she stated, "*I think that my biggest… issue with the stigma growing up was that no one talked about it… like it was such a cliché to be like… you live in a town with a bunch of workers… they all go to work at 4am… your dad works hard, your neighbor works hard… if you aren't feeling well… well the rest of us have issues too*." Furthermore, Skye noted that the "*when it's like logging or mining base is the biggest industry… there is that stigma of just 'suck it up, you can get through it… keep working'… I feel like a lot of people don't speak out… especially the loggers*." Skye acknowledged that she had to learn to recognize her mental health adversity as valid, worthy, and real in the face of discrimination and stigma.

Josie also discussed the ways in which experiences of stigma have impacted her wellness, stating, "*there is a real sense of… shame… you feel really ashamed when you're not well because I think society… can be really negative but they want you to be positive, they want you to be cheerful.*" Josie noted the stigma of 'danger' associated with mental health as a challenge in her life, stating that she has been asked if she is a "*safety threat*" in work settings upon disclosure of her mental health condition. Akin to Skye's disclosure, Josie noted that she too had to learn to view her mental health needs as valid and worthy, noting that she "*used to really care*" about hiding her mental health status from people, referring to it as her "*dirty little secret*."

Amy highlighted her experience of "*society in general*" having a problem with low mental health literacy and associated stigma, stating, "*it's more prevalent in a small community*." From her perspective, as a society we are not taught about mental health at an appropriate level.

Conservative/Traditional Values

Josie and Amy discussed the ways in which conservative, traditional values held within the Arrow Lakes region have challenged their wellness, predominantly through the maintenance and enactment of sexist, patriarchal values and dated perceptions of mental health. Josie noted that she has encountered individuals with "*high degrees in education*" that hold the belief that mental health "*doesn't exist*." Amy voiced her struggles of being a professional woman with a child in her community, disclosing that community members and local service providers have questioned her capacity to take on non-traditional gender roles within her familial structure. Amy identified her social location as a young woman who has immigrated to Canada as an additional space for aggression and ideological violence in her community, "*I'm a female so there's added pressure there because of the female experience… and I'm an immigrant, so there's the whole 'oh you have an accent'… so I'm already not normal… if you look at… the normal Canadian*."

Of these experiences, Amy acknowledged that these oppressive values challenge "*mental health… because it's hard when you have to do the validation, or the self-validation*."

Small/Close-Knit Communities

Four participants identified the size of the communities, and the close-relationships, as challenges to living with mental health needs. Predominantly these factors of their communities posed challenges related to anonymity, confidentiality and social belonging – in all factors of life. Skye described the community context as a "*bubble*," while Josie labeled her community a "*fishbowl*." Amy spoke of the challenges posed by this form of surveillance, stating that she often feels the need to act in a "*performative*" role or "*dance*" to maintain her relationships in community. In Alien's experience, the close-knit relationships held in his community resulted in social exclusion and alienation, "*people are still kind of sketchy of me… right, they go, 'okay, new face, ahhhhh,' they don't want to talk to me…they'll listen to BS… I had to show them my criminal record…over… some BS rumors that someone started*."

Gaps/Lack in Services Available

Four participants outlined the gaps in, and lack of, services available within the Arrow Lakes region. Both mental health and general services were discussed in these conversations, ranging from lack of outreach psychiatry to the inability to buy a carton of milk in community. This theme presents a snapshot of the reality of the gaps in service provision in the Arrow Lakes region from the perspective of four adult mental health service consumers. The discussions regarding gaps/lack of services in the Arrow Lakes region were categorized into the sub-themes of: long wait periods for service/availability of services, leaves community for care, and general lack in services available.

Long Wait Periods for Service and Availability of Services

Skye and Josie acknowledged their frustrations with the availability of services and the long wait periods for services in the Arrow Lakes region. Skye identified the long wait periods, and schedules of care services, as her "*biggest issue*" in utilizing formal mental health services. She voiced the inaccessibility of formal care services for individuals with full time employment, stating, "*many mental health programs in community are run during… average work hours… it's usually the 9 to 5… that's when most people are working."* Further, Skye expressed how "*frustrating*" accessing formal services is in times of need, noting, "*it's 7 o'clock at night when I need them most, I've had a terrible day, I can't just pick up the phone and be like okay can I schedule something for tomorrow… there is only limited availability of counselors as well, which I find frustrating.*" Similarly, Josie discussed her experiences with the un-availability of mental health crisis services, disclosing, "*I've actually phoned the line and I swear on my mothers grave that nobody answered the phone at 2 o'clock in the morning, nobody answered the phone… that's a system that needs to be changed."*

Leaves Community for Care

Amy and Josie framed out-of-community care services as their personal solutions to the gaps in, and lack of, services in the Arrow Lakes region. Amy shared that she continues to seek formal mental health support in an urban setting for the increased anonymity/confidentiality and choice in service provider(s). Josie ended her interview with the statement, "*to summarize it, I leave the Arrow Lakes to access my mental health supports*." Josie seeks mental health services and support in a community that is a five hour round trip from her home on account of the diversity in available services and the choice in service provider(s).

General Lack of Services in Arrow Lakes Region

Three participants discussed, broadly, the lack of services in the Arrow Lakes region. Discussing frustrations with exclusive criteria for accessing available mental health services, gaps in the services that are available, and antiquated views held by local service provider(s) as barriers to access.

Barriers to Accessing Existing Services

This theme presents the real – or perceived – barriers to accessing services in the Arrow Lakes region as an adult mental health service consumer. Barriers to accessing existing services were discussed by five of the six contributors to this project. The identified barriers to access include: lack of promotion/advertisement of existing services, proximity to services, lack of choice in service providers, and anonymity/confidentiality concerns.

Lack of Promotion and Advertisement of Existing Services

Josie and Skye identified the lack of promotion and advertisement of existing services as a barrier to accessing mental health services in the Arrow Lakes region. In relation, Josie highlighted the circulation of false service information – specifically 'help-line' informational posts on social media – as a problematic social occurrence, stating, "*you'll see 'phone the crisis line,' and I actually phoned it once and it was veteran affairs for the United States, there's a lot of wrong information and I think it is in the places that people are regularly hanging out, like Facebook*."

Skye suggested that more networking between local service providers has the potential to contribute to better promotion and advertisement of existing services in the Arrow Lakes region. From her perspective, mental health workers should refer consumers to other services available

at a community or regional level when their expression of need is met with a three-week wait period for care.

Proximity to Services

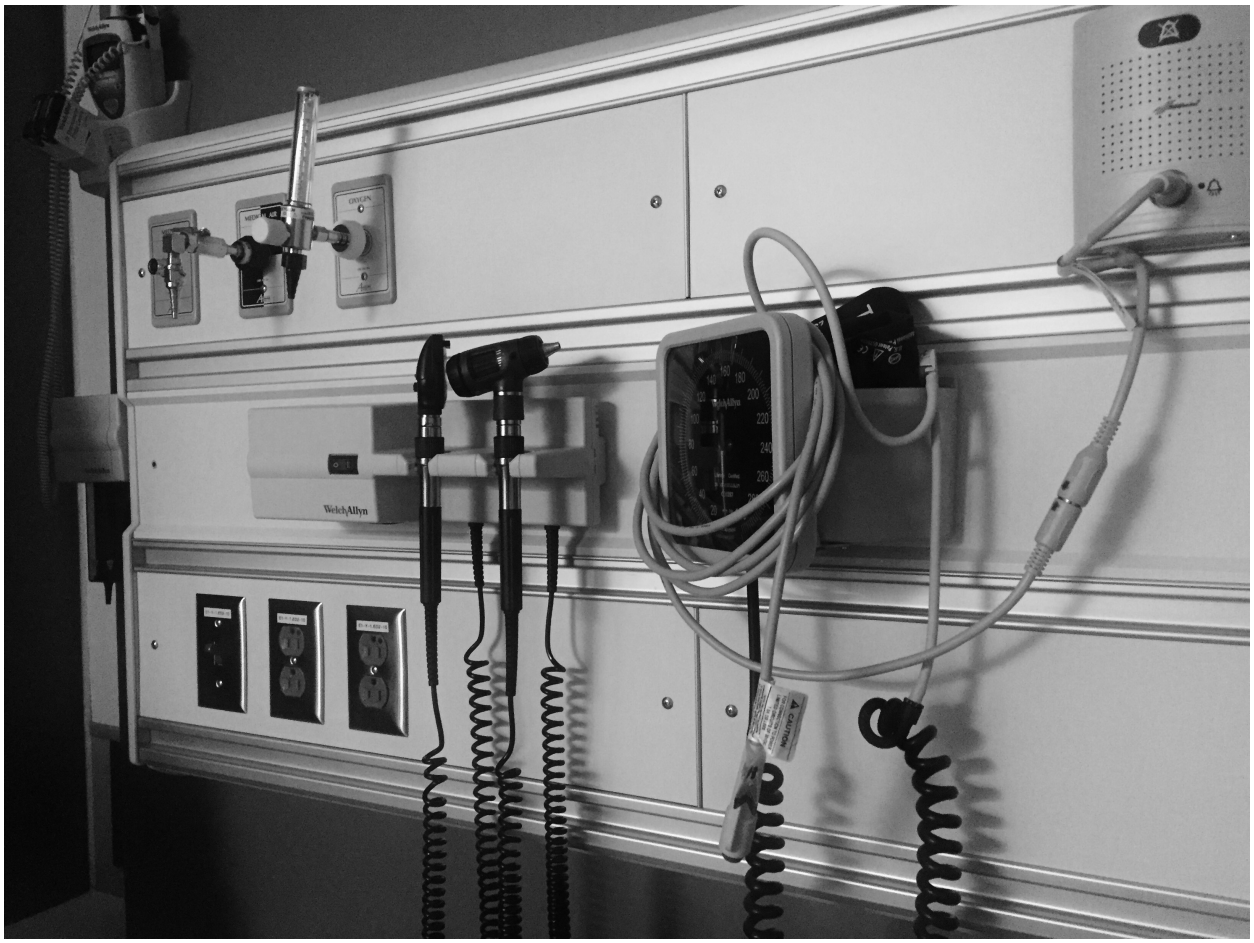

Figure 13. Artist: Skye. "*What Challenges Me*" - Skye disclosed that the medical equipment visually represents the challenges she faces in maintaining her wellness as a resident of the Arrow Lake region. Skye noted the image was taken on a day when she was required to travel to an urban setting for health care – a reminder of the barrier to care presented by the Arrow Lake region's proximity to specialized services.

Three participants concluded that the proximity of services was a barrier to receiving care. Participants discussed the challenges that presented in relation to the need for travelling to access services, including financial burden, missing regular appointments, and sacrificing self-care. In reflection upon the financial demand of travelling to care Alien stated, "*that's money out of our pockets that we can't even afford... I pay for these medical trips.*" As a result of these

financial demands associated with travelling for care, Alien disclosed that he has cancelled "*two doctors appointments already*."

Josie discussed the reality of "*going without a lot*" as a result of the proximity of both mental health and general services. Of the rural, remote reality, Josie noted, "*getting places and doing things is often a big deal, going to the Okanagan to go shopping… you don't get your hair cut so often, you go without milk… everything is kind of self sufficient."* Josie specified "*lots of the time care*" is something that is impacted by her rural residency, disclosing that when she lived in an urban setting she accessed more support services to promote her mental wellness. Akin with Josie's experience, Skye expressed her frustration with not being able to "*buy essentials in town for self-care*," noting that the lack of transportation in the Arrow Lakes region is a barrier to accessing wellness supports.

Lack of Choice in Service Providers

Josie, Skye and Amy acknowledged the lack of choice in service providers as a barrier to accessing mental health services in community. These women discussed the discomfort of conflicts in personalities and oppressive views held by practitioners as reasons for the importance of having choice in service providers. Josie mentioned that she has personal relationships with mental health professionals in community, and does not respond to the "*superiority thing*" presented in clinical settings, stating, "*there are people that I will open up to and there are people that I won't… I want to feel like an equal to you*." Josie highlighted the importance of having the opportunity to find "*the right person for you*" in care settings, noting, "*we're all different and so are healthcare providers.*" Building off of Josie's recognition for the importance of choice in service providers is the rural reality identified by Skye, "*if someone*

doesn't work, same thing as doctors right, it's… limited selection that if you don't get along with your professional well… accept it."

In response to this lack of choice in service providers, two of the six participants seek formal mental health support outside of their communities in the Arrow Lakes region.

Anonymity and Confidentiality Concerns

Josie, Kitty and Amy discussed their confidentiality and anonymity concerns as barriers to accessing services in the Arrow Lakes region. These concerns arise from the population size(s) of the communities in the Arrow Lakes and dual-relationships with professionals. Kitty, Josie and Amy all discussed the unpleasantness of having dual-relationships with service providers, framing this component of service provision as a barrier. On this topic, Kitty shared, "*everybody knows each other… I often thought of that, of going to the hospital… you know, even if you're supposed to keep it confidential, it doesn't… my daughter knows them… they find out who I connected with.*"

As a result of this barrier, Josie and Amy disclosed going long periods waiting for the availability of care services out of community. Josie shared that "*it's kind of awful"* because she sometimes can not access her doctor in Vernon and subsequently will be required to access care in a setting in which she does not "*feel comfortable*."

Cost of Living and Financial Burden in Arrow Lakes Region

Figure 14. Artist: Alien

Three of the participants discussed the cost of living and financial burden(s) of living in the Arrow Lakes region. Highlighting the costs associated with housing, transportation, grocery and health care. This theme works to discuss the impacts of the cost of living and financial burden(s) on the overall wellness of adult mental health service consumers in the Arrow Lakes region.

Alien shared the challenges that he faces in budgeting his basic needs on a set *Persons With Disability* (PWD) income. In his experience, rent and utilities consume the majority of his income – leaving a "*big gap*" in the finances needed to secure food, transportation and health care. Alien shared his methods for survival, noting, "*it is tough… I don't get enough to live on… in this life you have to be resourceful for everything that you do*," sharing his successes in subsidizing his PWD income with collecting empty cans for recycling. Alien also noted the recent increases in the cost of groceries, stating, "*the prices of the food at the grocery store… I go in with 50 bucks, I'm walking out with two items*," which has resulted in his reliance on the local food bank.

Figure 15. Artist: Alien.

On the topic of health care, two participants noted the financial burden of receiving care and maintaining health. Skye discussed the availability of private counselors in community, but noted the financial burden of accessing these services as an adult without extended healthcare benefits as a barrier to health maintenance. Similarly, Alien noted the gaps in financial support for healthcare services, and health care related travel, stating, "*that's money out of our pockets that we can't even afford… I cancelled two doctors appointments already."*

Work Place Discrimination and Stigma

Four of the six participants disclosed their experiences of discrimination and stigma in their work sites. This theme discusses the negative experiences – and implications – of work place discrimination and/or stigma in the Arrow Lakes region in the lives of four adult mental health service consumers.

Josie recollected an experience in her worksite and summarized, "*you think that employers and such are supportive of mental health issues, and again it's bullshit, they're not, they're terrified of it, like 'are you a safety threat?' it's like, 'no'."* Josie noted that questions like

this support stigma related to the stereotype of individuals with adverse conditions of mental health as violent and dangerous. This reality of workplace discrimination in the Arrow Lakes region was also discussed as a barrier to necessary conversations surrounding mental health, and potentially to connecting with mental health services. Skye spoke of these impacts of workplace discrimination on individuals involved in the forest industry in her social circle, stating, "*I've personally had interactions with certain people in the forest industry that are… worn out… they think that if they say something that they're going to get put down for… not feeling well*."

Alien disclosed that he feels he has not been given fair opportunity to employment as a result of his physical disability, which can be understood as discrimination in the hiring process.

Visions for Mental Health in Arrow Lakes Region

All participants shared their visions and reimaginings for mental health in the Arrow Lakes region, presenting creative and concrete ideas for developing a community that promotes and supports mental health. This theme presents the visions, reimaginings, and calls to action presented by the six adult mental health service consumers who contributed their knowledge and expertise to this project. The presented visions were categorized into four sub-themes, including mental health education and awareness, reform/reimaginings in mental health care services, new/increased services, community based changes, and inclusion of service consumers in mental health program and policy development.

Figure 16. Artist: Alien. Alien utilized the image of the earth, chicken and egg to represent existence at this time. The egg next to the chicken symbolizes the capacity for growth and change.

Mental Health Education and Awareness

Four of the six participants identified community mental health education and awareness as a necessary component of creating a community culture that supports and promotes mental health. Mental health education and awareness in community, as well as in the public school system, was discussed.

Community-based mental health education.

Three participants acknowledged the need for mental health education and awareness in the Arrow Lakes region. Education was framed as a basic action for beginning to dismantle community stigma and misconceptions of mental health. From Josie's perspective, community education should be developed, in part, by individuals living with adverse conditions of mental health in the Arrow Lakes region, disclosing that she believes curriculum must be developed and presented "*in a funky awesome way*" including artistic representations of the realities of mental

health. Similarly, Skye noted the importance of developing curriculum that works to personalize the experiences of mental health, stating that people need to understand the ways in which negative mental health impacts their families and friends.

As a result of increased mental health education and awareness, participants were hopeful that collective consciousness in the Arrow Lakes region would shift to an ideological position where, as described by Josie, mental health – and people living with adverse conditions of mental health – "*would be embraced and supported… people wouldn't be so afraid of [mental health]*."

Youth mental health education.

Three participants discussed the importance of introducing mental health education and awareness in childhood and adolescence. Participants discussed younger generations through a narrative of hope, resilience and social change, focusing on the ways in which community collectives can work to promote and support youth mental health literacy. Amy stated, "*I want to focus on [youth] and I know that it's a handful of shoots coming up from the forest floor, but the forest is changing*." Four participants identified the school district as a site for implementing mental health related curriculum targeting youth populations. Skye voiced, "*I think [mental health education] should be taught from an early age just as long as… we have physical education we should have mental education*." Josie highlighted the curriculum changes that have occurred in the recent past, including more inclusive sexual health education and introductory mental health education, stating, "*there's a lot of stuff that's happening today that I think in many ways will help the next generation… it will be ingrained in them.*"

Reform/Reimaginings in Mental Health Care Services

Four participants shared their recommendations for – and reimaginings of – mental health care services in the Arrow Lakes region. These visions for change include: creation of a streamlined process/service hub, increased promotion and advertisement of existing services, and mandatory continued professional development for all human service providers.

Streamlined service process/service hub.

Two participants described the value of developing a streamlined approach to care and/or a service hub. The streamlined approach to care was imagined as a network of support within which the service consumer is only required to disclose their personal information once, granting the service provider permission and authority to share information freely on behalf of the service consumer, allowing the service provider to work at connecting relevant community partners and resources. Parallel to the proposal of a streamlined service process was the suggestion of creating a service hub in which all community and health services are located. Alien discussed his experience with a community service hub in the Okanagan, stating, "*it's all there, anything you need, they know what you need, they send you to the right people right then and there, they don't mess around.*" The implementation of these suggestions was seen as a potential solution to barriers related to transportation as well as the potential for re-traumatization during the intake process with differing support agencies.

Increased promotion and advertisement of existing services.

Two participants discussed the need for increased advertisement and promotion of mental health related services available in the Arrow Lakes region. Further, it was suggested that community service providers have a working knowledge of the services that are available – at both a community and regional level – with a willingness to make referrals. Skye suggested that

increased community networking and referral in Interior Health's adult mental health services would be an attainable solution for the commonly long wait periods for care.

Mandatory continued professional development.

Two participants suggested the implementation of mandatory continued professional development requirements for all service positions – and service providers – in the Arrow Lakes region. Amy framed the potential of this requirement as a "*professional obligation*," which would support service providers in remaining competent in their roles through "*new training, new concepts, and new terminology*." Mandatory continued professional development was presented as an ethical safeguard that promotes competency in professional practice, promotes reflexivity, and keeps service providers engaged in their fields. In support of this requirement, Amy noted, "*science evolves everyday… you have to have professional development, you have to keep current*."

New/Increased Services

Four participants identified the need for new and/or increased services in discussions around their visions for mental health in the Arrow Lakes region, with a focus on outreach, clinical services, psychiatry, and transportation.

Outreach.

Outreach services were described as support services that are available to assist in the maintenance of mental health management and care plans in the communities, and sometimes homes, of service consumers. Three participants expressed their desire for more outreach services in the Arrow Lakes region. In Josie's discussion she imagined a mental health outreach service similar to public health services available to mothers of newborns, "*when your new baby is born and the health nurse comes to your house and makes sure that you're getting everything*

you need and that baby is doing well and family is doing well and… make an assessment," noting that when check-ups are conducted over the phone it is easy to lie and say, "*I'm doing great, fantastic*."

Clinical services.

Clinical services, in the context of this research, can be understood as community resources and programming which is available in a controlled setting for the treatment, management and prevention of psychosocial dysfunction (Barker, 2014). Four participants presented ideas for a range of new clinical services in the Arrow Lakes region. Skye called for more "*culturally relevant options*" when reflecting on the services she had accessed in an urban setting. Josie proposed the introduction of a mental health support group that is similar in structure to Alcoholics Anonymous, stating, "*there could be a… 'Nuts Anonymous' or something that's just to… live and laugh and support with each other*" with the inclusion of a group therapist as a facilitator. Further, Josie described the importance of having a group that is creative and task oriented, noting, "*nobody wants to sit around*."

Alien voiced a general need for clinical outreach services, stating, "*you need social workers, you need doctors, you need everything to be [in community]*." He also expressed the need for clinical outreach services in times of community emergency and/or tragedy, noting, "*if there's a murder or a death in the family you need someone… like some kind of special counselor*."

Kitty imagined an Arrow Lakes region with more specialized clinical services related to trauma work and in-patient psychiatric treatment, stating the need for "*more [professionals] that can go and can help the deeper part"* that can negatively impact mental health.

Psychiatry.

Three participants discussed potential new applications for the delivery of psychiatry in the Arrow Lakes region, which would be more conducive to their mental health care needs. These reimaginings included: outreach to the rural communities in the Arrow Lakes region and increased availability of psychiatrists.

Transportation.

Two participants identified the need for increased availability of public transportation in the Arrow Lakes region. Skye imagined the creation of a "*ride-sharing board*" in a local community hub, such as "*Community Services*," where locals could "*take initiative in a small town*" to offer carpooling services as a solution to the geographic isolation associated with residency in the Arrow Lakes region. Alien tasked community and government organizations with the responsibility of finding a solution to the limited public transportation in the Arrow Lakes region. Alien suggested that local transportation, such as the "*community bus*" and "*shopping bus*," should expand the availability of their services, as "*the price is right*," which promotes "*freedom*" in mobility.

Community-Based Changes

Two participants framed community-based changes as integral components of their visions for mental health in the Arrow Lakes region. These changes include: the development and promotion of general wellness supports and the development of a mental health peer advocacy group.

General wellness supports.

General wellness supports were framed as mental health promotion services, such as yoga and self-care courses, that are advertised and designed to promote mental health literacy

and support all community members in maintaining their wellness. Skye envisioned a "*yoga instructor and a mental health worker*" teaming up to provide a series of self-care classes that are "*not just limited to people that feel… depressed*." From Skye's perspective, local businesses would play a role in supporting and promoting these services.

Mental health peer advocacy group.

Skye and Josie both noted the need for increased collaboration, support, and advocacy by, for and with community members living with adverse conditions of mental health. Josie presented the idea of the creation of a partner in wellness program, noting that she currently has a "partner in wellness," which provides her with peer support in her community. She envisioned this program replicating aspects of the Alcoholics Anonymous programming, stating that partners would require the "*I'll come get you come hell or high water*" mentality.

Skye discussed the importance of a mental health peer advocacy group in promoting mental health literacy and combating stigma in the Arrow Lakes region. From her perspective, this approach would be successful, as it would help community members "*understand that it's [their] kids, it's [their] family… that would be the most impactful,*" noting, "*people need to recognize it from within before just having information shoved at them*." Skye believes the creation of this group would require a few "*like-minded individuals*" to come together and allow the "*ripple effect*" to follow.

Inclusion of Service Consumers in Mental Health Program and Policy Development

Two participants voiced the necessity of including service consumers' input and expertise in the development of mental health programs and policies. Both participants noted that this would result in mental health services that are more sensitive and relevant to the community-

specific needs. Josie noted that research should be done exploring "*community need*" with a focus on developing mental health supports that meet said needs.

Summary

During the analysis of six interviews with adult mental health service consumers in the Arrow Lakes region, eight themes emerged, including: informal supports of mental health in the Arrow Lakes region, formal supports of mental health in the Arrow Lakes region, community culture as a challenge to maintaining mental wellness, gaps/lack in services available, barriers to accessing existing services, cost of living and financial burden(s) in the Arrow Lakes region, work place discrimination and stigma, and visions for mental health in the Arrow Lakes region. Despite the small sample size, it was evidenced that adult mental health service consumers living in the Arrow Lakes region have worked to develop strategies for maintaining mental wellness, which are attainable and relevant in their rural, remote geographic settings. All participants discussed the role of informal supports in their mental health maintenance in the Arrow Lakes region, identifying community, family and friends, nature, animals/pets, and work as specific spaces of support. Informal support was broadly characterized by access to resources, emotional connection, and relief from negative symptoms of mental health.

All participants discussed the role of formal services in the maintenance of their mental wellness in the Arrow Lakes region, discussing the Interior Health Authority's services, psychiatry, community services, access to out of town services, public transportation and alternative wellness opportunities. A formal service, in the context of this research, refers to a professional, publicly available service that promotes, directly or indirectly, mental wellness. Formal services were broadly recognized for their therapeutic/clinical benefits and pharmaceutical management.

In reflection upon components of their lived experiences in the Arrow Lakes region that have presented challenges to maintaining mental wellness, the following themes were presented: community culture as a challenge to maintaining mental wellness, gaps/lack in services available, barriers to accessing existing services in community, and the cost of living and financial burden(s) in the Arrow Lakes region.

All participants contributed their ideas and visions for the ways in which the Arrow Lakes region could promote and support mental health. These visions included increased mental health education and awareness, reform/reimagining's in mental health care services, new/increased services, and community based changes.

Despite the adversity and challenges present within the rural, remote communities of the Arrow Lakes region, the individuals involved in this research presented their resourcefulness, creativity and resilience in the pursuit of mental wellness.

CHAPTER FIVE: DISCUSSION AND CONCLUSION

This research project was conducted in efforts of gaining insight into the lives of adult mental health service consumers living in the Arrow Lakes region with the intent of utilizing their voices to advocate for structural, consumer-driven change in related health and community services. In Chapter Five, I will discuss the conclusions reached through this research, locate the findings from this project within existing literature, and outline the recommendations from this project.

Discussion

The purpose of this research was to develop an introductory understanding of the experiences of adult mental health service consumers living in the Arrow Lakes region. It worked to explore adult mental health service consumers' experiences of mental wellness, challenges to mental wellness, and visions for a community that promotes and supports mental health. In reflection upon their experiences, all participants identified their reliance on informal mental health supports, with family/friends identified as the '*biggest support'* of mental wellness by the majority of the sample. The informal supports identified by the participants worked to create an image of the unique socio-geographic context in which people in the Arrow Lakes region are tasked with surviving and thriving in a space characterized by a lack of formal, clinical resources for health maintenance. This collectively created narrative of mental health maintenance in the Arrow Lakes region demonstrates the importance of implementing, or incorporating, integrated approaches to care planning with a focus on supporting, including and honoring the value and work of informal supports in rural, remote health maintenance.

Formal supports were discussed for their therapeutic, clinical benefits, however, several challenges and/or barriers to accessing these services were acknowledged, including lack of

choice in service providers, anonymity/confidentiality concerns and proximity of services. In my analysis, it was apparent that these barriers/challenges to formal support in the Arrow Lakes region require further attention, analysis and restructuring from relevant community and healthcare stakeholders to promote equity in health outcomes for rural, remote service consumers in this region.

In recognition of British Columbia's health authorities' responsibility to work collaboratively with communities to develop healthy behaviors and safe health care services, it is integral that service-consumers needs, input and experiences are represented within future praxis and policy development pertaining to the provision of adult mental health in the Arrow Lakes region (Government of British Columbia, 2015). While health authorities have an apparent responsibility in the deliverance and provision of health – and mental health – services, the contributors to this research also identified the importance of community stakeholders and other government organizations – such as the school district – in creating a community that promotes and supports mental health. These community-based responsibilities were identified as mental health education/awareness, advocacy, and alternative health services – such as increased transportation.

Locating this Project Within Existing Literature

Realities of mental health, rural, remote residency, and health management are represented within existing provincial, national and international bodies of literature. Existing literature has explored topics including the presence – and negative implications – of stigma in rural communities; place-based barriers to accessing mental health services; and the reliance on informal supports and/or self-management strategies (Caxaj & Gill, 2017; Coen et al., 2013;

Deen & Bridges, 2011; Levin & Leyland, 2005; Parr & Philo, 2003; Robinson et al., 2012; Singh, 2017).

The implications of stigma and/or discrimination on mental health and health maintenance in rural geographies has been explored by researchers including Robinson et al. (2012), Singh (2017), Caxaj and Gill (2017), Polaha, William, Heflinger and Studts (2015), Stewart, Jameson and Curtin (2015), Crawford and Brown (2002), and Kennedy (2018). These inquiries have unveiled understandings of the ways in which stigma poses a barrier to mental health maintenance in the lives of rural residents. For instance, Polaha et al.'s (2015) research with rural parents of children with psychosocial concerns found that stigma acted as a barrier to accessing services, and subsequently, recommended that non-traditional service settings be utilized to promote access. Similarly, Stewart et al.'s (2015) research with rural, older adults found that self-stigma and public-stigma contribute to increased desire for self-management of mental health.

In solidarity with existing literature, this project captured the implications of stigma and/or discrimination in the lives of adult mental health service consumers in the Arrow Lakes region, specifically in relation to community based stigma and workplace stigma/discrimination. Stigma was identified as a threat to wellness as it works to silence and devalue the health implications of mental illness; creates barriers to employment; and contributes to individuals' feelings of isolation and shame as a result of their health status. However, in contrast to existing literature, the participants in this project did not identify stigma as a barrier to accessing mental health services, but rather discussed the personal, professional and community-based implications of stigma on their wellbeing.

While stigma was not discussed as a barrier to accessing mental health services, participants did identify place-based barriers to mental health maintenance. These included proximity to services, lack of choice in service providers, lack of promotion and advertisement of existing services, and anonymity/confidentiality concerns. These identified barriers to accessing mental health services in rural geographies are echoed in existing literature produced by Robinson et al. (2012), Bodor (2009), Dyck and Hardy (2013), Panazzola and Leipert (2013), and Ryan-Nicholls and Haggarty (2007). Participants also discussed informal mental health supports, such as nature, animals/pets, community, and family/friends as a support network, which were linked to their residency in the Arrow Lakes region. Both the barriers and the informal supports identified in this project work to frame the realities of mental health maintenance in the Arrow Lakes region. The geographically bound features of these realities substantiate Ryan-Nicholls and Haggarty's (2007) call for the development of place-based policy and procedures for the provision of equitable mental healthcare in rural communities.

Recommendations and Future Research

Mental health in the Arrow Lakes region was explored through the experiences of six adult mental health service consumers. As a part of this project, I inquired about participants' visions for communities that promoted and supported mental health, and subsequently, what they viewed as necessary for the Arrow Lakes region to actualize this vision. Participants discussed macro, mezzo, and micro spaces for reform and reimagining's of mental health. Recommendations, which were categorized as sub-themes of 'Visions for Mental Health in the Arrow Lakes region,' included: education/awareness, reform/reimaginings in mental health care services, new/increased services, and community-based changes. In efforts of upholding and honoring the participants as experts on the topic of mental health in the Arrow Lakes region, the

visions shared during the interviews will be framed as the recommendations from this research project. This section will also discuss the implications of these recommendations for social work practice and suggestions for future research.

Education/Awareness

The implementation of mental health education presents an opportunity for positive advancements in mental health literacy in the Arrow Lakes region. As recommended by participants in this project, education must be provided at the community-level through accessible, active, engaging avenues such as art and mental health advocacy groups. Ryan-Nicholls and Haggarty (2007) suggest that a focus on mental health promotion and education has the potential to minimize barriers related to accessibility of mental health services in rural contexts, while working to engage community stakeholders in advocating for congruency between policies, legislation, and funding pertaining to mental health.

Secondly, mental health education must be presented – in a more significant capacity – to youth. Mendenhall, Frauenhaultz, and Conrad-Hiebner's (2014) research on child and youth mental health literacy found that children's mental health literacy is often low, inaccurate and inconsistent, with peers identified as children's key 'educators' on mental health disorders. Children and youths' limited mental health literacy can result in an inability to recognize symptoms of mental illness, and subsequently, can act as a barrier to seeking formal support (Mendenhall et al., 2014). In solidarity with Mendenhall et al. (2014), participants in this project recommended the introduction, and further development, of school-based curriculum promoting mental health literacy. As noted by Mendenhall et al. (2014) the introduction of school-based mental health curriculum presents a "potentially effective way to universally increase the mental health literacy of all children and adolescents" (p. 289). By supporting the development

of mental health literacy in youth populations, there is potential to shift the collective consciousness surrounding mental health to a place of understanding, compassion, and transparency.

Reform/Reimaginings in Mental Health Care Services

Recommendations for reform – and reimaginings – in mental health care services in the Arrow Lakes region included discussions of streamlined processes and/or a community service hub, increased promotion/advertisement of existing services, mandatory continued professional development, and the inclusion of service consumers in program and policy developments related to mental health care.

The development of a streamlined process and/or a community service hub could help to increase the accessibility of services by minimizing the travel burden associated with accessing services. Ideally, this service hub would have a shared-confidentiality clause, allowing for the sharing of relevant information between service providers, working to minimize service consumers' labor of navigating health and social systems (Malachowski, Skopyk, Toth & MacEachen, 2018). Participants suggest that this service hub should include both healthcare and social services. Malachowski et al.'s (2018) research on the use of the Integrative Health Hub Model (IHHM) in community-based mental health provision supports participants' recommendations – and reasoning's – for the creation of a community service hub in the Arrow Lakes region. The IHHM, as discussed by Malachowski et al. (2018), works to ensure an integrated health care team and/or community service providers address all determinants of health. Furthermore, the IHHM model bridges community-identified – and community specific – gaps related to mental health management (Malachowski et al., 2018). Malachowski et al. (2018) note that IHHM has "evolved to take into account what is required for individuals living with

mental health problems to become healthier, or as healthy as possible, over the longer-term, from a broader social perspective" (p. 6).

Adjacent to the creation of a streamlined process/community service hub, is the recommendation for increased advertisement and promotion of existing services available in the Arrow Lakes region. This recommendation could be attained through increased collaboration between community stakeholders, the development of an Arrow Lakes region mental health resource directory, and a policy-amendment requiring mental health service providers to make referrals to interim supports – such as crisis lines, regional options, and private-sector mental health providers – for service consumers waiting for clinical care. Community Futures – North Okanagan (2015) created a regional health and social resources directory, titled *North Okanagan Community Reference Guide*, which was further categorized into directories such as mental health, housing, specialized housing, food services, substance use and addictions, and child, youth and family services. The *North Okanagan Community Reference Guide* (2015) provides a template for the development of a localized health and social services directory in the Arrow Lakes region, addressing the need for increased promotion and advertisement of existing services.

Service consumers involved in this research identified conservative, traditional values held by service providers as a barrier to maintaining wellness and accessing mental healthcare in the Arrow Lakes region. As a solution to this barrier, it is recommended that social agencies responsible for providing mental health – and health adjacent – services implement organizational requirements for ongoing professional development in the respective field of the employed service providers. Certain health organizations, such as Interior Health Authority, have implemented criterion for employment – such as the requirement for social work professionals to

be registered with the British Columbia College of Social Workers – which indirectly ensures continued professional development through collegial requirements (Interior Health Authority, 2017). Additionally, existing literature, such as Cleary et al.'s (2011) research with mental health nurses, demonstrate professionals' interests and desires to have access to, and participate in, clinically focused and work-based educational opportunities to aid in their competency. With increasing organizational investment in continued professional development and respective interest in learning opportunities from health care providers, the implementation of mandatory continued professional development offers an opportunity to challenge and minimize the existence of conservative, traditional values presented in care settings in the Arrow Lakes region.

Individuals involved in this project called for an increased inclusion of service consumers in future developments of mental-health related policies and programs. As exemplified in this project, those experiencing the related systems of care best understand the realities of mental health – and the challenges and benefits of the associated care services. In support of this recommendation, Ryan-Nicholls and Haggarty's (2007) research calls for the inclusion of mental health service consumers, and their families, in the development of programming and policies related to mental health in rural contexts. However, Ryan-Nicholls and Haggarty (2007) noted that to ensure meaningful consumer-involvement in rural decision-making processes safeguards, such as confidentiality protection measures, would need to be implemented.

New/Increased Services

Participants identified a need for increased – and additional – outreach, clinical, psychiatric, and transportation services. The introduction of additional formal mental health services in the Arrow Lakes region would reduce the travel – and associated financial – burden

with receiving care out of community, provide service consumers more choice in their provider, and promote positive health management.

Due to the regionalization of healthcare services across British Columbia, the responsibility for mental healthcare provision has been decentralized from large psychiatric hospitals to community health care structures without the addition of increased community resources (Morrow et al., 2012). This shift in provision has resulted in a demand for self-sufficiency within local healthcare structures in regards to caring for individuals on both the inpatient and outpatient levels with limited resources (Morrow et al., 2012). Furthermore, the process of regionalization has resulted in the extinction of a diversity of healthcare services in rural contexts, requiring service consumers to commute to urban centres for specialized care – or alternatively – go without care (Fleet et al., 2013). For instance, in the community of Nelson, British Columbia the introduction of the regionalized model of care resulted in the closing of three units at the hospital – one of which was the inpatient mental health unit (Fleet et al., 2013).

In recognition of the ways in which the regionalized model of care has impacted the availability of localized health services across the province, the call for increased services, and new services within the Arrow Lakes region reflects regionalization's negative implications for health management in rural geographies. In response, participants recommend that more specialized services – such as psychiatry and counseling – be provided on an outreach basis in the outlying communities of Burton, Fauquier and Edgewood. Participants called for increased funding to employ more mental health service providers, specifically postings working exclusively in outreach capacities. Additionally, participants called for an increase in the frequency of medical and public transportation linking communities in the Arrow Lakes region

to both Nakusp and proximal urban communities as an attempt to reduce the financial burden associated with receiving care.

Community-Based Changes

Recommendations for community-based changes include the development and implementation of general wellness supports and the formation of a mental health peer advocacy group. General wellness supports can be understood as public opportunities to maintain wellness and develop self-care strategies in a supportive environment. Participants imagined these supports as: yoga classes facilitated by an instructor and a mental health worker; a self-care group targeting employees of the forest industry; and a task-oriented mental health promotion collaborative, such as an art-group or cooking classes, available in outlying communities. Predominantly this recommendation calls for further development of alternative mental health support services in the Arrow Lakes region.

It is recommended that a mental health peer advocacy group be developed by, for, and with community members – and their families – who are impacted by adverse conditions of mental health. As defined by Simpson, Oster and Muir-Cochrane (2018) peer support is a component of mental health care where individuals with lived experience of mental health adversity provide support to peers experiencing similar challenges. Identified benefits of peer support for service consumers include: “reduced admission rates; increased empowerment, social support, and social functioning; empathy, acceptance and hope; and reduced stigma” (Simpson et al., 2018, p. 662). Further, peer support work offers benefits to the service providers, including: continued recovery; personal growth; skill enhancement and the therapeutic effect of helping others; and when a paid position, the benefits of being employed (Burke, Pyle, Machin & Morrison, 2018; Simpson et al., 2018).

As a consumer-driven initiative, participants envisioned this peer support group as a space for networking, advocacy, and community education. Further, this was seen as a potential interim solution for the gap in formal services available in outlying communities, such as Burton, Fauquier, and Edgewood, in the Arrow Lakes region as the service would be organized and delivered by members in community. It is recommended that a community health-related organization take responsibility – in part – for this initiative, working to create an affirmative employment opportunity, provide supervision and support for the peer support worker(s), and expand outreach service capacity to outlying communities in the Arrow Lakes region (Simpson, Oster & Muir-Cochrane, 2018). In recognition of the financial and labor related demands of this recommendation on the host organization, additional resources – specifically funding – would be required to actualize this service vision. As outlined in the literature review, intersections of municipal, provincial and federal government health-related responsibility could be investigated as sources for the financial support of this recommendation.

Implications for Social Work

The Canadian Association of Social Worker's (CASW) (2005) *Code of Ethics* outlines the ethical obligations of social work professionals in Canada with a framework inclusive of six core values. In solidarity with these core values, social workers have an ethical obligation to utilize their professional power to address the needs of service consumers, while pursuing social justice (CASW, 2005). The recommendations – or needs – presented by the participants in this project offer space for social work professionals to exercise their professional power in the pursuit of equitable health outcomes for rural residents in the Arrow Lakes region. These social work roles could include: conducting organizational research on the accessibility of mental health services in the Arrow Lakes region, advocating for the inclusion of service consumers in

future developments of mental health programming and policies, community education, and reimaginings of the scope of current practice in relationship to outreach capacities.

Future Research

As this project was exploratory, it presented multiple facets for further inquiry related to the intersections of rural residency and mental health maintenance in the Arrow Lakes. In consideration of the sample size of this project, it would be beneficial to attempt a project – with a similar point of inquiry – with a larger sample in the Arrow Lakes region. I would recommend the incorporation of a survey based upon the findings of this project, offering an alternative opportunity to express experiences with mental health. Ideally, this project would partner with the Interior Health Services Authority for the purposes of recruiting adult mental health service consumers in the Arrow Lakes region.

Research exploring the themes presented in this project has the potential to contribute to a more holistic, comprehensive understanding of mental health in the Arrow Lakes region. On account of the amount of data items associated with the theme 'Informal Supports of Mental Health in the Arrow Lakes Region,' I would suggest this as a preliminary space for further inquiry – investigating how, where, and when these services are utilized in health management strategies. Further, inquiry into the ways in which community members, friends, and family working in care roles are supported in the Arrow Lakes region would offer opportunity for further collaboration between formal service providers and unpaid care-workers, promoting the longevity and wellness of informal supports.

By producing further academic literature pertaining to the experiences of adult mental health service consumers in the Arrow Lakes region – and broadly, mental health in the Arrow Lakes region – the foundation and framework from which future structural shifts in the provision

and development of health-related policies and programming in the Arrow Lakes region could be developed would be more comprehensive, representative, and diverse.

Conclusion

This thesis report presented existing literature on the intersections of rural, remote residency and mental health; the value of creative arts in mental health interventions at the micro, mezzo, and macro levels of practice; the distinctions between informal and formal mental health services; the recent history of mental health in Canada; and the roles of federal, provincial, and municipal governments in the provision of mental health related services. As demonstrated by the literature there was a need for research exploring the experiences of adult mental health service consumers in the Arrow Lakes region. The purpose of this exploratory, text and image-based qualitative research was to develop an understanding of the experiences of adult mental health service consumers living in the Arrow Lakes region with the intent of contributing to structural, consumer-driven shifts in mental healthcare policy and positive developments in community consciousness regarding mental health. From the knowledge and expertise of six adult mental health service consumers, eight themes emerged, including: informal supports of mental health in the Arrow Lakes region, formal supports of mental health in the Arrow Lakes region, community culture as a challenge to maintaining mental wellness, gaps/lack in services available, barriers to accessing existing services, cost of living/financial burden in the Arrow Lakes region, work place discrimination/stigma, and visions for mental health in the Arrow Lakes region. This project has presented consumer-driven recommendations for mental health care reform and reimaginings in the Arrow Lakes region, with the hopes of contributing to structural, systemic shifts in health-related services to promote safe, accessible health maintenance opportunities for adult mental health service consumers.

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APPENDIX A: RECRUITMENT POSTER

Through Our Lens: Adult Mental Health Service Consumers' Lived Experiences in the Arrow Lakes Region

RESEARCH PARTICIPANTS WANTED

Looking for:
Adult (19+) mental health service consumers who have lived in the Arrow Lakes region for 12 or more months

I will be interviewing potential participants about their lived experiences with a focus on what supports mental wellness, what challenges mental wellness, and visions for mental health promotion in community. Participants will be asked to create visual representations (art or photographs) of these experiences – supplies will be provided.

If you are interested please contact me, Kiara McLean, at 250.265.1832 or mclean3@unbc.ca, to discuss your potential involvement!

Supervisor: Dawn Hemingway, School of Social Work, 250.960.5694 or dawn.hemingway@unbc.ca

This research is being conducted through the University of Northern British Columbia and in accordance with the standards and regulations of the Research Ethics Board for the partial fulfillment of a graduate degree.

UNBC UNIVERSITY OF NORTHERN BRITISH COLUMBIA

APPENDIX B: INTERVIEW GUIDE

1.	Could you list three words/phrases that you associate with being a resident of the Arrow Lakes? ➢ What makes these words the most representative of being an Arrow Lakes resident?
2.	What helps to maintain your wellness (ie. Nature, art, support groups)? ➢ How does this work to maintain your wellness?
3.	What challenges do you experience while working to maintain your wellness? ➢ How does this challenge your wellness? ➢ What could help (ie. Public transportation, community centre) to reduce or eliminate these challenges?
4.	What supports (informal: such as family, friends, art groups; formal: counselling, support groups) have you accessed while in community? ➢ Can you describe the role that these supports have played in supporting your wellness?
5.	If you were asked to write a book about your life here in the Arrow Lakes, what title would best summarize and represent your story? ➢ What made you choose this title specifically?
6.	Please describe your vision of a community that promotes and supports mental health. ➢ Have you lived in a community where you felt mental health was supported and promoted? ➢ Were there differences between this community and your current community? IF YES: What are the differences that you have noticed between these communities? ➢ Please specifically describe the informal and formal support networks that you would include in your vision.
7.	What would your community need (ie. Funding, support groups) to achieve this vision? ➢ From your perspective, where would these resources come from?
8.	Is there anything else that I should know about your experiences as a mental health service consumer in the Arrow Lakes region?

Questions 2, 3 and 6 were used as prompts for the creation of visual data in this research

APPENDIX C: CONSENT/INFORMATION LETTER

UNBC UNIVERSITY OF NORTHERN BRITISH COLUMBIA

"Through Our Lens: Adult Mental Health Service Consumers Lived Experiences in the Arrow Lakes Region (ALR)"

This research is being conducted in partial fulfillment of a graduate degree. The results of this research will be presented in a public document (Masters of Social Work thesis) that will be searchable on the Internet and visual images created will be presented in an art exhibit in the Arrow Lakes.

Purpose of the research: The purpose of this research is to develop an understanding of the experiences of adult mental health service consumers living in the Arrow Lakes region with the intent of contributing to structural, consumer-driven shifts in health care policy and positive developments in community consciousness regarding mental health.

1. **Who is conducting the study?**

Student Researcher: Kiara McLean, Master of Social Work Student, School of Social Work, University of Northern British Columbia, Ph: 250.265.1832, Email: mclean3@unbc.ca

Supervisor: Professor Dawn Hemingway, Chair, Associate Professor, School of Social Work, University of Northern British Columbia, Ph: 250.960.5694, Email: Dawn.Hemingway@unbc.ca

2. **Why are you being asked to take part in this study?**

- You are being invited to take part in this research study because you are an adult (19+) living in the Arrow Lakes region for more than 12 months who has accessed mental health services. We want to learn more about the unique experiences you have lived as a result of residing in these rural communities.
- Your participation in this research is entirely voluntary; you are in no way obligated to participate in this research. You are free to withdraw from this study at any time. You are also free to not answer any questions that make you uncomfortable. If you choose to withdraw from this study, all existing information provided by you will be securely destroyed.

3. **What happens if you say, "Yes, I want to do this study"**

- If you say, "yes", here is how the study will be conducted:
  - Participate in two 1 to 2 hour, face-to-face interviews. In the first interview you will be asked about what supports your mental wellness, what challenges your mental wellness, and what your vision is for a community that supports and promotes mental health. The first interview will be audio-recorded and transcribed. You will receive your arts supplies at the end of this interview. In the second interview, we will review the visual images you have produced and discuss what they mean to you. We will create a written description of

your visual images. We will review the transcript of your first interview and member-check initial themes from your data to ensure it represents your experiences. These interviews will be audio-recorded. If corrections are needed to create a more accurate representation of your experiences the conversation about the corrections will be audio-recorded and transcribed.

- Produce visual images (photographs and/or visual art). You will be provided with a disposable camera and/or art supplies, which will be used to visually represent your experiences of accessing mental health services in the Arrow Lakes region.

4. Is there any way that participating in this study could harm you?

- Risks may include emotional and/or psychological discomfort. These feelings may arise as we reflect on, and discuss, times that have challenged your mental wellness. Additionally, reflecting on what resources your community needs to achieve your vision of community mental health may cause feelings of discomfort.
- If at any time you feel uncomfortable and want to end your participation, please notify the researcher and your request will be respected with no further questions. As mentioned previously, all documents that were collected up to termination would be securely destroyed.
- You are welcome to disclose as much, or as little, about your experiences as an adult who has accessed health services in the Arrow Lakes region as feels comfortable for you.
- Attached below is a list of emotional supports available in community:
- *These community resources are free to access*
    - **Mental Health and Substance Use Services:** 97 – 1st Ave NE, Nakusp, BC. 250.265.5253
    - **Terra Pondera Clubhouse:** 97 – 2nd Ave NW, Nakusp, BC. 250.265.0064
    - **Crisis Line:** 24 hours / day, 1.800.784.2433
    - **West Kootenay – Boundary Regional Crisis Line:** 24 hours / day, 1.888.353.2273

5. What are the benefits of participating?

- Your participation in this research will provide an opportunity for you share your experiences in the Arrow Lakes region as an adult who has accessed mental health services. Additionally, your participation in this research will contribute to a community art installment addressing community consciousness and mental health stigma.

6. How will your identity be protected?

- Interviews will be audio recorded. Only the researcher and their supervisor will have access to these files.
- Visual data will be presented at a community art installation following the completion of this research. Images will be presented without names.
- Data collected will only be used for the purposes of this research.
- Information that discloses your identity will not be shared without your consent, unless required by law. Pseudonyms will be used in the final report – together, we will decide on a name to represent you.
- Five years following the completion of this research, all data will be securely destroyed, except for the images which you will have ownership of following the art exhibit.

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7. **Study results.**

- The final thesis will be available at the University of Northern British Columbia's library, as well as on the online library forum.
- This research may be published in journal articles or books.
- Visual images will be presented in a community art installment and the final thesis.
- If you wish to receive a copy of the final thesis please circle preferred receiving method: Canada post or email.
  Please provide receiving address:

8. **Who can you contact if you have questions about this research?**

- If you have any questions about what we are asking you, please contact the student researcher or student supervisor. The names and contact information are available at the top of the first page.

9. **Who can you contact if you have complaints or concerns about the study?**

- If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the UNBC Office of Research at 250-960-6735 or by e-mail at reb@unbc.ca.

Consent

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study at any time without giving a reason and without any negative impact on the mental healthcare or other services you are receiving or which you are entitled to receive.

I have read, or been described, the information presented in the information letter about this project:

YES NO

I was given the opportunity to discuss any questions related to my involvement in this project:

YES NO

I recognize that my participation is entirely voluntary and I may withdraw from this project at any time prior to the final report without penalty. I have received a copy of this consent/information letter:

YES NO

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I agree to be audio-recorded (being audio-recorded is a selection criterion for this research, if you do not wish to be audio-recorded you will not be able to participate in this research):

YES NO

I agree to be contacted by the researcher to organize our second face-to-face interview:

YES NO

I agree to be contacted by the researcher to organize to have my visual data collected:

YES NO

I agree to have my visual data (photographs and/or art) included in the final community art exhibit:

YES NO

I understand that my visual images will not be utilized in the final report or art exhibit if any identifying images of non-consenting adults are included:

YES NO

I agree to be contacted by the researcher to receive details about the art exhibit showcasing the art from this research:

YES NO

- Your signature below indicates that you have received a copy of this consent form for your own records.
- Your signature indicates that you consent to participate in this study.

_____ _____

Participant Signature Date (DD/MM/YEAR)

_____ _____

Printed Name of Participant Participant Email

_____

Participant Phone Number

Consent to Art Exhibition Display

I consent to have my visual images created for this research displayed at the community art exhibition. I understand that if I chose to attend this event and disclose to participants what art pieces I have created that I will be impacting my privacy and anonymity in the context of this research. Further, I understand that if I choose to submit my art using my real name that the researcher cannot be responsible for my privacy and anonymity related to the visual images displayed. I understand that the researcher will not disclose who was involved in creating this art unless I consent to attaching my real name to my art pieces at the exhibit. I understand that I will take possession and ownership of my visual material following the completion of the exhibit.

I wish to have my visual data displayed anonymously

YES NO

I wish to have my visual data displayed using my pre-determined pseudonym

YES NO

I wish to have my visual data displayed using my real name

YES NO

- Your signature below indicates that you consent to have your images displayed at the community art exhibit.
- Your signature below indicates that you have received a copy of this consent form for your own records.

_____ _____

Participant Signature Date (DD/MM/YEAR

_____ _____

Printed Name of Participant Participant Email

_____

Participant Phone Number

APPENDIX D: DEMOGRAPHIC QUESTIONNAIRE

UNBC UNIVERSITY OF NORTHERN BRITISH COLUMBIA

1. Age: _____
2. Gender: _____
3. Ethnicity: _____
4. Income:
    a. Less than $10,000
    b. $10,000 - $15,000
    c. $15,000 - $20,000
    d. $20,000 - $25,000
    e. $25,000 - $35,000
    f. $35,000 - $50,000
    g. $50,000 - $75,000
    h. $75,000 - $100,000
    i. $100,000 - $150,000
    j. $150,000 - $200,000
    k. $200,000 and over
5. Highest level of education:
    a. Less than high-school
    b. High-school Diploma
    c. Post-secondary Certificate/Diploma
    d. Bachelors Degree
    e. Masters Degree
    f. PhD
6. What community do you live in currently?
    a. Edgewood
    b. Fauquier
    c. Burton
    d. Nakusp
    e. Outlying of:_____
7. How long have you lived in the Arrow Lakes region?
    f. 1-5 years
    g. 6-10 years
    h. 11- 15 years
    i. 16 or more years