



ALL OR NOTHING: EXPERIENCES OF MENTAL HEALTH IN VICTORIA, BC

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2015

VIPIRG WOULD LIKE TO ACKNOWLEDGE THAT THIS RESEARCH WAS CONDUCTED IN THE COMMUNITY KNOWN AS VICTORIA, BRITISH COLUMBIA, WHICH RESTS ON LEKWUNGEN AND WSÁNEĆ TERRITORIES

 **VIPIRG**

WHY THIS RESEARCH?

The purpose of this research was to explore how experiences of self-identified mental health problems and disabilities intersect with broader systemic issues in the community of Victoria, BC (Lekwungen and W̱SÁNEĆ territories). Research focused on privileging the voices of those who have been silenced due to their mental health struggles and honouring the epistemological significance of their lived experiences. By exploring lived experiences of mental health in Victoria, BC, broad systemic issues could be situated within “our own backyard.”

WHAT DID WE ASK?

We wanted to know:

- What barriers people face when identifying with mental health problems and disabilities
- How experiences of mental health and mental health resources have impacted their lives
- What changes or improvements they would like to see in mental health services, and in the general public’s view(s) of mental health
- Who they would like to know about this research and their experiences

HOW DID WE DO IT?

Fifteen semi-structured interviews were conducted in the community through collaboration with various community organizations working with (often) marginalized populations. Participants represented a combination of staff and/or clients at these organizations, which primarily worked with populations such as immigrants, refugees, and newcomers to Canada; those who identify as living with mental health problems and disabilities; those who are homeless and/or living in poverty; and those accessing harm reduction-oriented substance use services.

Research drew on methods and perspectives from both Community-Based Research and Intersectional Feminist Frameworks. Community-Based Research (CBR) involves the communities and people experiencing social problems in all aspects of the research process, including the identification of a problem, research questions, analysis, and knowledge dissemination. CBR attempts a redistribution of power in the research relationship by breaking down the barrier between “researcher” and “researched.” Additionally, DataCenter (n.d.) write that CBR “is about challenging who controls and defines knowledge and creating our own liberatory system of knowledge” (as cited by VIPIRG, n.d.). Due to time limitations, participants in the research process were approached with research questions already established; however, in recognition that prior collaboration with participants was not possible, interviews were only semi-structured to allow for other topics of enquiry to emerge beyond the scope of the research questions. Additionally, questions about what participants would like to see happen with the research results, and who they would like to know about their experiences, were integrated into the semi-structured interviews.

Intersectional Feminist Frameworks (IFF) require researchers to locate themselves within the research process and to articulate their effect on the research process, a practice known as reflexivity. As the writer of this report and as someone with lived experience, I came from the perspective of a peer while conducting this research. My lived experience, my professional experience, and my academic experience informed the design of this project. IFF may also provide a starting point for unearthing power relations within the research process, including a critical understanding of:

- What questions are asked and how they are posed
- Who is included and excluded in the research process

- The power relations that govern interactions between “researcher” and “researched”
- How and what knowledge is produced

Additionally, principles of social justice, the inclusion of those with lived experience, and an intersectional perspective were integrated into the research project.

WHAT DID WE FIND?

This research process revealed larger systemic issues surrounding mental health in British Columbia and Canada, including barriers to access and restricted resources in the mental health system, experiences of stigma and discrimination from various levels of society, and multiple intersections of people’s experiences of mental health with other experiences of marginalization.

The overarching concern that was discovered during data analysis was that Victoria’s mental health system is designed to deal solely with extremes. If crisis and wellness were placed on a spectrum, it is clear that there is a distinct lack of resources for those who fall within the middle or the “wellness” end of that spectrum. Within this middle ground, community organizations that approach mental health from a “recovery” perspective and others that serve marginalized populations carry the burden of filling this gap in both access and resources.

THEMES

WE DON’T HAVE ENOUGH RESOURCES DEVOTED TO MENTAL HEALTH AND IT IS DIFFICULT TO ACCESS THOSE THAT DO EXIST

Serious issues around a lack of mental health resources and difficulty in access have been reported in B.C. and across Canada for over a decade, with the former Office of the BC Mental Health Advocate

(now abolished) reporting that the highest proportion of calls they received (44%) were regarding difficulties in accessing help (Hall, 2001). As the Canadian Mental Health Association (CMHA) BC Division discussed in a 2015 Budget Consultation submitted to The Select Standing Committee on Finance and Government Services, mental health is underfunded in BC. The CMHA BC cited the Auditor General and noted that of the \$12.6 Billion in total revenue for health authorities in 2011/2012, acute care received the lion’s share of 58.7% percent, while mental health and addiction services received 7.26% percent, and population health, which includes mental health promotion and prevention, received the smallest share of 4.25% percent. Additionally, Morrow, Frischmuth & Johnson (2006) write that an analysis of the Canadian Health and Social Survey “found that 5.4 percent of all British Columbians have unmet mental health care needs,” with accessibility, availability and acceptability of services identified as significant barriers to receiving care (p. 11).

Participants in this research reported difficulties in accessing help that manifested in a variety of experiences, including long waitlists for services, being turned away when attempting to access mental health services, and a general lack of appropriate services for their (or their clients’) concerns in Victoria.

“[There is] complete and utter lack of anything to do with people in my situation who just have some mild-moderate mental health concerns, there’s no programs, there’s no fuck all. There’s absolutely nothing for us.”

“Instead of road block after road block for people that are already struggling and can’t advocate for themselves in that place, I feel that . . . the access to services needs to be more, more clear and easier, easier to get.”

OUR APPROACH TO MENTAL HEALTH IS DOMINATED BY A BIOMEDICAL PERSPECTIVE, RESULTING IN A LACK OF HOLISTIC RESOURCES

On the state of mental health in BC, Morrow, Fuschmuth & Johnson (2006) write, “the mental health care system continues to be bio-medically and clinically focused with an emphasis on symptom management and psychopharmacology with much less attention on addressing the social determinants of mental health” (p. 10). Treating mental health problems/disabilities as solely a biomedical dysfunction comes at the expense of embracing a holistic view of health that encompasses the range of emotions, experiences, and struggles that make us “human.” Thachuk (2011) writes that common criticisms of the biomedical model include

- (1) their reinforcement of notions that persons with mental illness are of a fundamentally ‘different kind,’
- (2) their entrenchment of misperceptions that persons with mental illness are inherently more violent, and
- (3) their promotion of psychiatric labeling and pharmaceutical treatments, which some argue further stigmatizes and disempowers mental-health services users. (p. 151)

Participants referenced a variety of experiences related to a lack of access to resources outside of the acute care environment and beyond psychiatric medications. Participants observed the lack of a middle ground for mental health services and discussed how the system was designed to deal only with “crises” and “extremes.” Additionally, psychiatric medications were mentioned frequently in the sense that people need resources beyond simply “popping a pill,” including a sense of community or connection, counselling, assistance with developing social supports, nutrition, and other activities such as exercise.

“I would really like something that is in between for those people who might not

need [crisis intervention]. . . For some people it just might be getting that connection back and that doesn’t need to have a hospital bed or tons of medications.”

“I’ve gone in, you’re in crisis, you’re hospitalized. Okay maybe they’re gonna refer you to a day hospital program, through the hospital, outpatient, or whatever, and then that’s it. You know, they kinda tell you to, oh well, you know, have a social life and you know, keep active and do that stuff. But, you don’t know where to go, you’re all alone, no support.”

“GATEKEEPERS” ARE SHUTTING THE DOOR

The systemic issue of stigma and mental health will be addressed in more depth below; however, a prevalent theme uncovered in this research was the experience of feeling unheard, shut out, and systematically barred from access to help by gatekeepers to the mental health system - primarily physicians. The Mental Health Commission of Canada (MHCC) writes, “People who seek help for mental health problems report that they often experience some of the most deeply felt stigma from front-line health care personnel” (2013, p. 4). The MHCC goes on to say that key areas for action in relation to stigma from health care practitioners include:

- (1) negative attitudes and stereotypes
- (2) prognostic negativity (being negative about a person’s chance to recover)
- (3) diagnostic overshadowing (falsely attributing unrelated symptoms to a mental health diagnosis), and
- (4) marginalization (for example, not wanting to treat mental health symptoms in a “medical” setting). (ibid)

Participants spoke of feeling unheard by health care providers who have the power to refer a client to mental health services, such as general practitioners

and physicians working in clinics. Experiences of being silenced were also mentioned by those who had accessed mental health services, resulting in not being able to continue accessing help as their struggles were minimized and/or they were turned away from services.

“And then with psychiatrists it seems sometimes like, well, then again, they weren’t listening either ‘cause sometimes they would just say well no, you’re not feeling this, you’re not feeling that.”

“So far there are several times I have gone to the doctor with my clients, and then some of the appointments were quite disappointing. Because the doctor, well actually, [they] didn’t seem to be ready to listen to this client and help.”

THERE IS NO ACCESS TO INDEPENDENT ADVOCACY

In addition to feeling shut out by gatekeepers to the mental health system, participants reported feeling as if they didn’t have rights while trying to access help. Participants spoke of fears of being “locked up” within the mental health system, or incarcerated due to police responses to mental health concerns.

As it stands, those with mental health problems and disabilities in British Columbia have no access to a dedicated and independent mental health advocate to provide advice and assistance in navigating the system, questions/concerns related to access, or human rights violations. While BC once had access to the office of the Mental Health Advocate of British Columbia (MHABC), their work continued only until 2001, when the office of the MHABC was abolished. The MHABC was supposedly replaced with a Minister of State for Mental Health and the Minister of Health’s Advisory Council on Mental Health; however, they too have since been eliminated (Morrow, Frischmuth & Johnson, 2006).

“I wish they [mental health facility staff] had to live with mental illness for a week

or a month or something. I wish it on them. I wish they had to feel the way I feel. And I wish they had to be locked up in that place themselves and be treated the way I was treated and let them know what it feels like to be treated like crap and not believed and locked in a room and held down and forcibly medicated.”

“I just don’t like the power that they wield . . . and then they can do whatever they want with you. Which, I think, why don’t mental people have rights? You know, they don’t seem to have any rights.”

EXPERIENCES OF STIGMA

Stigma operates by placing a firm boundary between those who experience mental health struggles and those who do not. Once branded as a person with mental health struggles, people are perceived as “other than” when measured against those who are supposedly “normal” in comparison. This “othering” marginalizes those with mental health struggles through processes of systematic exclusion. The stigma associated with mental health problems and/or disabilities is well documented by organizations such as the World Health Organization (2013), the Canadian Mental Health Association (2012), and the Mental Health Commission of Canada (2012).

Participants reported feeling stigmatized in a variety of settings, reflecting the variety of societal arenas in which stigma operates. For participants, the stigma associated with mental health problems/disabilities resulted in experiences of discrimination within the workforce, feeling excluded from family, friends, and colleagues, as well as being silenced by health care providers (as mentioned above). Participants additionally spoke about how pejorative language and beliefs about mental health problems/disabilities circulate through society, including the media’s sensationalized representations of mental health, resulting in them feeling unsafe in disclosing their lived experiences to others.

“I hear jokes and comments people make about crazy people and mental illness and so I spent my life up until very recently like trying to act as if I don’t have a mental illness but also being very ashamed and embarrassed and feeling less than.”

“Do you face additional consequence if you identify? Yes, you face a lot of that, from your employer, your community, your peers, and even some community workers themselves.”

EXPERIENCING MENTAL HEALTH PROBLEMS/DISABILITIES IS NOT A CHOICE

Against the backdrop of the stigma and discrimination associated with mental health problems and disabilities, feeling shut out by “gatekeepers” to the mental health system, and experiencing a lack of advocacy in the mental health system, participants relayed experiences of being treated as if their mental health struggles were a personal choice. Inherent in the assumption that mental health struggles are a personal choice is the belief that those who experience them are simply “not trying hard enough.” However, framing mental health struggles as a personal failure negates an analysis of how our beliefs and experiences of mental health are shaped by dominant social structures and discourses.

“I wish they understood how debilitating it really is. Like people look at me and, you know, see that I’m not working and I’m not cleaning the house and I’m not . . . you know, and don’t understand that I’m paralyzed by anxiety. I can’t do it. You know, I’m not just being a lazy ass.”

“What I would like others to understand is that it is not a choice. Number one. Mental health issues are . . . do you think I chose to waste [many] years of my life? . . . At the time that you’re in the situation, all that matters is making the pain stop.”

And you’ll do literally anything to make that pain stop.”

POSITIVES IN THE COMMUNITY

As participants were clients of various community organizations, they were able to speak to the power of receiving support in the community beyond the scope of the institutionalized mental health system. Many of the community organizations mentioned as helpful by participants are not run by Island Health – with the exception of the ACT (Assertive Community Treatment) teams and the Quadra St. Clinic. Police in the community were mentioned both negatively and positively by participants; however, an ongoing theme regardless of how they were viewed was that police alone responding to mental health calls is not enough. Participants expressed feelings of intimidation when police responded to mental health calls and a wish for other health professionals, such as nurses or counsellors, to respond alongside the police.

Services in the community that participants found most helpful were those that were peer-based, provided counselling, provided support and/or educational groups, and/or provided outreach services related to system navigation.

Examples mentioned included:

- AIDS Vancouver Island (AVI) and their harm reduction and counselling services
- British Columbia Schizophrenia Society (BCSS) and their peer support and the WRAP (Wellness Recovery Action Plan©) program
- Citizen’s Counselling
- Inter-Cultural Association of Greater Victoria
- George Jay Elementary school, which has a worker in the school for multicultural students
- Our Place
- Quadra Street Clinic and their variety of addictions/substance use services

- The Pandora ACT team (PACT) and the Downtown ACT team (DACT)
- The Men’s Trauma Centre
- Umbrella Society and their peer services
- Victoria Cool Aid Society REES program and their outreach and peer services
- Victoria Immigrant and Refugee Centre Society (VIRCS)

HOW DO EXPERIENCES OF MENTAL HEALTH AND MENTAL HEALTH RESOURCES INTERSECT WITH OTHER EXPERIENCES OF MARGINALIZATION?

From an intersectional perspective, it is not simply that experiences occur together; analysis goes further in an attempt to recognize the significance of how multiple experiences of marginalization intersect to create more barriers to inclusion. Barriers such as discrimination can occur at the individual level, at the group level, and at the structural level in society.

On intersectionality, Simpson (2009) writes, “Intersectionality takes a holistic approach because it involves looking at things together, for example, viewing race and gender together, as opposed to viewing them in isolation” (p. 8). While taking care not to homogenize the differences we do experience, intersectionality can provide a sense of common ground by acknowledging that we all move through experiences of exclusion and inclusion in life; oppression and privilege affect us all.

Intersections uncovered in this research mirror broader systemic issues regarding mental health and marginalization that have been reported elsewhere, including:

- A need to reduce inequities in access to mental health care, and to build a stronger response to the needs of diverse communities (MHCC, 2012)

- Difficulties in receiving disability benefits and accessing housing (Hall, 2001; Morrow, Fischmuth & Johnson, 2006)
- Being less likely to gain access to help or housing with a concurrent addiction (ibid)

Reflecting these broader systemic issues, participants spoke about how mental health intersected with experiences of being a newcomer to Canada, experiences of homelessness, and experiences of addiction. Intersections that are listed here are those which were mentioned explicitly by participants, and are not meant to be viewed in isolation. Participants (or their clients) may have experienced multiple intersections far beyond those listed here. The intersections of mental health and newcomer status to Canada, and of mental health and homelessness and/or addiction are both large and complex. A deep analysis is beyond the scope of this report; however, it is paramount to create space for the voices of those who experience these intersections in the community of Victoria, BC.

MENTAL HEALTH AND NEWCOMER STATUS TO CANADA

For newcomers, language was identified as the most prominent barrier to accessing not just mental health services, but any social services whatsoever. While interpretation services are available at times, many newcomers needing help are falling through the cracks. Compounding a paucity of language resources is a lack of culturally diverse services. Victoria’s mental health services are dominated by Western, individualistic, and biomedical perspectives, leaving little room for those whose views fall outside of such a narrow view of health. Participants reported that staff at community agencies and health care facilities expressed impatience with clients’ language abilities or interpreter services, that trying to find an interpreter delayed their treatment even further, and that a general sense of not belonging led clients to cease trying to access help.

Participants additionally discussed a general lack of understanding around other cultures' perspectives of mental health and how that may affect someone's ability or willingness to access resources for themselves or their children. Mental health can be stigmatized to an even greater degree in the countries that newcomers to Canada have arrived from, making it difficult to identify with mental health problems/disabilities or ask for help. Furthermore, participants mentioned experiences of trauma and/or torture being reframed as solely mental health problems/disabilities, with no acknowledgement of factors that fall outside the realm of "mental health."

MENTAL HEALTH AND HOMELESSNESS, MENTAL HEALTH AND ADDICTIONS

The Canadian Mental Health Association (2015) writes of the results from the annual Homelessness Count in Metro Vancouver in 2014, "half of respondents reported having an addiction (49%), about one third (34%) of respondents reported a mental illness and one fifth (21%) of respondents reported a concurrent disorder (i.e., both mental illness and addiction) – and these percentages continue to increase" (p. 6). Quantitative analysis was not a part of this research project; however, participants did discuss their experiences of homelessness and/or addiction in relation to their mental health.

Participants reported that not only did mental health and/or addictions affect their ability to find (and keep) housing, but also that a lack of housing affected their mental health and/or addictions. For many participants experiencing these intersections, securing housing was a process that spanned years, even if they had multiple community workers advocating on their behalf. For some, life-saving healthcare treatments were delayed until they had secured "clean" housing. Participants who were able to secure housing mentioned a lack of housing where they felt safe or comfortable, and substandard housing units in general.

In terms of addictions, participants reported that experiencing addictions led to being turned away from health services because the concerns that brought them to mental health or health services were reframed as addiction issues, resulting in them being denied help. Participants reported experiences such as intentional overdoses due to mental health concerns being reframed as accidental by health care practitioners due to substance use, or the presence of substances in their system resulting in being turned away from crisis-oriented mental health services. Those who had been silenced or turned away from help due to substance use reported that they coped with the erasure of their suffering by no longer asking for help, even during times of crisis.

RECOMMENDATIONS FOR ACTION

Provided here are recommendations for further action. These recommendations were developed from participant responses regarding changes they would like to see in the mental health system and/or people's views of mental health, and who they would like to know about their experiences.

INCREASE COMMUNITY-BASED MENTAL HEALTH RESOURCES

Morrow, Fischmuth & Johnson (2006) write, "Since the deinstitutionalization movement of the 1950s and 1960s, advocates have consistently pointed to the lack of supports for people with mental illness at the community level and highlighted the links between mental illness, poverty and social disenfranchisement" (p. 11). In Victoria, while participants lauded many community organizations and services as helpful, they also experienced difficulties in access or availability because services and organizations have limited resources - predominantly funding. The Canadian Mental Health Association (CMHA) BC Division writes in their 2015 Budget Submission, "B.C. lacks robust and accessible

community-based mental health services, effective housing supports, and adequate income supports” (p. 3). CMHA BC Division recommendations in this area include:

- (1) Increase spending in the area of community-based mental health and substance use services. Track subsequent cost avoidance (e.g., reduced hospitalizations, police response, incarceration) to ensure that savings are re-invested in programs and services which support mental health
- (2) Invest in other community-based supports that form part of the community resource base, including housing, income supports, education, and employment. (p. 8)

When participants spoke about what resources had helped them with their (or their clients’) mental health, community-based resources were mentioned most frequently. As mentioned above, resources and organizations they considered most helpful were those that provided peer-based support, educational groups, support with system navigation and outreach, and other elements of mental health care that fall outside of the dominant biomedical model.

MORE CULTURALLY DIVERSE SERVICES ARE NEEDED

The Canadian Mental Health Association (CMHA) Winnipeg branch and the Public Interest Law Centre of Manitoba write,

Mental health services do not always respect the diversity among people living with a mental illness and recognize that every person’s experience with mental illness is different, particularly the cultural differences in understanding mental illness and supporting/treating a person living with a mental illness. (2011a, p. 22)

As stated above, the greatest barrier mentioned by participants in relation to Newcomer status to Canada was language. Staff at community agencies

often have to act as interpreters, and even if the health care system is able to provide an interpreter, practitioners often appear impatient with the interpretation process. Also mentioned was the general lack of culturally diverse services either within the mental health system or the community in general; for example, it is very difficult to find a counsellor or practitioner in the community who is culturally aware and/or can speak in a language that is not English. For children of newcomers to Canada, the dominant Western, individualistic approach to learning in schools can result in their experiences being painted in a “mental health colour” unnecessarily. A positive example of cultural diversity in the school system that was mentioned was George Jay Elementary School, which has a dedicated multicultural worker for children and families. Furthermore, participants spoke of the alienation that newcomers to Canada feel when trying to access services, leading them to give up trying to find help and “suffer in silence.”

“I want to see, you know, my clients very happy because they feel welcome there. When they go to see a doctor or when they go to some agencies, they feel quite alienated. . . . You know, you feel like ‘oh maybe I’m in the wrong place.’”

“More staff, definitely more staff in the services. And also if the professionals in this field . . . have some training. More trainings or workshops about multiculturalism because this topic is not something we can avoid any more ‘cause now we have many people coming to Canada every day.”

HELP WITH SYSTEM NAVIGATION

Help with system navigation was mentioned by both participants with lived experience and those who work in community organizations. Participants mentioned experiences of needing to “know the right person” in order to access help, not knowing where to turn for assistance when they wanted to ask for help, feeling lost after accessing help, and a

lack of follow-up from acute care. Organizational staff discussed the need for services to become more integrated, and greater collaboration between the institutional mental health system and community organizations.

“As an organization we . . . would like to see some connection, either with mental health or with the psychiatrist; I think they’re all under Mental Health VIHA.”

“But then I kind of feel like you’re left on your own to kind of flounder and figure out where you can go for support. I think that there needs to be some kind of person that is almost like their role would be to help navigate people through the mental health system and through the community organization and to . . . help them to become aware of what’s available out in the community.”

ACCESS TO INDEPENDENT ADVOCACY

In 2010, Canada ratified the UN Convention on the Rights of Persons with Disabilities. The Canadian Mental Health Association (CMHA) Winnipeg branch and the Public Interest Law Centre of Manitoba (2011b) created an instrument to evaluate Canadian policies, legislation, and standards that would embody the principles of the UN Convention on the Rights of Persons with Disabilities. Measurable outcomes related to advocacy include:

- (1) Persons living with a mental illness are able to openly and actively advocate for their human rights
- (2) Persons living with a mental illness have access to a competent person or body, independent of the mental health system, who can, if necessary, assist them to understand and exercise their rights
- (3) Independent and sufficiently resourced advocates in hospitals and in the community are available
- (4) Independent advocates should be present and consistently monitor mental health

facilities and community-based practices that provide services to persons living with a mental illness.

As stated above, participants discussed experiences of feeling as if they had no rights when trying to access mental health help, or when being forced to access mental health help by being certified as an involuntary client under the BC *Mental Health Act*. While BC once had an independent BC Mental Health Advocate, this office existed for less than five years. As of 2015, there has not been an independent advocate for mental health in BC for over a decade.

“Maybe they should have like, a committee, like a watchdog that watches over them . . . and it shouldn’t be made up of those people but it should be made up of mental patients.”

INCORPORATE A CRITICAL UNDERSTANDING OF MENTAL HEALTH INTO STUDENT CURRICULA

Participants also focused on increasing a critical understanding of mental health for students, largely because of the negative experiences that they had had with staff who are already working in (or around) mental health. Participants mentioned that the best audience for a fresh understanding of mental health was students, who are already “ripe for learning.” Students in the post-secondary environment were mentioned most often in relation to a change in how we educate practitioners who end up working in (and around) mental health. Younger students, such as those in elementary, middle, or secondary schools, were also mentioned as potential audiences for an increased understanding of mental health.

“Again it would be really good if it was [discussed] in university or colleges as well . . . but especially yeah, students . . . who are anyway, anywhere involved with clients with mental illness or addictions or anything like that.”

CONCLUSION: WHERE DO WE GO FROM HERE?

This project was designed to provide a snapshot of the lived experiences of mental health problems and disabilities in the community of Victoria, BC. The overarching concern raised during the research process was that Victoria's mental health system has no "middle ground" and is designed to deal solely with extremes. Many services that are available fall under the category of "all or nothing" - a person can either access basic help in a "timely" manner when experiencing a mental health crisis, or they are left alone to navigate poorly integrated services only to be placed on waitlists that are often months long. Mental health resources that are partially filling this void of the "middle ground" are those which are community-based, including the services and programs of many non-profit community organizations, and some community-based programming on behalf of Island Health.

Through this snapshot of experiences of mental health in Victoria, BC, we were able to situate broader systemic issues within "our own backyard." It is our hope that by making visible the (often) invisible experiences of marginalization associated with mental health struggles, we can create space for a new conversation about mental health, a conversation that honours peoples' lived experiences and reveals the processes and practices that produce and reproduce marginalization.

"We have to talk about it . . . and say, 'hey, this is what's going on here,' so it's not a big deep dark secret that's just swept under the rug, right. This is right here, this is real, this is what people in everyday life are facing."

Author's Note

As a person with lived experience, I would like to extend my sincere gratitude to all participants in this project for sharing their struggles and triumphs in order to make this project a reality. I would also like to thank all individuals and community organizations (not identified for confidentiality reasons) who collaborated with myself/VIPIRG during the research process by helping to spread the word, participating in brainstorming sessions, recruiting possible participants, providing space free-of-charge, and coordinating interview schedules.

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