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# PATHWAYS TO COUNSELLING FOR LOW-INCOME CALGARIANS

BY

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## Dedication

This project was designed to support my community, and I received a community of support to get this done. I want to thank my partner Scott, for giving me the space, encouragement, and grammar to work on this thesis. I also want to thank my supervisors Dr. Jerry and Dr. Edwards for guidance, nudges, and pointing me in the right direction. To my friends and family, thank you for inspiring my exploration into journey mapping, punching up my posters, and your patience as I proudly showed my progress along the way. In appreciation of my dad who shared his curiosity and love of exploration with me. Lastly, I want to thank and give hugs to my critters: Jones, for being by my side every step of the way, and Rachel, for inspiring me to get this done. I love you all.

**Abstract**

This study explores the question: What are the pathways and experiences of seeking mental health support for people with lower incomes? Qualitative semi-structured interviews were conducted with five Calgarians who self-identified as lower-income and who had sought out mental health support. Data were analyzed using heuristic inquiry and journey mapping. Phases of the journey and key actions, facilitators, barriers, and opportunities were identified. Journey phases included: *navigating the unfamiliar, crisis, pipeline to medications, decision for further supports, counselling loop,* and *disengagement.* The study identified barriers and facilitators to counselling and mental health support linked to journey phases. These findings provide insight into opportunities to improve access to mental health support for lower-income individuals that can be owned at the systems, organizational, and individual levels. This research contributes to a more context-dependent understanding of the barriers lower-income individuals face in accessing mental health support and provides guidance for adjustments that can be made for improved processes.

*Keywords:* heuristic inquiry, journey mapping, mental health support, user experience, barriers to access, counselling.

## Table of Contents

## List of Tables

## List of Figures and Illustrations

# Chapter 1. Introduction

Counselling is an effective tool for aiding individuals grappling with mental health concerns. Its efficacy and cost-effectiveness are comparable to, and in some cases, surpass that of medication for specific mental health concerns (Cuijpers et al., 2020; Leichsenring et al., 2022; Sava et al., 2009; Shifrin et al., 2022). When people are given a choice, individuals across income brackets often show a preference for counselling over medication as their desired method of mental health support (McHugh et al., 2013). Despite this similar preference, those with lower incomes tend to use medications more and counselling less when compared to those with higher incomes (Bartram, 2019; Giebel et al., 2020; Lauzier et al., 2018).

The discrepancy in the use of counselling or medication between socioeconomic classes suggests that those who seek mental health support with lower socioeconomic statuses (SES) may have less interest, fewer opportunities, or more personal and institutional barriers to counselling. Understanding the paths people take to get support and their experiences on these paths allows us to audit our current model for mental health support. The journeys of these users can identify what is working well and opportunities for improvement to help meet the needs of this population. By making a more equitable system tailored to the usage patterns of lower-income individuals, decision-makers can create better access and options to support their mental health.

## Motivation For the Study

My motivation for this is rooted in my experience with individuals exiting homelessness. I became familiar with the community resources available to support lower-income Calgarians in my previous work. These resources included connecting people with doctors, psychiatrists, and other mental health support. The way the infrastructure was set up, having someone attached to a doctor and psychiatrist, was straightforward. However, it was more convoluted when connecting individuals with

counselling support. I also noticed that free or low-cost options connected some of Calgary's more vulnerable and higher acuity citizens with behaviourism-dominant short-term counselling. Alberta Health Services (AHS) offered other solutions that had long waitlists. Some initiatives would be funded for a short term and are challenging to find. Some individuals could get funding for other counselling services, but it varied among income-support case workers. These offerings showed multiple considerations when looking at the accessibility of counselling in Calgary.

Those with lower incomes are a necessary population to research because of the way the mental health system is set up in Alberta. In Canada, most vital health care is free of charge to all Canadians (Government of Canada, 2023, October 10). In Alberta and many other provinces, mental health care does not fall under this coverage (Government of Alberta, n.d.-b). This boundary in funding creates a two-tiered healthcare system that disproportionally affects those with lower incomes (Bartram, 2019).

My research interests led me to address a question that could provide practical solutions to support lower-income individuals seeking mental health support. I learned about user experience research. This approach examines a person's process to accomplish their goal so that this process can be optimized (Gibbons, 2018). This approach inspired me to investigate the process of lower-income individuals gaining access to mental health support. By looking at the intersections of opportunities, barriers, and decisions for lower-income individuals accessing mental health support, decision-makers can better understand our opportunities to create more accessible counselling pathways to this support in Calgary.

**Statement of Problem**

There is unequal access to counselling based on income. Despite having a preference for counselling, those with lower socioeconomic statuses are taking

medications at a higher rate than those with higher socioeconomic statuses (Bartram, 2019; Giebel et al., 2020; Lauzier et al., 2018). The purpose of this research is to understand the paths and experiences of people seeking mental health support, discover why there is this discrepancy, and consider system-level corrections.

More research is needed on the pathways to counselling for lower-income individuals in Calgary. Previous literature focuses on the internal and neighbourhood influences on why people with lower SES gravitate towards medication or away from counselling (e.g. Bartram, 2019; Ngamini Ngui et al., 2012). Other literature identified structures and availability options that limited one's access to counselling (e.g. Bartram, 2019; Moroz et al., 2020; Niemeyer & Knaevelsrud, 2023). The literature consistently shows the barriers to counselling independently and without time and place contexts (e.g. Bartram, 2019; Krupnick & Melnikoff, 2012). Information on barriers or facilitators linked to obtaining mental health support and counselling is missing. Research on the experiences of low-income people in a Calgarian context is also missing. Calgary has structural systems that aid or dissuade those seeking mental health support. This research explores individuals' step-by-step experiences as they navigate their pathway to accessing mental health support in Calgary. This approach can give us a better idea of what works, issues encountered, and opportunities for those seeking mental health support. Bartram (2019) argues that future research should aim to support lower-income Canadians in meeting their mental health support needs similarly to addressing their physical health needs. Using the user experience approach can uncover critical information around accessibility and further contribute to equity in mental health support access.

**Research Question**

Using heuristic inquiry, this study is guided by the research question: what are the pathways and experiences of seeking mental health support for people with lower

incomes? The purpose of this study is to gain an understanding of how people with lower incomes arrive at mental health support, as well as to understand the individuals' experiences when they took steps to support their mental health and how it affected their pathway to mental health support. The results of this study will further our understanding of the low-income individual's experiences, and this information will inform us of opportunities for system change.

**Ethical Considerations**

The research proposal was submitted and approved by the Athabasca University Research Ethics Board (see Appendix G). Working with marginalized populations requires several considerations. Those who have experienced marginalization may experience a more significant power imbalance between themselves and me (Arsel, 2017). To minimize this, I emphasized ongoing consent, built rapport with the participant, and observed for participant distress and addressed it if needed (Canadian Institutes of Health Research Natural Sciences and Engineering Research Council of Canada Social Sciences and Humanities Research Council of Canada, 2022). Participants were also provided with mental health support information (see Appendix D). Those with lower incomes have a disproportionately lower literacy rate (Denny & Grady, 2007). Therefore, the materials provided for participants were presented in plain language, verbally discussed, and I looked for signs of understanding.

# Chapter 2. Review of the Literature

## Introduction

Mental health concerns are prominent in Canadian's lives. Mental health is a person's overall mental well-being based on their emotional, psychological, and social state (Canadian Institute for Health Information [CIHI], 2019). This statement relates to how a person can respond to unexpected problems and handle day-to-day demands (Government of Canada, 2006). A *mental health concern* occurs when a person experiences changes to their thinking, mood, or behaviour that results in distress or lowered functioning (Moroz et al., 2020). Mental health concerns are common in Canada, with an estimated one in five Canadians requiring a mental health intervention (CIHI), 2019). A mental health concern is considered a disorder when a person meets the criteria according to the most current diagnostic and Statistical manual of Mental Disorders (DSM) and is diagnosed by a professional (Moroz et al., 2020). The most common mental health disorders in Canada are mood disorders, anxiety disorders, and substance-related disorders (CIHI, 2022; Steel et al., 2014), with those who fit the criteria of mood and anxiety disorders comprising 20% of the Canadian population (Government of Canada, 2006).

## Mental Health and People with Lower SES

An income disparity in Canada results in a group of people being considered lower-income or lower socioeconomic status (SES). Lower SES refers to a person's position in the economic hierarchy based on income, assets, education, and social capital (Niemeyer & Knaevelsrud, 2023). A person with a lower SES is considered economically marginalized (Juntunen et al., 2022). Those with lower income are those whose income falls below or close to the poverty line. This number ranges based on where the person lives. Canada's lower income threshold in a metropolis is $26,426 (Statistics Canada, 2023b).

People with lower SES have a higher prevalence of mental health concerns compared to those who have higher SES (Government of Canada, 2006). This difference in prevalence includes having more complex mental health concerns involving multiple diagnoses, as well as higher acuity mental health concerns (Steele et al., 2007). Those with lower SES also have a higher propensity for mental health concerns such as post-traumatic stress disorder (PTSD), anxiety, depression and addictions due to their increased risk of trauma and violence (Cunradi et al., 2002). This research shows that those with lower SES have a greater likelihood of more complex mental health concerns and more interruptions to their daily functioning.

**Mental Healthcare Options**

Canada has two main clinical support systems for those seeking mental health care. These include psychotherapy and psychotropic medication (O'Donnell et al., 2017). Psychotherapy is a clinical application of evidence-based methods to assist a person in modifying their thinking, mood, or behaviour (Cuijpers et al., 2020). Psychotropic medications are prescribed drugs that are used to alter one's mood, thoughts, mental function or behaviours (O'Donnell et al., 2017). Both are used by professionals individually or combined to support an individual with their mental health concerns or disorders. There is a growing body of evidence that demonstrates the efficacy of psychotherapy is on par with psychotropic medications (Cuijpers et al., 2020; Kamenov et al., 2017; Leichsenring et al., 2022; O'Donnell et al., 2017; Ross et al., 2019; Sava et al., 2009).

**Terminology**

Moving forward, the term *psychotherapy* will be used when referring to research that specifically examines the formal application of evidence-based therapeutic approaches that assist with modifying the person's mental health concerns (Cuijpers et al, 2020). *Counselling* will be used when the research includes psychotherapy and other

non-medical psychosocial interventions. Psychotropic medication will be referred to as *medications*.

*Mental health care* will refer to formal and clinical interventions and medications that support mental health concerns (O'Donnell et al., 2017). *Mental health support* will be used as an umbrella term that includes mental health care, medications, psychotherapy, counselling, and other therapeutic approaches related to mental health (Cutumisu et al., 2022).

**Literature Review Strategy**

In this literature review, I reviewed research on those with lower SES and their relationship with psychotherapy and counselling support. First, I will make the argument about the efficacy of psychotherapy and the discrepancy between those with lower SES's preference for psychotherapy and their uptake of psychotherapy. Second, I will outline barriers to psychotherapy and counselling. I will also discuss how the existing research on barriers can benefit from context, and how this can be done using a user experience approach.

**Medication or Psychotherapy**

The primary evidence-based approaches for mental health disorders include medications and psychotherapies (O'Donnell et al., 2017). Multiple studies across common mental health disorders report comparable treatment outcomes between these two approaches (Cuijpers et al., 2020; Kamenov et al., 2017; Leichsenring et al., 2022; O'Donnell et al., 2017; Ross et al., 2019; Sava et al., 2009). Furthermore, there is growing evidence of a higher user preference among individuals for psychotherapy over medication. However, there is a trend toward individuals using medications over psychotherapy, particularly for individuals with lower incomes being prescribed medications over counselling (e.g. Dwight-Johnson et al., 2000). This section presents research demonstrating the relative effectiveness of medication and psychotherapy,

explores treatment preferences among individuals, and examines the relationship between SES and increased medication uptake. The goal of this section is to establish psychotherapy as a valid and evidence-based approach and highlight how its reduced uptake by lower-income individuals is a sign of barriers and accessibility issues.

### *Relative Effectiveness of Psychotherapy and Medication*

There is extensive research on the relative effectiveness of psychotherapy and medication. The research designs are often quantitative, randomized control trials (Cuijpers et al., 2020; Leichsenring et al., 2022; Sava et al., 2009; Shifrin et al., 2022) and focus on a single mental health concern (Cuijpers et al., 2020; Dwight-Johnson et al., 2000; Kamenov et al., 2017). All studies reviewed indicate similar efficacy in symptom reduction between these two approaches, with some suggesting a modest increase in effectiveness when combining both (Cuijpers et al., 2020).

Going beyond symptom reduction, Kamenov et al. (2017) used a meta-analysis to examine functionality and quality of life changes of those with a depressive disorder who participated in psychotherapy, medication, or a combination of the two. The authors found that both psychotherapy and medications had modest to moderate effects on the participant's quality of life and functioning. However, when the authors controlled for publication bias, they found that psychotherapy had more of an impact on quality of life than medications (Kamenov et al., 2017). The researchers went beyond the focus of mental health symptom reduction. They examined a more holistic exploration of a person's ability to perform daily activities and their satisfaction with their life and health. This research highlights multiple factors and considerations a person or practitioner should consider when determining what mental health treatment is suitable for the individual and how, in some cases, psychotherapy could be more beneficial, depending on the person's mental health goals.

Research has started to inspect the comparative longer-term effects of psychotherapy and medication. Cuijpers et al. (2020) completed a network meta-analysis for treatments for depression. This study contributed to the research by directly comparing psychotherapy and psychopharmacology rather than the previous studies that only focused on one of these treatments. This study expanded our understanding by including both these interventions' short- and long-term effects. The authors found that both psychotherapy and medications had equal effectiveness in reducing depressive symptoms. However, participants who used psychotherapy showed more acceptance of the therapy as well as had better long-term effects on their depressive symptoms.

As the evidence for the efficacy of psychotherapies grew, researchers began to increase the scrutiny of the studies. Leichsenring et al. (2022) expanded the scope of the literature analysis and completed an umbrella review. The authors compared psychotherapies, medications, and the combination of the two. In this study, the authors used stricter criteria, focused on effect sizes and disregarded waitlist studies. The authors found a smaller effect size on the efficacy of both medications and psychotherapies. The authors also found the combined treatment to be minimally better than the single intervention. The stricter criteria may have led to the smaller effect sizes they found. The researchers had a narrow view of what they considered good research, which excluded several studies. This level of quantitative meta-analysis can take the research findings further away from external validity and practical applications.

Leichsenring et al. (2022) found that psychotherapy had better outcomes than medications for those with obsessive-compulsive disorder, post-traumatic stress disorder, and borderline personality disorder. However, the authors note that this difference may not be clinically meaningful. The differences that favour psychotherapy over medications mentioned in the meta-analyses previously reviewed may be in a

similar situation. Until more research is completed to decipher this, the takeaway is that psychotherapy and medication interventions are generally at equal efficacy for common mental health disorders. Each has unique characteristics that can make them more effective for individuals or disorders. As it is substantiated that these two therapies are on par with one another, it is essential to look at patient treatment preferences.

### *Treatment Preferences*

Involving people in their treatment decisions improves their mental health outcomes (Lindhiem et al., 2014). American Psychological Association (APA) recommends that when evidence-based treatments show similar outcomes, the individual's treatment preference should be heavily considered (Silverman et al., 2015). In this section, I review literature that shows that people generally prefer psychotherapy over medications. This preference is consistent through different socioeconomic classes.

Client treatment preference impacts clinical outcomes. Lindhiem et al. (2014) completed a meta-analysis to understand the impact of client treatment preferences. They found that clients who received their preferred treatment had higher completion rates, better treatment satisfaction, and better treatment outcomes. The researchers attributed these results to the participants having a better therapeutic alliance with the provider who aligned with their preferences. Furthermore, the researchers found that treatments aligned with the client's preference as opposed to the client making an active choice led to better outcomes. This research highlights the importance of considering these patient preferences. Additionally, since there are increasingly more viable options for mental health support, it is important to consider patient preferences.

When given a choice, people seeking mental health treatment generally prefer psychotherapy over medication. Dwight-Johnson et al. (2000) explored the treatment preferences of those with depression. The authors found that those with higher incomes

sought treatment more than those with lower incomes. Those who did seek out the treatment tended to have a higher preference for psychotherapy than medications at a ratio of 3:1. The help-seeker's preference for psychotherapy was equal in all income brackets (Dwight-Johnson et al., 2000). This research was supported by a meta-analytic review of patient treatment of multiple common mental health disorders (McHugh et al., 2013). The authors found that individuals preferred psychotherapy over medications at a significantly higher rate, with no differences noted between income brackets (McHugh et al., 2013). This information suggests that the differences in treatment modality uptake between economic classes may relate to differences in opportunities, access, or barriers as opposed to preferences.

Some of the studies are not fully generalizable to the Canadian context. The Dwight-Johnson et al. (2000) study and most of the studies included in the McHugh et al. (2013) meta-analysis are cost-matrix studies. The costs are often chosen in an American context that does not reflect Canadians' realities. Canadians may be more inclined to choose medication if the costs are fully funded by their provincial government. Therefore, there is a need to explore client preferences in a Canadian context.

The cost matrix studies do not fully consider contexts, facilitators, and barriers. When choosing, the participants are asked to consider important factors such as costs, side effects, and success rate. The participant may not have to consider other practical concerns such as childcare, transportation time, and insurance coverage. Although the lack of these considerations may show diminished external validity, it can also reveal what a person would prefer if they did not have to contend with these barriers. This information illustrates the need to learn more about what is essential when making decisions.

As the research has become more robust for patient preferences, researchers have shifted focus from the psychotherapy of cognitive behaviour therapy (CBT) and investigated other psychotherapy modalities. Shifrin et al. (2022) examined multiple evidence-based treatments for those with post-traumatic stress disorder (PTSD). Consistent with previous evidence, participants showed a preference for the different psychotherapies. Those who had PTSD showed more significant interest in a CBT-type therapy over prolonged exposure (PE) therapy. The authors attribute this preference to the nature of PTSD and the natural avoidance of the exposure techniques found in PE therapy. These results highlight the heterogeneous nature of different treatments, as well as the preference differences that may continue to be seen in groups with different mental health challenges.

Psychotherapy is an effective tool that is generally preferred by those who are seeking treatments. However, the uptake of counselling does not match this preference, and this is more pronounced among people with lower SES (Bartram, 2019; O'Donnell et al., 2017; Wang et al., 2005). In the next section, I review the literature on SES and the uptake of mental health support.

### *SES and Medication Uptake*

Despite having equal preferences for psychotherapy over medication, those with lower SES have a higher uptake of medicines and lower uptake of psychotherapy when compared to those with higher SES (Bartram, 2019; O'Donnell et al., 2017; Wang et al., 2005). Barriers may influence the differences between service usage of those with lower and higher SES. Barriers to counselling are internal or external obstacles that make it difficult or impossible for a person to reach their goal or even formulate a plan (Moroz et al., 2020).

According to a study conducted by Wang et al. (2005), only 41% of English-speaking adults in America who had mental health concerns and lived in houses

received treatment. This percentage was even lower for those with lower incomes. Out of those who received treatment, the most common sources were general medical providers (22.8%), mental health specialists such as psychologists (16%), psychiatrists (12.3%), human services providers (8.1%), and alternative medical providers (6.8%). The study also found that people with lower incomes were less likely to receive specialized care for their mental health concerns, such as treatments from mental health specialists and psychologists. The authors noted that primary care doctors often act as gatekeepers for mental health concerns, meaning they may influence the type of treatment the patient receives. Therefore, the point of entry for mental health concerns plays a crucial role in the type of care a person receives.

In a Canadian context, Bartram (2019) took an in-depth look at how Canadians use mental health services. The authors compared the use of mental health services between higher-income earners and lower-income earners. Additionally, they considered the higher mental health care needs of lower-income individuals and standardized this inequitable distribution. They found that people with higher incomes were more likely to use non-physician mental health services such as psychologists and counsellors. They found that lower-income earners are more likely to use physician services, social workers, and psychiatrists. The authors argue that this evidence shows inequality in healthcare services due to Canada's current funding system.

The evidence from Bartram (2019) comes 14 years after the Wang et al. (2005) study. The Bartram (2019) study differs from Wang et al. (2005) in that their research shows that those seeking mental health support are using psychotherapy more than medications. However, the trend is that those with lower SES continue to have higher usage of medications than those with higher SES despite the authors controlling their acuity levels. This difference suggests that the higher uptake of medications for those with lower SES is influenced by more than the person's acuity levels.

Studies on neighbourhood deprivation supports Wang et al. (2005) and Bartram's (2019) research. In a British study, Giebel et al. (2020) found that those who lived in socially and economically disadvantaged neighbourhoods were more likely to use medication for their common mental health concerns than those living in more advantaged neighbourhoods. In a Quebec Study, Lauzier et al. (2018) examined whether neighbourhood deprivation affected the quality of psychopharmacology care. The researchers found that there was no significant difference between advantaged neighbourhoods and disadvantaged neighbourhoods in the quality of their care around medications. This study supports Bartram (2020) notion that Canada's two-tiered medical system may have effects on the uptake of medication by lower-income individuals.

***Notes on the Literature***

A recurring theme in the literature reviewed is the focus on the mood disorder depression. Mood disorders are some of the most prevalent mental health disorders in Canada (CIHI, 2019). Similarly, a large amount of the research that compares psychotherapy and medications is centred on mood disorders (Cuijpers et al., 2020; Dwight-Johnson et al., 2000; Kamenov et al., 2017). It is outside the scope of this thesis to cover the comparative efficacies, preferences, and uptake of all different mental health disorders. Even within the diseases and categories of disorders, these results can vary greatly. The section aims to give the reader general information about Canadians common mental health concerns and how they relate to the disparity between a person's preference and what is used. This review of the literature highlights the discrepancy between stated preferences and actual usage of psychotherapy by individuals seeking mental health support. Some preliminary findings speculate that this difference can be due to Canada's funding system (Bartram, 2019), the person's referral source (Wang et al., 2005), and neighbourhood advantages (Giebel et al., 2020; Lauzier

et al., 2018). In the next section, I review literature that explores further the reasons people who would otherwise prefer counselling would be led to medications.

## Barriers to Counselling

Researchers have found several general barriers to mental health support and counselling, as well as unique obstacles for lower SES individuals to access counselling. The barriers that dissuade individuals from counselling can contradict one another and the individual's specific context and characteristics. As those with lower SES are a heterogeneous population, not all the barriers found apply to the whole population.

### *List of Barriers to Counselling*

Appendix A includes a compiled table of 31 barriers to counselling derived from the literature. The table is divided into access/availability, personal, and structural/navigation categories. Many barriers listed could fit into multiple types but are represented in their best fit. Access/availability refers to external mechanisms that can prevent a person from physically going to counselling and the presence of the counselling source. Personal refers to internal circumstances, attributes, or culture that can move people away from counselling, and structural/navigation refers to systems-level barriers that dissuade people from counselling.

Access barriers to counselling generally relate to the fewer physical resources a person with lower SES has. These barriers include transportation time and costs, access to childcare, cost of counselling, and the lack of coverage from health insurance benefits (Abbas et al., 2017; Krupnick & Melnikoff, 2012; Moroz et al., 2020; Santiago et al., 2013). Other access barriers are related to time and mental load. These include the time it takes to research treatments and schedule them with competing priorities (Krupnick & Melnikoff, 2012; Santiago et al., 2013). Some of the access barriers relate to where the counselling services are situated. The locations may not be accessible by transit, or the services may have prohibitive wait times (Krupnick & Melnikoff, 2012;

Moroz et al., 2020). Additionally, the employment norms for those with lower SES can be restrictive to attaining counselling, such as working shift-work jobs that make it difficult to schedule weekly appointments or the requirements to take unpaid time off to attend counselling (Dwight-Johnson et al., 2000; Krupnick & Melnikoff, 2012; Santiago et al., 2013).

Personal barriers to counselling can relate to a person's personal or social capital, disposition, or consequences of being marginalized. Researchers have found that those who have less community support, less education, or less insight into their conditions are less likely to seek mental health support (Bonin et al., 2007; Fikretoglu et al., 2022; Steele et al., 2007). A person with a lower SES's values, beliefs, or culture could be dissuaded from seeking counselling support (Santiago et al., 2013). These include that those who value autonomy were taught by their peers to have lower expectations of service providers and feel misunderstood by middle-class psychotherapists (Alang & McAlpine, 2019; Krupnick & Melnikoff, 2012; Lavell, 2014; Santiago et al., 2013). A person's past choices and lifestyle may lead them away from counselling. For example, the person may have several competing obligations and may choose not to prioritize counselling, or the person may have already started medications and found that they are already managing their symptoms (Dwight-Johnson et al., 2000; O'Donnell et al., 2017; Santiago et al., 2013). Lastly, the person may be less likely to seek counselling due to the perceived societal stigma around seeking help. They may avoid counselling because they believe having a mental health problem is dishonourable, and it is hard to hide going to counselling appointments. They may have a history of being mistreated by authority figures and may have difficulties trusting a counsellor, they may feel judged by the middle-class therapist, and they may be avoiding the label of a person with a mental health problem (Fikretoglu et al., 2022; Krupnick & Melnikoff, 2012; Thompson et al., 2012).

Navigational and structural barriers to counselling relate to how the system is set up or how the government or other decision-makers design policy. The way the funding is allocated, the design of city neighbourhoods, and the quality of education have an impact on whether a person will access counselling (Abbas et al., 2017; Giebel et al., 2020; Moroz et al., 2020; Ngamini Ngui et al., 2012; Santiago et al., 2013). The psychotherapy institutional policymaker's decisions impact counselling uptake for those with lower SES. Researchers found that psychotherapists often have a lack of training to work with those with lower SES and that there is a scarcity of therapists for many cultural groups related to those with lower SES (Krupnick & Melnikoff, 2012; Santiago et al., 2013). Researchers have also found an implicit therapist bias where psychotherapists are more likely to offer treatment to those with higher SES (Niemeyer & Knaevelsrud, 2023). The process of navigating the structures to enter psychotherapy impacts uptake. Convoluted processes can lead to difficulties in obtaining low-cost services, and the first professional contact for mental health support can also influence what type of support a person receives (Bartram, 2019; Cutumisu et al., 2022; Krupnick & Melnikoff, 2012; Moroz et al., 2020; Santiago et al., 2013; Wang et al., 2005).

### *Quantitative Barriers*

Research on the barriers to counselling uses both quantitative and qualitative strategies. Researchers who used quantitative methods (O'Donnell et al., 2017) provided inferences on what barriers were more present among respondents than others. However, this strategy often employed a drop-down list of pre-selected responses. In the case of O'Donnell et al. (2017), nearly one-third of respondents selected "other," showing the limits of the pre-written list. Additionally, this survey style indicates the presence of the barrier but cannot capture the impact of each of the chosen barriers on the individual.

Quantitative researchers varied on the dominant influences to attending counselling. O'Donnell et al. (2017) found that those with lower incomes avoided mental health treatments because they valued managing their condition on their own. Fikretoglu et al. (2022) found that the leading facilitator for someone to enter counselling was the person's belief that something will work. Research from the Canadian Institute for Health Information (CIHI) reported that the majority (62%) of financially insecure respondents seeking mental health support did not believe they had adequate support to navigate the mental health care system in Canada. The variations of the top influencers for seeking psychotherapy show how what is included in the survey list can influence stated outcomes. It also shows the limitations of this assessment style as it would be difficult to survey people with over thirty answer options per question.

***Qualitative Barriers***

The qualitative research reviewed used open-ended questions that elicited a large amount of data on barriers to psychotherapy. These findings opened up a multitude of angles to consider, such as the systematic barrier of those with lower SES commonly not receiving paid time off to attend counselling (Dwight-Johnson et al., 2000) or the role that historical distrust of authority has in choosing mental health support (Krupnick & Melnikoff, 2012). A catalogue of possible barriers can support decision-makers when developing policies or help develop a hypothesis for evaluating current systems. This catalogue of barriers can be improved by developing theories on which barriers are most significant in different contexts.

The barriers found in qualitative research are conflicting. Shifrin et al. (2022) found that stigma was a barrier that stopped people from entering psychotherapy. At the same time, Reger et al. (2013) found that respondents reported a stigma to taking medication. When examined closer, both statements can be easily true. However, it

could be helpful to understand each of the circumstances and contexts better. Further research that contextualizes the different barriers can support these distinctions.

### *Barriers and People with Lower SES*

Many barriers could be applied to all SES classes, while others are more specific to those with lower incomes. For example, the CIHI data showed that those with lower incomes reported less satisfaction with the support they received for navigation than those with higher incomes (CIHI, 2022). Alang & McAlpine (2019) research found that those with lower SES and higher acuity mental health concerns had better outcomes when they were referred to mental health support as opposed to those with higher incomes and lower acuity mental health concerns. The latter group had better outcomes when they self-referred themselves for mental health support. This finding shows that there are some distinct barriers to counselling for those with lower SES, as well as general barriers affecting those across different income brackets.

### *Context Dependent Barriers*

Researchers have started contextualizing some of the barriers based on the clients' pathway to support. Fikretoglu et al. (2022) found that stigma plays a more significant role for those attending counselling before engagement, as well as at the initial stages. Stigma against counselling lessened or became less important as the person became more engaged in the process. This distinction allows decision-makers to make more targeted interventions to combat stigma. This research project aims to find more of these distinctions.

## Study Purpose

This study's purpose is to understand better how barriers interact with seeking mental health support for low-income individuals. There is significant research that shows the effectiveness of psychotherapy for common mental health disorders (Cuijpers et al., 2020; Kamenov et al., 2017; Leichsenring et al., 2022; O'Donnell et al., 2017;

Ross et al., 2019; Sava et al., 2009). Studies also show that people across incomes generally prefer counselling over medications (Dwight-Johnson et al., 2000; McHugh et al., 2013; Shifrin et al., 2022). Despite this, individuals with lower incomes use counselling as their mental health support less than those with higher incomes (Bartram, 2019; O'Donnell et al., 2017; Wang et al., 2005). This difference remains true when controlling for the acuity of their mental health concerns (Bartram, 2019). By engaging directly with individuals with lower incomes can facilitate a deeper understanding of their experiences when seeking mental health support, gaining insight into which barriers are most significant and in what contexts. This understanding will give us a better idea of what systematic changes can be done to improve access to counselling.

**Summary**

The literature review provides a foundation of published works examining the gap between the preference for counseling among individuals with lower incomes and their actual use of these services. Research shows that psychotherapy is an established evidence-based option to support those with common mental health concerns. It also indicates that those who are seeking mental health support, including those with lower SES, have a preference for psychotherapy over medication. Despite this, those with lower SES have a lower uptake of psychotherapy as compared to those with higher SES. This information indicates that other forces, including barriers, influence the actual usage of psychotherapy. Researchers have found a large number of barriers. However, research is mixed on which are the more influential aspects. Research on the context of these barriers and how they interact with the process of entering psychotherapy has started but is incomplete. By understanding the paths and experiences of those with lower incomes seeking mental health support, decision-makers can better understand what interventions could be instituted that would be impactful in increasing counselling accessibility.

# Chapter 3. Methodology

## Introduction

The goal of this research is to better understand how people with lower incomes arrive at mental health support and their experiences for each of these steps. In this chapter, I outline how I used heuristic inquiry (Moustakas, 1990) to create a journey map (Kalbach, 2021) of those with lower SES seeking mental health support. This format provides information on the participants' experiences and motivations while seeking mental health support. The analysis will focus on steps taken, what works, issues encountered and opportunities for Calgary services to align with the needs of these individuals in accessing mental health supports.

## Research Framework

This project used a qualitative research approach. This approach uncovers meanings a person or group assigns to human or social phenomena (Creswell & Poth, 2018). Qualitative research is used to understand phenomena with interrelated, dependent, and contextual variables and provides a holistic understanding of the studied area (Mertens, 2019). Qualitative researchers collect data from people and places in naturalistic settings and analyze the data using both inductive and deductive techniques to establish themes. They then present their interpretations of the data in rich and complex discussions (Creswell & Poth, 2018). The qualitative approach benefitted the research question because much is unknown about the interactions of barriers and the path to mental health support for lower-income individuals. This approach provided a holistic view of what is happening through the lens of the participants' experiences and supported the conceptualization of how these experiences relate (Wertz et al., 2011).

### *Paradigm*

The pragmatic paradigm guided this project. A research paradigm is a framework of beliefs and assumptions that guides research decisions, analysis and actions

(Creswell & Poth, 2018; Mertens, 2019). Researchers adopting a paradigm allow the reader insight into their assumptions. This insight enables the reader to place the research project among extant literature easily and communicates the author's intent to the reader (Mertens, 2019). The underlying assumption in the pragmatic paradigm is that there is a truth and that parts of this truth can be uncovered using multiple strategies (Mertens, 2019). A pragmatic researcher's goal is to find practical solutions to current problems, and they will use the tool that is most helpful for the question at hand (Creswell & Poth, 2018). This paradigm focuses the research study on practical solutions to increase counselling accessibility rather than universal or subjective truths around this problem.

### *Heuristic Inquiry*

This project was guided by heuristic inquiry. I used heuristic inquiry to discover new insights and reasoning to generate conclusions based on empirical data (Moustakas, 1990). Heuristic research aligns with the pragmatic paradigm because of its emphasis on contextual understanding of the research problem. This focus can lead to problem-solving and action-orientated outcomes. Using this research method, I collected data that focused on the participant's frame of reference (Moustakas, 1990).

I used individual interviews to collect data. Interviews are an opportunity to understand a person's experiences of social institutions, cultural phenomena, and the meaning they assign to them (Josselson, 2013; Mertens, 2019). Interviews enlarge our understanding of a phenomenon's complexities and nuances (Josselson, 2013).

To analyze this data, I used an iterative process that links the data with my private experiences (Moustakas, 1990). Additionally, I connected the findings from this research to my experiences and judgements (Moustakas, 1990).

**Setting**

Calgary is the most populous city in Alberta, Canada, and sits on the traditional territories of the people of the Treaty 7 region. Calgary is the third largest city in Canada, with a population of 1.3 million (City of Calgary, n.d.). Calgary also boasts Canada's highest income and gross domestic product per capita, with the second lowest cost of living (City of Calgary, n.d.). In Calgary, 8.1% of adults aged 18-65 meet the low-income threshold (Statistics Canada, 2023c). In 2020, this threshold is $27 352 for a single adult (Statistics Canada, 2023a). The City of Calgary, in partnership with the province of Alberta, has selected options for free to no-cost counselling services (InformAlberta, n.d.). These counselling services tend to be short-term and focus on acute concerns. Other support services offer counselling in conjunction with their programming.

The province of Alberta is also responsible for managing and delivering health care services, including mental health care (Government of Canada, 2023, October 23). Alberta Health Services does not cover community counselling or psychotherapy (Government of Alberta, n.d.-b). The province is also responsible for income assistance for those with low to no income. In Alberta, those on income assistance have health care benefits. These benefits cover most generic prescription drugs, dental, optometrist, and ambulance rides (Government of Alberta, n.d.-a). Those who earn a low income but are working can apply for subsidized health insurance through Alberta Blue Cross. The coverage is similar to those just mentioned, with additional coverage for counselling at $60 a session at a maximum of $300 a year (Government of Alberta, n.d.-c). The reduced rate for adult singles earning less than $20 970 is $530 a year. The average cost for private counselling in Calgary is approximately $150 a session, with some offering sliding scale fees (Psychology Today, n.d.). These health benefits show some reduction in the cost of counselling. However, this discount is not substantial when

factoring in the high cost of counselling and the low disposable income of lower-income Calgarians.

Canada is responsible for legislation, funding, and guidance for mental health support. The Government of Canada is responsible for national standards for health care via the Canada Health Act (Government of Canada, 2023, October 10). The Government of Canada guides provincial health care decisions and procedures via contingent funding (Government of Canada, 2023, October 10). The Canadian Health Act is a set of standards that provinces and territories must follow. These standards include the following: provincial health care must be administered on a non-profit basis, health care must be comprehensive, and the province must provide coverage for anything medically necessary. The act stipulates that coverage must be universal, medical services must be accessible, and the province must cover provincial residents when travelling across Canada (Government of Canada, 2023, October 10). However, outpatient mental health services are not included in the criteria for comprehensiveness.

## Sample

### *Sample Criteria*

This project used a small criterion-based sample. The criteria for this research project are:

1) the person self-identifies as low-income,

2) the person has sought out mental health support,

3) the person is over the age of 18,

4) the person lives in Calgary, AB, and

5) the person must be able to communicate with me as the researcher and be willing to share their story.

***Recruitment***

The participants were recruited via posting at the Calgary Public Libraries (see Appendix B) and the r/Calgary sub-Reddit. Five participants volunteered to be interviewed regarding their experiences in seeking mental health support in Calgary. Out of the five participants, one was recruited via the posting at the Calgary Public Library, three were recruited through r/Calgary sub-Reddit, and one was recruited through word of mouth. The ages of the participants ranged from 25 to 35 years old. They all self-identified as low-income earners. All participants have grown up in Calgary

Criteria for recruitment relied on self-identification. This flexibility allowed for emergent findings. For example, a participant currently has a moderate-income job but supports multiple individuals is in debt, and grew up on government assistance. The criteria for specific mental health disorders are also purposely omitted. Some participants may not have succeeded in their pathway to mental health support, therefore not receiving an official diagnosis. For example, a few participants in this study found their diagnosis changing as they worked with different providers.

Participants went through a series of steps before the interview. I invited them to a phone conversation where I explained the research study and answered the participant's questions (See Appendix D for Information sheet). I then asked pre-screening questions (See Appendix E for the Interview Guide). All five participants passed the screening test and verbally consented to set up the interview. The interviews took place at a Calgary Public Library at their closest convenience. I then offered to email the participant a copy of the information sheet. At the interview, I reviewed written informed consent with the interviewee (see Appendix F for Informed Consent Form).

Participants were compensated $35 for their time. The participant time calculation included informed consent time, the interview time, and their travel time. This

total time was approximately three hours. Additionally, participants were reimbursed for estimated travel expenses.

***Depictions of the Sample***

The participants are of similar ages, which gives them a common time frame in which they experienced these journeys. The individuals also have a diversity of different mental health concerns. The mental health concerns reported are treatable by both medications and counselling. The participants tend to be more resourceful, as they showed resourcefulness in finding, responding to, and attending this study. They possibly may lean towards those who hold less stigma against mental health support, as they volunteered to speak about their journey in depth.

The following section presents the pseudonyms and the descriptions of the study participants. Descriptors were based on the individuals' self-descriptions. However, the maps connected to each pseudonym have been blended with other participants for comprehensiveness, cohesion, and anonymity.

**Selma.** Selma describes herself as culturally and family-centered. She has been diagnosed with a thought disorder. The mental health concern that she has been seeking treatment for is related to her negative experiences interacting with Calgary supports. Most of her medical and crisis interventions have been centred around her diagnosis. Selma also receives and relies on government funding due to her diagnosis. Selma is currently in a place where she has been able to complete her education to support others who are having mental health concerns. She is now shifting to find volunteer work in this sector (Figure 1 is Selma's map).

**Sasha**. Sasha enjoyed playing in band growing up. She grew up in Calgary with a single mom who was reliant on government assistance and housing due to her mother's health concerns. Sasha was diagnosed early with a neurological and developmental disorder. She was connected early with both medication and mental

health program support. Sasha's mental health concerns were related to her diagnosis and environmental stressors. She completed post-secondary and secured employment in the IT field. However, due to the corona virus (COVID), layoffs, debt, and being the sole provider for her household, Sasha does not have much disposable income (Figure 2 is Sasha's map).

**Maria**. Maria has a dark sense of humour and is passionate about cats and supporting her community. Maria has been diagnosed with a personality disorder and informally diagnosed with mood, anxiety, and neurodevelopmental concerns. She has a history of needing crisis interventions as early as 13 years. Maria has mainly used the Calgary mental health systems to support her in crisis and crisis de-escalation, although symptom management interests her. Maria has been in and out of post-secondary for six years but has not completed a degree. She has also worked in many socially supportive roles in the community. Maria is living with her grandparent and withdrawing from her education so that she can attend in a way that makes sense for her learning style (Figure 3 is Maria's map).

**Nicole**. Nicole introduces herself as neurotic, eccentric, and a couch-bound cuddler. Nicole grew up with a mother whose mental health behaviour caused a high level of environmental stress for Nicole. She has also been dealing with symptoms related to her mood, anxiety, and neurodevelopmental concerns. Nicole's symptoms went undetected until well into adulthood. She loves video games and currently lives with her husband. Nicole's skill set is in early childhood development, and she has retained a lot of positive relationships through this work (Figure 4 is Nicole's map).

**Arthur**. Arthur is a curious person who is connected with his mindfulness-based spirituality. He grew up with his parents, who were lower-income earners. Arthur started his mental health journey by working with professionals to alleviate his mood and anxiety symptoms with low success. However, Arthur found more success when the

mental health providers focused their efforts on his specific type of obsessive-compulsive symptoms. Arthur is intellectual and passionate about research and discovery. He often volunteers his time to participate in research studies (Figure 5 is Arthur's map).

## Data Collection

### *Interviews*

Participants were interviewed individually in semi-structured interviews. The duration of the interviews was 45 minutes to 90 minutes. I asked open-ended questions to allow flexibility for the participants to respond in a way that is meaningful to them (See Appendix E for the Interview guide).

Interviews were conducted at Calgary Public Library locations. The Calgary Public Library has bookable meeting rooms. They are conveniently located across the city and are usually easily accessible by transit. The Calgary Public Library is a safe choice for meeting, as it is in a public space and has its security on staff.

The data from the interview was recorded and transcribed. Two recording devices were used to record the interview. I uploaded the data from the recording devices onto a local hard drive. Then, I used Microsoft Office to transcribe the data. This system is used because the enterprise agreement with Athabasca University ensures data privacy (Personal communication, R. Stobbs, November 2, 2023). I uploaded the transcriptions to NVivo 14 for coding and analysis. NVivo 14 information is stored locally and is password-protected.

### *Mapping*

During the interview, the participant and myself drew out timelines of their experience with accessing mental health support. The participant was given two highlighters and asked to circle up to three experiences, interactions, or components

that were 1) most facilitative to receiving mental health support, and 2) cause the largest barriers to mental health support.

***Observational Data.***

I journaled observations from the interview after the interview was complete. These observations included basic information such as the location and time of the interviews. I noted observations about non-verbal cues and emotional reactions. I also commented on the relationship dynamics between interviewer and interviewee and contextual information. Additionally, I wrote reflections on the interview. I used this supplemental information to support data analysis.

**Data Analysis Process**

Heuristic inquiry uses an iterative data analysis technique that highlights the individual's experiences. The project used Moustakas' (1990) data analysis strategy. I interviewed five participants over three weeks. Data collected included the transcripts from the interviews, the maps co-generated during the interviews, and observations and reflections recorded by me directly after the interview.

The steps taken during the interview process included:

1. Interview one participant while generating a map during the session.
2. Log reflections and observations after the interview.
3. Take a step back from the interview.
4. Create a transcript of the interview and journal possible themes.
5. Interview the next participant, repeating steps 1-4

After Participant Four, I noted a repetition in themes and no new significant themes. Indicating that the research is approaching saturation. I found no new significant themes emerging after the fifth participant interview.

### *Transcription*

Each interview was transcribed in four rounds using an intelligent verbatim style (McMullin, 2023). I used Microsoft Office automatic transcription for the first round of transcription. The second round involved manually editing the previous transcript while listening to the audio recording. The third round involved reading the transcript, checking for meaning, removing filler words, correcting spelling, adding non-verbal cues, and removing identifying information. The fourth round involved checking for clarity. I used field notes to support areas of incomprehensible speech.

### *Coding*

Transcripts were coded using NVivo 14, with preliminary codes generated from journey map points of interest, themes noted during interviews, and emerging themes from transcription. Codes were grouped into themes and integrated into journey map targets of activities and touchpoints, as well as what worked and what issues were encountered. Afterwards, I created an aesthetic synthesis of the investigated phenomenon using a journey map (Moustakas, 1990).

### *Journey Mapping*

In heuristic analysis, researchers are encouraged to create an aesthetic representation of the data analysis (Moustakas, 1990). A journey map visually represents a person's experience when interacting with a system (Kalbach, 2021). In this research project, the focal point of the map is the touch points a person encounters when interacting with Calgary services, the person's actions and experiences, what worked and issues encountered. Using a journey map allows the viewer to see the moving parts of a person's journey to better to understand the experience (Kalbach, 2021).

The data was abstracted into separate journey maps in Excel and Miro. Rows were labelled for journey map targets and columns were labelled with emerged themes

and phases. After creating five maps, I consolidated the data into a master map in Microsoft Word. I formatted the final master map for clarity and readability with updated phases, descriptions, visuals, and icons. Table 1 shows the workflow of the data collection and data analysis.

**Table 1**

*Data Collection and Data Analysis Workflow*

| Heuristic Research (Moustakas, 1990). | Customer Journey Mapping (Kalbach, 2021). |
|---|---|
| Interview one participant and log observations. | |
| I immerse myself in the interview data and create a transcript. | |
| I take a back from the data. | |
| I review data for themes – keeping close to the original language of the participant's experience. | |
| Repeat for the next participants. | |
| Gather individual depictions | |
| Complete group analysis with intermittent rest intervals | |
| Arrange themes | |
| Create individual portraits | Lay out touch points in the timeline. |
| | Lay out themes on the timeline. |
| | Add actions, what worked, and issues encountered. Using rich descriptions and quotes. |
| | Add roles of organization. |
| | Simplify, amplify, clarify, and unify. |
| | Show relationship with lines. |
| | Add colour coding for major themes. |
| | Add icons. |
| | Map emotional intensity. |
| Create a synthesis of the investigated phenomenon. | Build a composite journey map. |
| | Plot touch points. |
| | Plot themes. |
| | Add opportunities. |
| Write out the analysis. | |
| Connect with extant literature. | |

### *Inclusion and Exclusions*

All of the participants' interview data was included in this analysis. No data pertaining to the actions taken by the participant or the experience of seeking mental

health support were omitted. However, during the master journey map process, some data contents shifted to different phases to support the best fit. This change reflects the non-linear nature of the path and how a person could straddle two phases at once. Quotes included were used evenly across participants.

**Qualitative Rigor**

There are several perspectives to consider to ensure the quality of heuristic research. *Credibility* is a constructivist concept where the reader deems the research valid (Mertens, 2019). In heuristic research, the researcher ensures credibility by staying close to the data. I began the analysis by looking at the data paragraph by paragraph. Then, I further supported credibility by triangulating results with extant literature (Mertens, 2019). *Applicability* is a standard for qualitative research that determines if the study fits with the intended field of study, if the research findings are general enough to be useful without being too abstract, and if the research findings could support change (Mertens, 2019). To support applicability, I focused the research question and analysis on the data that can support change. *Transferability* is the qualitative version of external validity (Mertens, 2019). It involves the degree and ease readers can apply the research findings to their contexts (Mertens, 2019). I used thick descriptions to increase transferability, staying close to the individual's experience in the coding process (Moustakas, 1990). Each of the themes is comprised of many initial codes. These codes provide much context for the final concept. The concepts are then articulated in the research report using thick descriptions so the reader can judge the transferability (Mertens, 2019).

# Chapter 4. Results and Discussion

## Introduction

Understanding the journeys of low-income individuals seeking mental health support reveals insights into the barriers and pathways they navigate. This section examines the results of the research question, “What are the pathways to and experiences of seeking mental health support for people with lower income?”. Five participants were interviewed. A heuristic data analysis uncovered six non-linear phases the participants experienced in their search for care. The phases are: *navigating the unfamiliar, crisis, pipeline to medications, decision for further supports, counselling loop*, and *disengagement*. For each phase, key actions, challenges, successes, and opportunities for improvement were identified. This chapter presents five depictions of individuals seeking mental health services alongside a composite map synthesizing their experiences. The analysis will also explore the implications of these findings and relate them to existing literature.

## Journey Maps

The journey maps provide a person-centred, visual perspective on how individuals interact with Calgary’s institutions. The maps emphasize their experiences, challenges, and successes in seeking mental health support (Kalbach, 2021). These maps highlight areas where Calgary’s systems can be improved to enhance accessibility to mental health services and counselling for lower-income residents.

Six maps were created: five maps are *individual depictions* that follow individual study participants as they seek mental health support. These maps allow readers to connect with specific details of a target group by linking them to personal stories and making the information more relatable (Kalbach, 2021). Grounded in the research data, each map reflects key attributes of the participants and offers a personalized view of

their experiences. These individual depictions highlight unique challenges and opportunities and provide insights rooted in context.

The sixth map is a *composite depiction*, synthesizing the five individual maps into a cohesive narrative (Kalbach, 2021). This map provides a generalized representation of the data and highlights common patterns and experiences shared across the research group (Kalbach, 2021). The composite map reveals recurring challenges and shared opportunities for improvement. It serves as a tool to identify broader trends and offers a more holistic view of the mental health support journey for low-income individuals aged 25-35 in Calgary.

### *Interpreting the Maps*

There are two styles of maps in this chapter. The *individual depiction* map is a journey based on the data gathered from each of the study's low-income mental health service seekers. The *composite depiction* is the combined experiences of the five study participants in a generalized map that represents common patterns and shared experiences (Kalbach, 2021). These maps are divided into phases that depict the study participants' individual and composite journeys such as *navigating the unfamiliar* or *crisis*. These phases are represented in the columns.

**Individual Depictions.** In the individual depictions, the target information is organized into rows, including: key actions, current activities, institutions encountered, emotional responses, quotes, and opportunities.

- Key Actions: details the steps the person takes to seek mental health support.
- Doing: provides context of the person's experience by describing what the person is doing at each phase.
- Institutions: includes images representing the Calgary services used during each phase.

- Emotions: captures the person's emotional levels to illustrate how interactions impact them.
- Quotes: reflects the person's inner experiences, offering personal insights into their journey.
- Opportunities: identifies potential changes or improvements that could improve the person's experience in each phase.

In the individual depiction maps, icons and bold text emphasize areas highlighted by participants. During the interviews, the participants identified the experiences that most facilitated or hindered their mental health support journey. Additionally, they were asked to suggest the changes that would be most meaningful to them. These insights are visually represented in the maps with icons and bolded text. This emphasis draws the reader's attention to the participants' priorities and recommendations for improvement.

**Composite Depiction.** The composite depiction map's rows are organized with key information such as activities and touchpoints, quotes, successes, issues encountered, and opportunities. The rows that differ from the individual depiction maps include:

- Activities and Touch Points: combines key actions, doing, and institutions, focusing on common elements of participant interactions during each phase.
- What Worked: highlights a collection of experiences and interactions participants reported as beneficial in their mental health support journey.
- Issues Encountered: summarizes the barriers participants faced when seeking mental health support.

Readers are encouraged to explore the maps and reflect on their initial impressions. They are also invited to revisit the maps at the end of the chapter or after

some time for reflection and to identify potential opportunities based on their role within the system. This process allows the reader to gain deeper insights and consider areas for improvement from their perspective.

**Figure 1**

Selma's Map

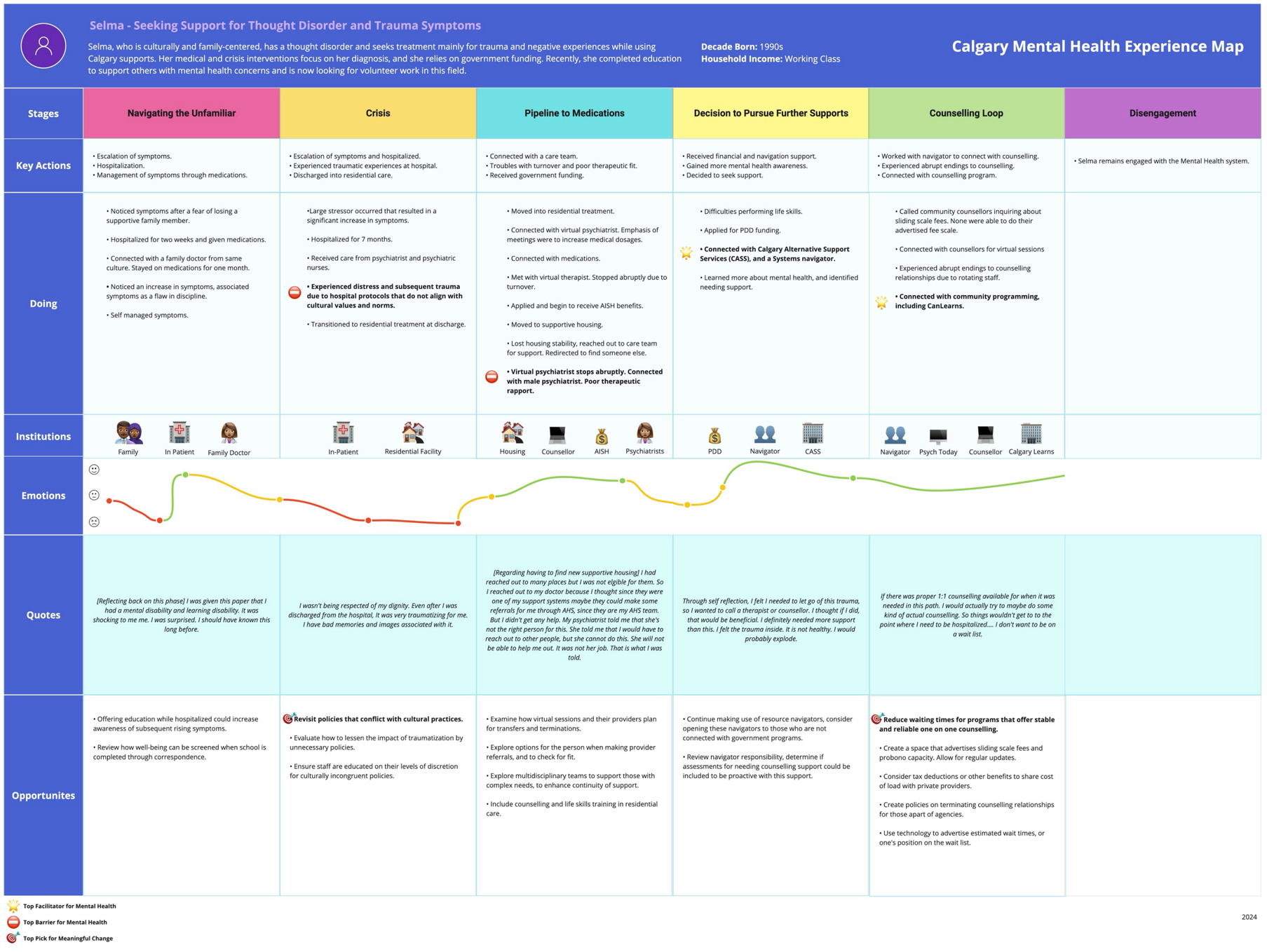


**Figure 2**

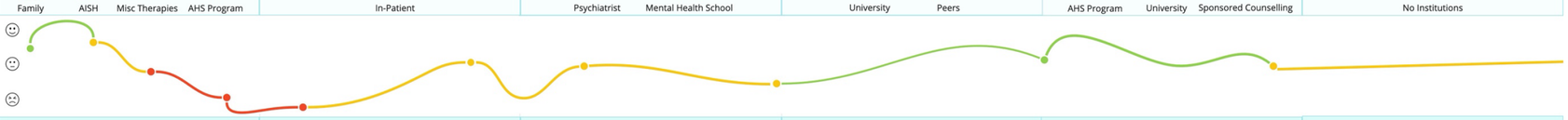
Sasha's Map

## Sasha - Seeking Support for Autism Related Symptoms

Sasha grew up in Calgary with a single mom on government assistance due to health issues. She enjoyed band and was diagnosed early with a neurological and developmental disorder, receiving medication and program supports. Her mental health concerns stem from her diagnosis and environmental stressors. Sasha completed post-secondary and works but has limited expendable income due to COVID layoffs, debt, and being the sole provider for her household.

**Decade Born:** 2000s
**Household Income:** Government Assistance

## Calgary Mental Health Experience Map

| Stages | Navigating the Unfamiliar | Crisis | Pipeline to Medications | Decision to Pursue Further Supports | Counselling Loop | Disengagement |
|---|---|---|---|---|---|---|
| Key Actions | • Early signs and early intervention for mental health.<br>• Mismatch of services.<br>• Escalation of symptoms. | • Continued escalation of symptoms.<br>• Hospitalization.<br>• Discharge without counselling supports. | • Connected with psychiatrist and medications.<br>• Connected with mental health school.<br>• Stopped both treatments due to poor fit. | • Learnt about opportunities and available supports.<br>• Decided to seek support. | • Connected with programming.<br>• Testing offered, no follow up included.<br>• Stopped due to non-financial barriers and turnaround. | • Lack of accessible programming. |
| Doing | • Symptoms for a neurological development disorder were identified early.<br>**• Entered play therapy at five years old. Attended for 1-2 years. Found the environment inviting and facilitated her engagement in the program.**<br>• Received testing for mental health concerns.<br>• Entered family counselling. Had a bad rapport with the psychologist and found the target of the therapy was not focused on her concerns.<br>• Escalation of symptoms.<br>• Entered a AHS program for mental health support. Appreciated the check ins, however did not find the programming match her needs or acuity. | • Continued escalation of symptoms.<br>• Self referred to hospital due to concerns over safety.<br>• Worked with Psychiatrist.<br>• Not consulted on medication planning or potential side effects.<br>• Negative experience with the group programming.<br>**• Was able to stabilize, and not harm self.**<br>• Discharged with updated medication, and connection to a mental health school. | **• Referred to mental health specific school. Self-discharged after one month due to poor fit.**<br>• Connected with community psychiatrist.<br>• Stopped using medications due to not being the right fit. | • Learned about further supports from peers.<br>• Offered government funded testing.<br>• Decided to pursue opportunities presented.<br>• Entered waitlist. | **• Started attending counselling program: Bridging the Gap**<br>• Built rapport with counsellor.<br>• Counsellor left due to income constraints. Made decision to stop attending due to this.<br>• Received funded assessment services through university. No funding for recommended follow up supports.<br>• Received therapy sponsorship fundings. Attended therapy through program.<br>• Stopped therapy due to non-financial barriers, such as scheduled offered, and not having a space to do virtual therapy. | • Ended supports due to non-financial barriers.<br>• Unable to access youth mental health supports due to aging out.<br>• Would like to reengage but cannot afford therapy.<br>• Currently here. |
| Institutions | Family, AISH, Misc Therapies, AHS Program | In-Patient | Psychiatrist, Mental Health School | University, Peers | AHS Program, University, Sponsored Counselling | No Institutions |
| Emotions |  | | | | | |
| Quotes | *Play therapy was awesome as a kid. I think that it made me feel more comfortable with therapy. It made me more likely to seek therapy later on because, like, who doesn't like toys.*<br>*[Why the AHS Program didn't work] I was in a pretty dark place at the time. I think had I've been in a better spot, it would have. I would have gotten better. But I do think that it helped me not just completely implode on myself for a while. So i was grateful for that.* | *I think the introductory medication was not particularly good. But I found that the while the point was to keep me safe while I was trying to come back from things.* | [Re the mental health school] I felt like it was very patronizing and they were like it were weirdly strict about things... I got strep and they wouldn't let me have tea, I couldn't have cough drops. I couldn't have anything, so it was just really uncomfortable. So I quit and my mom let me quit. | *Part of the problem is that the program has to be the right fit. But you don't really know until you are there. Every time I accessed a new support, it was like starting over. I know that obviously they can't know everything about me. But I just wish there could be a way I can express what didn't work for me. Because every single program, when you start. They want you to try that again. So I was often exposed to things that didn't work for me over and over again because I had to start from the start.* | *[Bridging the Gap] I had a good experience there, but the therapist that I've been seeing for quite some time. She couldn't afford to continue on the program anymore. She had to look for somewhere that paid a bit more... then I just ended my time there because I was afraid to go try and find someone else because my experience has been kind of negative.*<br>*The problem I had was [Sponsered Counselling] as much as I would have liked to have continued. I had to be able to have a quiet private place during the week to host my meeting. But I don't drive. I didn't have anywhere private to go. I had to go to work and I couldn't just leave for an appointment. You know, I mean, so it wasn't really very accessible to me. So I ended up quitting that one* | *I feel like now that I'm 25, I'm seeing less resources available to me and I'm still struggling financially ... and it's it's kinda scary and like right now I could really really use a mental health support and I can't afford it, so I wish there was more things for people my age.* |
| **Opportunities** | • Early connection with system for more physical mental health disorders opens opportunities for further ongoing mental health supports.<br>• Continue with client led programming to support feelings of independence.<br>• Consider how these supports can be extended to those who are not already connected with the system.<br>• Offer similar style programming for those approaching crisis levels, as opposed those who are already past these levels. | • Increase collaboration on treatment planning and medication changes.<br>• Provide flexibility for patients who may not benefit from all programming. | • Collaboration could help put the person into the supports that are a better fit and more buy in for the treatment.<br>• Collaboration for medications to support medication adherence.<br>• Avoid one size fits all programming. | • Word of mouth supports interest in entering supports. However, this requires stability of the programming and availability of the resource.<br>• Consider strategies to bypass starting from scratch. | **More funding for programs like Bridging the Gap. As well as other mental health options that are free, low barriered, and tailored to the individual.**<br>• Examine impact of staff turnover in the social programming available to lower income individuals. Look into possible causes such as compensation, and recruitment model.<br>• Consider funding to help individuals follow up on recommendations after their assessments.<br>• When choosing providers for programming, include those who are available in a variety of hours. | • Expand programming that is available to youth, and create opportunities for older adults to participate. |

**Top Facilitator for Mental Health**
**Top Barrier for Mental Health**
**Top Pick for Meaningful Change**

2024

**Figure 3**

Maria's Map

## Maria - Seeking Support for Borderline and ADHD Symptoms

Maria, with a dark sense of humour, loves cats and supporting her community. Diagnosed with a personality disorder and informally with mood, anxiety, and neurodevelopmental concerns, she needed crisis interventions from age 13. Maria has been in and out of post-secondary education for six years without completing a degree and has worked in supportive community roles, including homelessness support. Currently living with her grandparent, she is withdrawing from her education to find a learning modality that suits her.

**Decade Born:** 2000s
**Household Income:** Working Poor

## Calgary Mental Health Experience Map

| Stages | Navigating the Unfamiliar | Crisis | Pipeline to Medications | Decision to Pursue Further Supports | Counselling Loop | Disengagement |
|---|---|---|---|---|---|---|
| **Key Actions** | • Sought out emergency care.<br>• Entered outpatient care.<br>• Cycle of being kicked out and re-referred. | • Escalation of symptoms.<br>• Hospitalization.<br>• Discharge without counselling supports. | • Received helpful medication.<br>• Faced difficulties refilling medications due to stigma.<br>• Refused counselling waitlist. | • Received mental health assessments.<br>• Received updated medications.<br>• Became eligible for financial support. | • Moved straight to disengagement. | • Lack of access to meaningful supports.<br>• Awareness of professional stigma.<br>• Disengaged from process. |
| **Doing** | • Symptoms began before age 10.<br>• Learned about mental health through a friend's hospitalization.<br>⛔ **• Sought hospitalization but was turned away from urgent care due to not being a risk. Diagnosed with depression and social anxiety.**<br>• Received medications for new diagnosis.<br>• Referred to a youth psychiatry day program via Access Mental Health.<br>• Removed and re-referred to the program three times for missing mandatory group therapy. Re-referrals from family doctor.<br>• Fired doctor due to consistent increases in meds. Found new doctor and built a good rapport. | •Entered University; mental health symptoms escalated.<br>•Tried free university counselling but left due to mismatch with needs.<br>🌟 **• Hospitalized by on-call doctor for self-inflicted injuries; received inpatient psychiatric care.**<br>• Received medication and some counselling.<br>• Discharged with referrals but no follow-up.<br>⛔ **•Voluntarily readmitted to hospital, no new supports, then discharged again.** | • Placed on medication that was helpful for symptoms.<br>• Loss employment due to lack of accommodations with mental health disability.<br>• Entered work in the mental health field.<br>• Switched family doctor due to doctor leaving the field of medicine.<br>• Difficulty with finding new doctor and filling prescriptions due to diagnosis.<br>⛔ **• Refused counselling program referral due to wait time.** | • Attended university program for free mental health assessments.<br>• Saw a psychiatrist for ADHD assessment; diagnosis denied due to prior diagnoses.<br>🌟 **• Prescribed Vyvanse, which helped symptoms.**<br>• Received psychoeducational assessment.<br>🌟 **• Granted disability status and Disability Tax Credit with advocate's help.**<br>• Gained insights from assessments but no counselling offered.<br>• Chose not to pursue further supports. | • Chose not to pursue further supports. | • Working in the field, developed a better understanding of what is said on the professional side around people with her diagnosis.<br>• Currently here. |
| **Institutions** | Peers, Urgent Care, Family Doctor, AHS Outpatient | University, Drop-in Doctor, Police, In-Patient | Family Doctor | University, Psychiatrist, Advocate, Funding | No Institutions | No Institutions |
| **Emotions** |  | | | | | |
| **Quotes** | *It was outpatient counselling and it was free, which is why I went there and I was in and out of that for three or four years. The reason I was in and out of it was because I just wanted to do regular counselling there, and I really enjoy just doing like 1 to 1 counselling. But it's it was a requirement of their program at the time that you had to do group counselling as well. I really didn't want to do that.* | *I have been ignoring my mental health for a very long time before I was hospitalized the first time. So I thought it was helpful to actually do worksheets and stuff and I was like, damn, this is crazy. I can work on myself.*<br>*[Re discharge] There they told me you have to call Access Mental Health while you're here . And they basically give you the unit phone and then they they don't make sure you actually do it... I remember sitting there with the phone for a really long time and I never called them. I don't remember why, but it's just like they don't, really care. They're like, okay.., here you go.*<br>*Unless someone reached out to me for a service, I wouldn't have done it. That's why I didn't do anything.* | *I can't get out of bed and I can't do anything that I need to do and I want to hurt myself all the time and I'm doing these risky behaviours. They're like, OK, well, my, we're going to refer you to the DBT program and then they'll call you in 10 months. And it's like, OK, that's good.10 months from now, it's really delayed every single time.* | *Vyvanse has helped me, and it's very hard when you don't have an official ADHD diagnosis to get Vyvanse from healthcare providers, even if you've already been on it. So that really sucked.* | *If there was proper 1:1 counselling available for when it was needed in this path. I would actually try to maybe do some kind of actual counselling. So things wouldn't get to to the point where I need to be hospitalized.... I don't want to be on a wait list.* | *Once you start to know people in the field, trying to go back to these programs where it's like, I probably know people who work in these programs. The thing is, is that I also know how, how certain people who work in mental health talk about people with BPD and it is not nice. So I'm like, oh, it's that kind of also discourages me.* |
| **Opportunities** | • Offering more flexibility in service delivery to fit the person's needs and preferences.<br>• Evaluate criteria for AHS emergency services. Consider direct referrals for those who don't meet crisis criteria. | 🎯 **More guidance and more follow up for counselling supports following discharge.**<br>• Continue the introduction to counselling style activities while the person is in in-patient care. | • Review wait times for counselling supports.<br>• Determine if interim supports may be helpful while a person waits for a program. | • Consider the role of a diagnosis, and how this can support an individual to get treatments.<br>• Provide avenues for funding after assessments and diagnoses.<br>• Provide more transparency for referrals and waitlists. | 🎯 **Have opportunities for support available that is meaningful for the person seeking support.** | 🎯 **Provide programming for those aging out of youth mental health programs.**<br>• Increase staff awareness in helping professions that colleagues may also have mental health concerns. |

🌟 **Top Facilitator for Mental Health**
⛔ **Top Barrier for Mental Health**
🎯 **Top Pick for Meaningful Change**

2024

**Figure 4**

Nicole's Map

## Nicole - Seeking Support for Depressive and ADHD Symptoms

Nicole is a neurotic, eccentric, and couch-bound cuddler who grew up in a stressful environment due to her mother's mental health issues. She has mood, anxiety, and neurodevelopmental symptoms that went undetected until adulthood. Nicole loves video games, lives with her husband, and works in early childhood development, where she has maintained many positive relationships.

**Decade Born:** 1980s
**Household Income:** Working Class

## Calgary Mental Health Experience Map

| Stages | Navigating the Unfamiliar | Crisis | Decision to Pursue Further Supports | Disengagement | Pipeline to Medications | Counselling Loop |
|---|---|---|---|---|---|---|
| **Key Actions** | • Taking on the adult role at home.<br>• Connecting with guidance counsellor.<br>• Lack of action from system. | • Escalation of symptoms<br>• Avoidance | • Improved mental health literacy and sought support.<br>• Faced negative consequences after seeking help.<br>• Disengaged from mental health supports. | • Stops actively pursuing supports.<br>• Switches doctors.<br>• Guided by doctor to referrals for mental health needs. | • Placed on waitlist for mental health supports.<br>• Receiving updated medications.<br>• Interim mental health supports by family doctor. | • Enters AHS outpatient mental health supports.<br>• Receives 10-20 counselling sessions.<br>• Receives updated diagnosis. |
| **Doing** | • Caring for self and sister due to mom's absence.<br>• Social worker visits, no action advised.<br>• Skipping School<br>**• Meet with Guidance Counsellor, continues with this relationship.**<br>• School work adjusted by guidance counsellor so they can graduate high school.<br>**• No school mental health interventions**<br>• Met with family doctor, prescribed meds for physical symptoms; mental health not addressed.<br>**• Engage in online games for coping.**<br>• Graduate HighSchool | • Escalation of mental health symptoms.<br>• Left abusive partner.<br>• Dropped everything and left town. No supports sought out. | • Returned to Calgary.<br>• Mother enters mental health supports.<br>• Speaks about mental health with mother.<br>• Gain mental health literacy.<br>• Entered University.<br>• Escalation of stressors.<br>• Made choice to seek out support with a trusted University professional.<br>**• Negative reaction from professional led to the ending of education.**<br>• Made decision to not seek mental health supports again. | • Disengages from seeking mental health supports.<br>• Continued engagement with online games for coping.<br>**• Moved to small town with no supports.**<br>• Increase in symptoms.<br>• Moved back to Calgary<br>• Switched family doctors due to retirement.<br>• Switched family doctors due to finding a better fit.<br>**• Participated in both a physical and mental health check-ups.**<br>• Received referrals and follow ups for both. | • Placed on AHS waitlist for Mental Health Supports [16 month wait].<br>• Receives updated prescriptions for both mental health and physical health.<br>• Attended specialists for physical health.<br>• Received mental health support from family doctor while on waitlist. | • Connected with a social worker. Referral for psychiatrist goes missing. Social worker is able to sort this out.<br>•Social Worker leaves and is connected with psychologist. Session limit is reset.<br>**• Builds strong rapport with psychologist.**<br>• Receives updated diagnosis from psychiatrist.<br>• Currently still in sessions.<br>• Likely to remain connected with psychiatrist after psychotherapy sessions are completed. |
| **Institutions** | Highschool, Family Doctor, Family, CFS | No Institutions | Family, University | No Institutions, Family Doctor | AHS Outpatient Waitlist, Family Doctor | AHS Mental Health Outpatient Treatment |
| **Emotions** |  | | | | | |
| **Quotes** | *My family doctor was not stellar and I didn't know they weren't stellar. They were great for all sorts of things. Mental health was not one of them.*<br>*[Re if she asked for help with MD] I didn't know how to talk about [mental health symptoms] or give them words. I didn't know how important vocabulary is when you're trying to advocate for your healthcare.*<br>*[Re recommended supports] We were told to use the children's helpline, which is just a bunch of volunteers with almost no training and that's it.* | *I held it together until after high school. And then went off the rails. I barely remember it, but I definitely needed help, but I had to shut down my family at that point. So again, with nobody around, it was just me trying to figure out how to exist... and I did not exactly have a good example of what adulthood looked like growing up.* | *My mom had started to get healthier. I was more able to pick up on words from her because she had started talking more openly about that sort of stuff. I was more able to communicate that I was depressed. But I'm not talking to my mother about it. So that's why I said to one of my professors who I liked the most, "I don't know what to do" and that's when that whole fiasco happened. And then I dropped out.* | *Now I'm withdrawing from telling people about my issues at all, because that was the immediate well, don't do that again.*<br>*It is nice to have a doctor treat my mental health in the same way that a doctor treats physical health. She booked me a physical appointment and a mental appointment. And she books them separately.* | *[Re wait list for AHS funded therapy] During that 16 months I was not getting care. I received basic maintenance from the family doctor, but she is not a specialist. She's not as psychiatrist, and so it's just getting the bare bones care. She's phenomenal, but it was sixteen months of just waiting to get in.*<br>*[Re why she waited for AHS care] I simply cannot afford therapy. In the end, it's expensive. I didn't have benefits.* | *I started seeing the new psychologist and psychiatrist. It's been really nice to have them coordinate because if my therapist picks up on something that she thinks my psychiatrist should know, it actually gets there. Even if I don't know that I should tell the psychiatrist. That it's it's so nice.*<br>*[Re follow up supports after counselling sessions limit is reached] He's a doctor, so I assume I just keep seeing him for a while and if I need to leave, he'll just refer me to a different psychiatrist because psychiatry is covered. Don't worry too much about that, but therapy. Yeah, that one is just coming to an end. Which is sad, I like her.* |
| **Opportunities** | **Therapy availability within schools that do not require parental permissions or knowledge.**<br>• Establish a way to check-in on students, including the quiet ones.<br>• Education on mental health awareness and navigation. | • Provide peer mentorship and navigation supports. | • Provide employees and sessional profs with mental health support protocols, and make them aware of campus supports. | • Continue to support the engagement between doctor and patient for mental health screening.<br>• Continue to support mental health visit income modifiers for doctors. Educate public that this is a service offered by family doctors.<br>• Inquire around doctor barriers to providing mental health screenings.<br>• Provide more transparency for referrals and waitlists. | • Review waitlist times for AHS mental health supports. Determine if additional resources are needed.<br>• For patients on the waitlist, provide AHS mental health billing codes to mental health specialists who specialize in psychotherapies. | • Provide more transparency around staff turnover.<br>• Provide referrals to other programs that provide low-income counselling.<br>• Continue to provide multidisciplinary health care services.<br>• Choose service locations that are accessible by bus or train. |

**Top Facilitator for Mental Health**
**Top Barrier for Mental Health**
**Top Pick for Meaningful Change**

2024

**Figure 5**

Arthur's Map

## Arthur - Seeking Support for OCD Symptoms

Arthur, a curious and mindful person, grew up in a low-income family. His mental health journey began with professional help for mood and anxiety, but progress was limited. Greater success came when focusing on a somatoform disorder. Arthur is intellectual, passionate about research, and frequently volunteers for studies.

**Decade Born:** 1990s
**Household Income:** Working Class

## Calgary Mental Health Experience Map

| Stages | Navigating the Unfamiliar | Crisis | Pipeline to Medications | Decision to Pursue Further Supports | Counselling Loop | Disengagement |
|---|---|---|---|---|---|---|
| **Key Actions** | • Increase in mental health symptoms and awareness.<br>• Treatments for incorrect diagnosis<br>• Stopped counselling and medications. | • Escalation of symptoms.<br>• Hospitalization.<br>• Received better fit diagnosis. | • Received fragmented treatment.<br>• Discontinued services.<br>• Engaged in learning about mental health concerns. | • Built up mental health awareness.<br>• Prepared for change.<br>• Reached out to doctor for supports. | • Entered waitlist.<br>• Struggled with institution's follow-up methods.<br>• Counselling was ineffective for symptoms. | • Frustration towards mental health system. |
| **Doing** | • Noticed mental health symptoms. Decided to seek support.<br>• Early diagnosis didn't fit concerns; ineffective medications.<br>• Tried counselling targeted at current diagnosis, but was unsuccessful.<br>• Increased stressors, decreased protective factors.<br>• Accessed Calgary Counselling Centre (CCC), switched counsellors, but found no benefit.<br>• Self-weaned off medications. | •Entered University; mental health symptoms escalated.<br>• Went to psychiatric hospitalization.<br>🌟 **• Received proper diagnosis.**<br>• Received counselling worksheets.<br>• Discharged under psychiatrist care. | • Connected with an medical doctor and psychiatrist.<br>⛔ **• Experienced fragmented sessions with psychiatrist and discontinued services.**<br>• Read more about current diagnosis. | • Increased mental health literacy through reading.<br>🌟 **• Beginning of acceptance of ongoing mental health concerns.**<br>• Mentally prepared for lifestyle changes needed to fully embrace therapeutic treatments.<br>• Connected with doctor when ready to access counselling supports during a prescription renewal appointment. | • Referred to mental health programming; placed on waitlist.<br>⛔ **• Struggled to follow up on referrals due to neurodivergence and mental health, like missing voicemail responses.**<br>⛔ **• Socioeconomic status also hindered follow-up, such as avoiding calls due to past bill collectors and work constraints.**<br>•No government funded counsellors specializing in OCD; counselling was unhelpful. | ⛔ **• Increased feelings of generalized institutional failings.**<br>• Return to self-coping mechanisms. |
| **Institutions** | Family Doctor, CCC | University, In-Patient | Family Doctor, Outpatient Psychiatry | Family Doctor | Counselling | No Institutions |
| **Emotions** |  | | | | | |
| **Quotes** | *I don't think it was entirely my fault that I didn't reap the benefits that I could have with therapy when I was younger. I think that I could have benefited from knowing more people who had had similar experiences with seeking supports for mental illness and also just exposure to a generally more open social dialogue about those things. This would have probably prepared me better for what to expect and what I needed to provide in terms of my own input.* | *Perhaps a lot of people who have spent time hospitalized for mental health concerns, or really any other reason, can probably relate to how long and slow days are in the hospital. The employment of free time and relative lack of access to distractions... you turn to other things like worksheets to keep busy. You realize that incidentally or by accident they are also actually helpful.* | *[Re why he stopped psychiatry services] We're always in a little bit of a rush to get to the next patient. It seemed session to session like I would have to fill them in on and remind them of a lot of things... if I felt that it was just a problem that the individual doctor, I might have continued to try more. I liked my doctor's they seemed like nice people but that they just they did not have the time and the resources to give me exactly what I needed, and that to be able to get some of those things I would have to be paying a lot more out of pocket rather than accessing socialized therapy.* | *I was trying to do some of the [counselling] work that was provided to me. I was finding them helpful but I also was struggling a lot with the fact that they required of me to change my lifestyle in in a number of big ways.*<br>*I can't pinpoint a specific day, but like around the age of 25 is when I started to content myself more with the feeling that even if I ended up living a little bit differently than I thought I would when I was younger, you know staying in more, going to bed a lot earlier, doing all of the boring but helpful things like exercising and eating healthy and stuff. That I was going to be a happier person.* | *I don't like to be on the phone. I don't like making calls, and as is probably the case for a lot of people who are of low-income status, I definitely think there have been times in my life where I was moving and dodging phone calls, particularly if they were from numbers that I didn't recognize... I think there are avenues that could still be more assertive. In particular, added follow-up and scheduling help, whether that be by text or email, could certainly be helpful for me.* | *If I have any resentment about any of this, it is definitely in regards to difficulties with managing things like appointments and, accessing these supports, difficulties being on the phone, stuff like that are so common. With a lot of people who are mentally ill. Yet there is a lack of alternative alternative methods... The fact that there is not even an option. The simplest, just like checking a box when you were filling out forms*<br>*If I could afford more specialized or expensive healthcare, my experiences would be different.* |
| **Opportunies** | • Provide education in school around what therapy is, what you can expect, and signs that it is time to consider it.<br>• Create a space for mental health dialogue.<br>• Investigate diagnoses and targets given in socialized therapy programs, and how the person is screened for possibly more specific concerns. | • Provide peer mentorship and navigation supports. | • Build in time for mental health professionals to prepare for their clients.<br>• Make use of a multidisciplinary team that can provide continuity between sessions. | • Continue to support the engagement between doctor and patient for mental health inquiries.<br>• Lessen burden of load on the person experiencing symptoms by having professionals inquire about mental health, as opposed to waiting. | 🎯 **Review institutional policies for how they engage and recruit their clients. Include discerning the client's preferred way to be contacted.**<br>• Inquire into a coordinator that can determine if someone needs to be sent to a specialist for counselling. | • Explore what needs are not being met for those with similar diagnosis who meet with general practitioners. |

🌟 **Top Facilitator for Mental Health**
⛔ **Top Barrier for Mental Health**
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**Figure 6**

Composite Journey Map

**Calgary Collective Mental Health Experience Map**

| | NAVIGATING THE UNFAMILIAR | CRISIS | PIPELINE TO MEDICATIONS | DECISION FOR FURTHER SUPPORTS | COUNSELLING LOOP | DISENGAGEMENT |
|---|---|---|---|---|---|---|
| | *A person experiences worsening mental health symptoms that they may not recognize or know how to address. The symptoms build up, eventually disrupting their daily life. They mostly cope on their own but might seek help if it's easily accessible.* | *A stressful event or loss of protective factors causes a significant escalation of symptoms, going beyond the scope of available counselling interventions. The person is hospitalized, where they may receive some counselling.* | *After leaving the hospital, the person is connected with a psychiatrist and prescribed medication. Some counselling supports are suggested at discharge. During this time, some stabilization occurs.* | *The person has stabilized after their crisis. They have used medication and medical support and noticed lingering mental health symptoms. They decide to seek further support.* | *Search, Wait, Engage, Repeat. The cycle of finding, using, and dealing with disruptions in counselling.* | *An event causes the person to lose trust in counselling, leading them to stop seeking and using support.* |
| **Activities and Touch Points** | •Core group determines initial understandings.<br>•Notice symptoms.<br>•Self-coping<br>•Engage with supports if it's easy to access or guided.<br>•Receive medication from a doctor. | •Experiencing critical mental health symptoms.<br>•Sought out supports, but leaves because it wasn't suitable.<br>•Enter state of crisis and is hospitalized<br>•Meets with psychiatrist, psychiatric nurse and sometimes counsellors.<br>•Complete counselling type worksheets and participates in groups. | •Exits hospital or crisis situation.<br>•Continues with medication regiment.<br>•Connects with outpatient psychiatrist or MD.<br>•Receives a passive list of counselling referrals.<br>•May partake in transitional care.<br>•Goes through a stabilization period. | •Learn more about mental health.<br>•Notices gap in current treatment.<br>•Prepares for counselling interventions.<br>•Seeks support from trusted professional<br>•May apply for government funding. | •Search for providers<br>•May connect with resource coordinators.<br>•Wait.<br>•Start counselling<br>•Stop due to poor fit, limited sessions, staff changes, or non-financial barriers.<br>•Decide whether to continue or stop. | •Disengages from counselling supports.<br>•Uses their own coping methods.<br>•Mental health symptoms worsen.<br>•Remains in contact with MD. |
| **Quotes** | *Selma:" [Reflecting back on this phase] I was given this paper that I had a mental disability and learning disability. It was shocking to me. I was surprised. I should have known this long before.* | *Maria: "They told me you have to call Access Mental Health while you're here. They basically give you the unit phone and then they don't make sure you actually do it…. I remember sitting there with the phone for a long time and I never called them. I don't remember why."* | *Selma: "I reached out to my doctor because I thought since they were one of my support systems maybe they could make some referrals for me… my psychiatrist told me that she's not the right person for this. She told me that I would have to reach out to other people. It was not her job"* | *Sasha: "Part of the problem is that the program has to be the right fit. But you don't really know until you are there. Every time I accessed a new support, it was like starting over."* | *Arthur: "It's usually a long time before anyone is able to call or reach out to me. I don't do great with phone calls. I would have an easier time if there was an option with some of these booking services to have them text or email me."* | *Nicole "[After backlash] Now I'm withdrawing from telling people about my issues at all, because that was the immediate well, don't do that again."* |
| **What worked** | •Learning about mental health, including awareness, terms, and skills.<br>•Being able to switch providers to find the right fit, if possible.<br>•Professionals advocating for resources and responding to needs.<br>•Quick waiting list for youth programs.<br>•Positive experience promotes future persistence.<br>•Previous involvement in social programming.<br>•Establish routine and have someone to check in with. | •Receiving help for non-mental health concerns leads to more immediate support.<br>•Staying safe while stabilizing.<br>•Using hospital downtime to engage in active support.<br>•Receiving an accurate diagnosis and treatment plan. | •Connecting with AHS psychiatrist or transition facility for ongoing support.<br>•Taking medications supports stabilization. | •Gaining mental health skills and knowledge through previous steps.<br>•Using existing connections to seek support.<br>•Accessing government funding and programs expands mental health support options. | •Skills development supports persistence in loop.<br>•More involvement when in multidisciplinary programs.<br>•Most progress with ongoing one-on-one counselling.<br>•Being able to access due to convenient hours or location.<br>•Participating in effective parts of the program.<br>•Partnering with systems navigator. | •Reengaging because of positive interactions with a trusted professional. |
| **Issues Encountered** | •Fear of a mentally ill identity increased avoidance of seeking help.<br>•Trouble finding the right words to ask for help.<br>•Limited understanding of therapy.<br>•Expected to take initiative.<br>•Funding concerns.<br>•Limited or no access to appropriate support.<br>•Incorrect or missed diagnoses<br>•Using one-size-fits-all programs. | •Hard to find higher-level support before hospitalization.<br>•Receiving poor communication about the hospitalization process.<br>•Required to do unhelpful mental health activities.<br>•Loss of autonomy and adherence to hospital rules<br>•Additional counselling recommendation are given as an afterthought at discharge. | •Taking medications because it is cheaper than therapy.<br>•Psychiatrist meetings lack continuity.<br>•No choice in care team.<br>•Difficulties refilling medication due to MD turnover.<br>•Self-weening off medications when doctors are unsupportive.<br>•Unmet basic needs disrupt stabilization.<br>•Current point persons cannot help with instrumental needs. | •Needs the capacity to manage the challenges involved in accessing publicly funded programs.<br>•Risk of negative experiences with initial supports if they are untrained or unprepared. | •Disengaged due to waitlist.<br>•Sessions are fragmented due to case load and funding.<br>•Loss of therapeutic alliance due to changing staff.<br>•Loss of contact with online counsellors.<br>•Couldn't reach therapeutic goals due to funding limits.<br>•Can't access specialized treatments in social programs.<br>•Avoided or lost engagement due to follow-up method<br>•Difficult to find community providers who honor their advertised sliding scale fees. | •Recognizing the limited access to programs.<br>•Aging out of previous programs target at youth and young adults. |
| **Opportunities** | •Educate and discuss mental health symptoms, supports, and expectations.<br>•Provide longer-term one-on-one counseling that fits the client's needs.<br>•Use doctors or teachers as gatekeepers for mental health support.<br>•Remove unnecessary attendance requirements for programs.<br>•Improve access to supports for those not receiving government assistance. | •Create and promote easily accessible, high acuity mental health supports.<br>•Incentivise doctors to screen for worsening symptoms.<br>•Include counselors as part of the hospital team.<br>•Provide one-on-one counseling during hospitalization and have a continuation plan after discharge.<br>•Allow people to switch doctors if needed.<br>•Set up an urgent care equivalent for mental health issues.<br>•Remove unnecessary rules that create problems for cultural groups. | •Give professionals more time to prepare for client meetings<br>•Use multidisciplinary teams to ensure continuity of care.<br>•Collaborate with patients on discharge planning. | •Increase capacity for gatekeepers to support people at different readiness stages.<br>•Keep mental health program available and consistent.<br>•Train frontline staff on the organization's support protocols. | •Offer more ways to communicate and engage with service seekers.<br>•Update protocols for ending therapy online or in agencies.<br>•Increase the number of systems navigators.<br>•Advertise programs and ensure availability matches the ads.<br>•Partner with community providers and specialists.<br>•Address staff turnover issues. | •Incentivise MDs to screen for mental health.<br>•Fund adult programs like those available for youth. |

## Phases of Seeking Mental Health Support

Phases in a journey map help organize and visualize the stages a person experiences when interacting with key players, institutions, and systems. Using heuristic analysis, six non-linear phases emerged from the data: *navigating the unfamiliar, crisis, pipeline to medications, decision for further supports, counselling loop*, and *disengagement*. Each phase has common activities, things that work, and challenges. This phased approach highlights how different barriers become more or less salient over time and how the priorities for opportunities shift depending on where the person is in their mental health journey.

### *Navigating the Unfamiliar*

*A person experiences worsening mental health symptoms that they may not recognize or know how to address. The symptoms build up, eventually disrupting their daily life. They mostly cope on their own but might seek help if it's easily accessible.*

In this phase, the individual is typically younger (youth to early university years) and is often naive about mental health issues. They have limited skills in navigating external supports and resources. As their symptoms develop, they may not recognize or label them as mental health concerns. They may attribute the symptoms to personal flaws. During this time, they rely primarily on internal coping mechanisms. They are usually connected with a family doctor and may be prescribed medications for emerging mental health issues. The individual may engage in counselling-like activities if they are accessible and low-barrier.

Transitioning from this phase often leads to the *crisis* phase. This transition is related to the lack of available resources that can adequately address the severity of the individual's concerns. Many of their available supports focus on specific symptoms rather than addressing the person's broader mental health needs. This narrow focus leads to worsening symptoms and, frequently, a crisis.

***Crisis***

*A stressful event or loss of protective factors causes a significant escalation of symptoms, going beyond the scope of available counselling interventions. The person is hospitalized, where they may receive some counselling.*

During this phase, the person's mental health issues have become more severe than their current coping abilities can handle. They recognize the need for outside help and seek both medication and counselling. However, the available interventions are not intensive enough to address their heightened condition. The person's symptoms worsen, which leads the person to experience a crisis that often results in hospitalization. While the person is in the hospital, they meet with psychiatrists, psychiatric nurses, and sometimes mental health counsellors. They are assessed and receive prescribed medications. During their stay, they may also participate in group activities and receive mental health worksheets. The person is discharged from the hospital once a treatment plan has been established.

Transitions from this phase often lead to the *pipeline to medications* phase. The individual stabilizes to the point where they are no longer considered a danger to themselves or others. They are then discharged from the hospital with an updated prescription and a referral to a medical provider. Some individuals are also connected with transitional care, which may include counselling-like support.

***Pipeline to Medications***

*After leaving the hospital, the person is connected with a psychiatrist and prescribed medication. Some counselling supports are suggested at discharge. During this time, some stabilization occurs.*

The person is discharged from the hospital or de-escalates from their crisis. Directly from the hospital, the person is set up with a medication regimen and is connected with a community psychiatrist. The person received a sheet of paper with counselling referrals but is not likely to

have called or followed up with them. Also, the person may be engaging in transitional care. The person goes through a period of stabilization.

As the person's mental health symptoms become more manageable and stability improves, they may notice that certain issues persist despite medication. This awareness may prompt them to seek additional support and enter *decision for further supports*. Alternatively, based on previous negative experiences where their concerns were left unaddressed by the current system, they may choose not to seek further care and enter the *disengage* phase. All participants determined that they needed further support than the medications provided.

***Decision for Further Supports***

*The person has stabilized after their crisis. They have used medication and medical support and noticed lingering mental health symptoms. They decide to seek further support.*

The person's crisis state has de-escalated to a place where they can function better. They have gained knowledge about mental health issues and have noticed that their current medication is not sufficient to address all of their concerns. They seek support from a trusted professional with whom they have a pre-established relationship. They may also be eligible for and choose to apply for government funding.

The person who does not find suitable support may transition to *crisis* or *disengagement*. Those in a more stable state, have acquired knowledge, and have had previous positive interactions with the Calgary mental health system move forward to the *counselling loop*.

***Counselling Loop***

*Search, Wait, Engage, Repeat. The cycle of finding, using, and dealing with disruptions in counselling.*

The person starts looking for counselling support, which is done through referrals from peers, internet searches, the resource sheet from the hospital, or assistance from resource coordinators. They reach out to the resources they find and are put on a waitlist. After waiting a few months to over a year, they start counselling. The counselling continues until they

determine that the service provider is not a good fit, they exceed their allotted session limit, their provider quits and can no longer see them, or they face other financial and non-financial barriers. After this disruption of services, they decide whether to reengage or disengage.

The person often oscillates between this phase and *disengagement*. They move to *disengagement* when they become disillusioned with their current support system while knowing that the necessary services exist but are unavailable to them. This understanding leads to a loss of efficacy and a belief that they cannot access the help they need. Additionally, they may be struggling with the fallout from a broken therapeutic alliance, making them reluctant to seek support from another counsellor.

### *Disengagement*

*An event causes the person to lose trust in counselling, leading them to stop seeking and using support.*

The person has disengaged from pursuing further counselling support and uses their coping resources or those learned during their journey to support them with their present mental health symptoms. They remain connected with their family doctor and move from this stage when an external professional provides support and direction.

## What Worked

Participants encountered many beneficial interactions that supported their mental health journey and entry into counselling. Highlighting these successes helps emphasize effective practices that the system influencers should continue and expand upon. It also aids in identifying best practices and guiding future improvements.

### *Doctors Who Promote Mental Health*

Doctors are a common initial touchpoint for individuals seeking mental health support. This finding is supported by research which identifies that physicians often act as gatekeepers for mental health support (CIHI, 2022; Cutumisu et al., 2022; Wang et al., 2005). A doctor who screens and refers out for mental health support is instrumental during the phases: *navigating*

*the unfamiliar, crisis,* and *disengagement*. During these phases, the person commonly has a smaller network of professionals they can reach out to. They may also lack the mental health literacy or motivation to seek help independently. A family doctor who screens for mental health concerns and directs patients to appropriate resources can significantly aid in connecting them to the necessary support. Alternatively, when doctors are not trained for or fail to screen for mental health issues, it represents a missed opportunity to connect individuals to the support they need.

### *Navigators and Guides*

A navigator or support person facilitated the participants in obtaining mental health support. These individuals came in the form of a guidance counsellor who made accommodations and systems navigators that guided the participants to finding available mental health support. These individuals were involved in the *navigating the unfamiliar*, *decision for further support*, and *counselling loop* phases.

The utility of using a navigator is that they unburden some of the load from the mental health seekers, which promotes more success in seeking mental health support. The navigators take on cognitively pressing tasks such as researching what is available and following up with referrals and applications (Krupnick & Melnikoff, 2012; Santiago et al., 2013; Waid et al., 2021). The participants noted that the navigators were helpful because they were able to be flexible and meet the person where they were. The navigator was also noted to support participants in maintaining motivation while they sought mental health support. This sustained motivation is instrumental when faced with low access to programs or long waiting lists. These findings are supported by Waid et al. (2021), where patient-centred care was key to a person's satisfaction with the navigation program.

### *Mental Health Literacy*

An overall increase in mental health literacy can increase a person's positive attitude toward and uptake of mental health support (Aguirre Velasco et al., 2020; Cheng et al., 2018;

Kutcher et al., 2015; Milin et al., 2016). The participants reported an increase in mental health literacy due to their experiences with the system, self-led learning, and dialogue with others who have mental health awareness. They reported that their increased mental health literacy supported their ability to recognize their symptoms, gave them direction on what services may be helpful for them, and supported their communication with professionals about their concerns. Higher levels of mental health literacy were related to the decision to pursue further support. This finding is supported by Milin et al. (2016), who found that mental health literacy supported health-seeking behaviour.

Conversely, this increase in mental health awareness at a systems level contributed to disillusionment among participants and the movement to the *disengagement* phase. This feeling can be related to increased awareness of social deprivation, leading to disengagement (O'Brien et al., 2009). For example, a participant who increased their mental health systems literacy also became aware of a lack of options for support. Therefore, they became disengaged with the process.

### *Hospitalization Down Time*

The hospital offered opportunities not usually available to lower-income Calgarians. It provided a safe place, removed from their consistent stressors, to support their stabilization. Participants had access to experienced medical professionals, allowing for more personalized assessment and diagnosis. The hospital also offered a slower pace with fewer responsibilities, allowing individuals to use their energy to engage in counselling-style activities. This finding is consistent with research from Abbass et al. (2015), who found that short-term counselling in conjunction with hospitalization led to long-term positive outcomes and decreased costs to hospitals and public health care.

### *Previous Positive Experiences*

Previous positive experiences with mental health support encouraged the person to seek out further mental health support. The participants reported this may be related to building trust

that mental health support can decrease their symptoms and address their concerns. This increased self-efficacy was noted to span across the phases and time, where positive experiences starting at under age ten supported interest in pursuing counselling in their 20s. This finding compares with the conclusions from Hom et al. (2015), which noted that positive views of service and increased mental health literacy relate to a person's increase in help-seeking.

## Issues Encountered

### *Mental Health Literacy*

Participants reported lower mental health literacy as a barrier to them seeking help. Low mental health literacy is related to lower awareness of mental health symptoms, less understanding of what can be done to manage the symptoms, where they can go to seek out assistance, and what can be done to prevent their symptoms (Aguirre Velasco et al., 2020; Furnham & Swami, 2020; Kutcher et al., 2015). The participants who reported lower levels of mental health literacy in earlier phases of their journey related it to not having peers or family members to speak to about the subject and not having accurate information from their medical teams. This finding aligns with Bonin et al. (2007), who reported that those who have less family and community support are less likely to access mental health support. The participants would attribute their symptoms as a flaw in their character or something that would go away on its own. As a result, they may not allocate the necessary resources to benefit from counselling. These resources include time, energy, overcoming the learning curve in finding and accessing counselling services, emotional investment, following through with treatment, and the financial and transportation costs of attending counselling. The reduced ability due to lower mental health literacy appears to be related to non-financial barriers found in previous research, such as transportation, treatment research, location, competing obligations, and recognition (Dwight Johnson et al., 2000; Fikretoglu et al., 2022; Krupnick & Melnikoff, 2012; Santiago et al., 2013).

Some participants noted that information on what therapy is and how it could benefit their symptoms may have proven helpful in buying-in and participating in mental health treatments.

### *Quality and Appropriateness of Treatments*

Accessing low-barrier and publicly funded counselling services that are set up to handle complex issues or higher acuity cases was a challenge for the participants. Some of the participants were misdiagnosed and received treatment that did not fit with their mental health concerns. Additionally, low-barrier therapies were noted to have engagement requirements that may not be relevant to the participant's needs, resulting in wasted time and frustration with the therapy process.

Another pattern of usage by the participants involved actively seeking out therapy when their symptoms have approached or bypassed their crisis point. The mental health services the participants had access to during this time did not match the acuity of their needs. This finding aligns with Paton et al.'s (2016) findings that pre-crisis interventions have low evidence of effectiveness in preventing crisis points. This finding also aligns with the Kim et al. (2023) systematic review, which suggests that single-session therapy effectiveness is geared toward people with lower acuity symptoms.

### *Cost and Funding Factors*

A barrier specifically to counselling as opposed to overall mental health support is related to how funding is structured in Alberta. In the *pipeline to medications* phase, participants noted that they use medications because it is the most-cost effective solution for them. They indicated that their choice of medication was weighted towards its accessibility rather than it being the most suitable option for their needs.

### *Collaboration*

A common issue encountered in the *crisis* and *pipeline to medication* phases was a lack of collaboration. This missing component is concerning because patient collaboration improves outcomes (Wright et al., 2016). During hospitalization, participants in this study noted losses in

autonomy and a general lack of collaboration with their treatment and discharge plans. After discharge from the hospital, multiple participants reported being assigned a care team without any input into the selection process. A participant noted that the meetings with their care team were short and lacked continuity between sessions. This experience resulted in the participant's concerns about their medications not being adequately addressed, leading them to self-wean off the medication without proper guidance.

### *Therapeutic Rapport and Turnover*

Participants encountered difficulties establishing a therapeutic rapport with their mental health treatment teams due to how meetings were set up. During hospital discharge, participants were connected with a medical professional (medical doctor or psychiatrist) and a prescription. This finding matches Mutschler et al.'s (2019) systematic review of transitions following psychiatric hospitalization, where the person is often given a prescription and is not connected with adequate social support. The meetings between the participants and their psychiatrists were depicted as short and disjointed. A participant noted that the provider did not have time to review their notes, and the sessions lacked continuity. This experience led the person to disengage from this provider.

Another difficulty with establishing a therapeutic rapport was related to staff turnover. During the *pipeline to medication phase*, some of the participants found it more difficult to have their new doctors honour their previous prescriptions because of the stigma towards their diagnosis and the protected nature of the medication. During the *counselling loop* phase, participants experienced frequent disruptions in therapeutic rapport due to high turnover. Participants reported stopping counselling or hesitancy to start again after an established relationship was ruptured due to employee turnover. In a study by Brandt et al. (2016), the researchers found that raw turnover was unrelated to poorer client outcomes. However, the staff density and continuity combination were related to better treatment outcomes. The difference between these studies may be related to Brandt et al.'s (2016) study participants being

connected to a residential facility with more than one practitioner per client. In contrast, the participants in current study were seeing a single practitioner in the community, thus having lower density. Additionally, the researchers' measure for success was lower acuity of symptoms, and their study did not consider dropouts. Furthermore, a study by Johnson-Kwochka et al. (2020) found that turnover was associated with declines for those with higher mental functions. Whereas turnover was associated with increased mental health functioning for those with low mental health function. This finding could suggest that the participants in this study may have higher mental health functioning than the participants in the Brandt et al. (2016) study.

Participants also encountered abrupt endings to established online therapeutic relationships. Participants noted that in this modality, there were instances of their counsellor or psychiatrist abruptly leaving without providing an explanation. This interaction created confusion, stress, and a hesitancy to continue with other services.

***Burden of the Load***

Participants noted a high burden of load left on them by the mental health support system. Participants described symptoms of their mental health concerns, such as low motivation, poor organization, and high social anxiety. They noted that these symptoms made it more difficult to complete the tasks needed to seek out and secure mental health support such as government-funded programming. This direction-finding is even more difficult when they experience increases in their symptoms. This issue is most salient when the person is not connected to any support but does not meet the emergency criteria, such as *navigating the unfamiliar, pipeline to medications*, and *disengagement*. This burden in navigation is supported by Dawkins et al.'s (2021) finding that navigation problems limit access for marginalized groups. Alternatively, Funk (2019) describes this issue from the system's side, where increasingly administrative and coordination tasks are being offloaded to the person seeking support or their

caregivers. This extra work is exacerbated by requiring this person to navigate complicated care systems.

### *Funding and Opportunity*

Issues related to counselling services in Calgary are closely linked to the limitations of publicly funded programs. Participants expressed frustrations about the waiting lists. There was a mixture of participants accepting wait times of over 18 months and participants refusing to engage with a program due to past experiences of long waiting times. This finding aligns with Punton et al.'s (2022) findings that waiting lists are a barrier to receiving mental health support rather than just a delay.

Participants also noted inconsistencies between counselling sessions, with their counsellor often being unprepared and lacking continuity between sessions. This experience was frustrating for participants and raised doubts about the quality of care. These issues were attributed to funding constraints and high caseloads rather than the counsellor's competence.

### *User Experience*

The user experience for individuals with lower incomes relying on publicly funded and charitable therapists is problematic. Participants with diverse neurodivergent symptoms and contexts found that traditional follow-up approaches did not fit well with their needs, as they were not offered follow-up support via text or email. This finding contradicts Dawkins et al.'s (2021) perspective on why service users from higher-income countries are more likely to delay care due to problems with organization and remembering appointments. The authors attribute this delay to the fact that those from higher-income countries take the availability of services for granted. This contrast in findings may reflect a lack of acknowledgement by Dawkins et al. (2021) of complications in follow-through due to neurodivergent symptoms.

Additionally, individuals attempting to find community counsellors offering sliding scale fees struggled to connect with counsellors who advertise this as an option. A participant found that the information on the counsellors' profiles were vague and not regularly updated to reflect

current availability. This poorly updated information resulted in the participant calling a long list of counsellors and being unable to connect with a single counsellor who would honour their advertised sliding scale fee.

### *Lower Income Earner Experiences*

There were several challenges in finding mental health support that were compounded by the participant's lower income. For example, it is difficult to attend to mental health symptoms via medication or counselling when a person is in a precarious housing position (Aubry et al., 2016). In this study, a participant who needed support with their housing reached out to their care team and was turned away due to it not being within their scope of practice. Others delayed and put off mental health support because they had to attend to basic needs such as food.

An interesting contrast between this study and external research is the role of assertive engagement when reaching out to those with lower incomes. Stein et al. (2014) found that assertive engagement supported the reliability of the clients in attending their appointments. However, one participant noted that phone calls are often associated with bill collectors or other negative news. This, combined with other factors, resulted in them not answering phone calls. This apprehension to answer the phone created a barrier to being connected with counselling programming. This finding suggests that actions must be taken to create more flexibility and options for assertive outreach.

Lastly, social program outreach and opening hours can conflict with the realities of those working lower-income jobs. Outreach from social programs is often during typical work hours. The participants noted working jobs where they could not answer the phone during these hours. This life circumstance is compounded by difficulties with responding to voicemail messages and prolonged telephone tag. Participants noted how they had to stop their counselling services because the service is only available during typical work hours, making attendance not possible.

This availability barrier includes virtual sessions, as the participant noted that their employment situation did not allow them to get to a private place to attend the meetings.

**Opportunities**

***Schools and Mental Health Literacy***

**Review mental health literacy programming in high schools and universities**. Participants did not recall this training during their high school years (approximately 2003-2016). It has been observed in this research that the development of mental health literacy, such as recognizing symptoms and being able to put words to what they are experiencing, supported movements towards mental health support. This finding is supported by Kutcher et al. (2015), who found that mental health curriculums such as *The Guide* (Kutcher & Wei, 2017) improved mental health literacy and behaviours that lead to seeking mental health. Alberta school systems appear to have a robust guide to support mental health literacy (Government of Alberta, 2021). More investigation is needed to see how this guide is followed and implemented in the current school system, as well as enforcing a strategy that supports mental health literacy uptake by the students.

**Support educators in focusing on their skill set by providing them with resources to refer to and workable caseloads**. The participant who received support from their school noted that their support person was going above and beyond their job duties, on top of being busy with a large caseload. It can be common for mental health support and interventions to become side of the desk work. An American article noted that there is an average of one guidance counsellor for every 500 students (Anderson & Cardoza, 2016). Consider incorporating mental health tasks into official duties or providing a resource to which the person can offer the student a warm transfer (Richter et al., 2022). In Calgary, there are emerging options such as the Summit, which acts as a day hospital for those with emerging but not urgent symptoms (Alberta Health Services, n.d.-c). This service can be accessed via referral from the school or self-referral.

### *Medical Doctors*

**Encourage mental health screenings by family doctors.** Family doctors were a common first point of contact for the research participants. This structure is likely related to how our mental health system is based on medical foundations, making the doctors gatekeepers for mental health resources (Biringer et al., 2017; CIHI, 2022; Cutumisu et al., 2022; Wang et al., 2005). In Alberta, doctors have billing codes with mental health modifiers designed to encourage family doctors to provide mental health screenings and support (Government of Alberta, 2024). In this study, the participants had mixed experiences with their medical doctors about whether they would provide mental health support. More investigation is needed to understand the medical doctor's decisions behind the level of mental health support they would provide.

The ability of doctors to provide mental health support is essential. However, diversification of who can provide these services should be considered. First, family doctors are scarce in Alberta (Malbeuf, 2024). Providing ongoing therapy support can tax the family doctor's time. Second, the counselling treatment they can provide is often short-term cognitive behaviour therapy, which has minimal indicators of effectiveness for higher acuity patients when provided in a primary care setting (King et al., 2002). A research participant noted that the counselling they received from their doctor while on the waitlist was appreciated. However, it was not the level of support they needed.

An alternative to this is to empower doctors by diversifying how their patients can receive treatment. This can be done by using multidisciplinary teams, more streamlined access to programming referrals, or opening up who can use the mental health billing codes. A growing commonality in Calgary is the Primary Care Network (PCN). The PCN is a team-based healthcare model (Alberta Health Services, n.d.-b). This model gives the family doctor direct access to professionals in multiple disciplines, thus, more options for patient-centred care. Second, Calgary family doctors have access to referrals through Access Mental Health (Alberta

Health Services, n.d.-a). Doctors could benefit from having real-time information concerning the programs available and their waitlist times to make an informed referral. Lastly, as participants in this study waited up to 16 months on waitlists for programs, it may be beneficial to offer interim support. This interim support could involve allowing registered psychologists or other regulated professionals to access the same mental health counselling billing codes as family doctors. In the meantime, family doctors can be educated on locally available initiatives such as OWL Pod (n.d.), which consists of medical doctors with mental health training who accept referrals.

### *Give More of What They Want*

**Focus funding on what the mental health service users find helpful and lessen mandatory requirements.** Individuals who were able to receive their treatment preference had better completion rates, satisfaction, and outcomes (Lindhiem et al., 2014). In this study, the participants found the most helpful form of mental health support to be one-on-one counselling. Therefore, funding efforts may be more beneficial in supporting individual therapy. Additionally, programming may benefit from removing restrictive funding requirements that involve participants having to partake in activities they deem unhelpful, such as mandatory group counselling.

**Provide higher acuity publicly funded services**. Participants continuously noted that they could not access treatment that matched their acuity levels. As participants often did not reach out for support until their acuity was higher, a support service is needed beyond single-session crisis counselling but below in-patient hospitalization. This space can also be used as a referral route for those seeking emergency care but not meeting the emergency threshold.

### *Screening and Assessments*

**Screening and assessments should be added as regular stops in the mental health support infrastructure**. Participants in this study noted being treated for the wrong symptoms or being paired up with supports that did not match their acuity level. A diagnosis or

assessment that provides direction for treatment can help inform further mental health professionals (Erford, 2021). As this population experiences a large amount of movement of treatment providers, it is even more essential that these providers are given information to support the continuity of care between professionals. This information can also help people advocate for themselves when higher support is needed.

### *Navigators and the Burden of the Load*

**Make in-person professional mental health resource navigators more readily available to the general public**. The participants used navigators to find appropriate supports, ensure sustained motivation, and provide the follow-up needed for the participant to enter the supports. Similar to other studies, navigators were deemed to be helpful when they were patient-centred, good with logistics, flexible, and collaborative (Waid et al., 2021). However, in this study, the navigators were restricted to those who were a part of government financial support programs. It appears that the navigators would support unburdening the load of other non-connected participants. An opportunity would be to make the navigators available in an easily accessible space, such as public libraries, schools, or universities.

### *Personnel Structure*

**Evaluate the structure and pay scales of those providing treatments to Calgary's more vulnerable populations**. Individuals with lower incomes tend to have the highest level of needs (Government of Canada, 2006). However, they are often matched with new counsellors, those in transitional programs such as practicum or provisional, or with generalists. Participants had concerns or lacked confidence that new practitioners would be equipped to handle the intensity of their issues. This concern is related to the common barrier of low perceived effectiveness (Dawkins et al., 2021). Additionally, the rapid turnover of practitioners makes providing the necessary training for this group more challenging. In my experience and perspective, this turnover can be addressed by revisiting funding and employee structure, such as offering competitive rates to increase retention and adjusting the balance of using unpaid

internships. An alternative program model based on what was successful for a participant is to focus on funding community counsellors. Offering tax credits or a stipend to counsellors to share the financial burden of providing pro-bono or sliding scale fees can help address this issue. This approach can also mitigate the turnover structure of programs and enable individuals seeking support to find the right fit in terms of personality, culture, and specialty.

### *Continuity Between Sessions*

**Provide more administration time for practitioners to make case plans more effective**. Participants noted that there was a lack of continuity between sessions. Those who were connected with a psychiatrist after hospital treatment noted the fragmentation between sessions. Sessions tended to be 10 minutes, and the practitioner rarely remembered anything from previous interactions, leading to a lack of therapeutic rapport and trust with the practitioner. This observation was related by the participant as the practitioner being too busy as opposed to a reflection of their skill.

### *Capitalize on Hospital Down Time*

**Give counselling options while a person has downtime during hospitalization.** In this study, hospitals were described as providing a unique setting where individuals with lower incomes can focus on mental health counselling and receive more benefits than they would in community settings. This downtime is an opportunity for mental health counsellors to plant the seeds of counselling and facilitate a pipeline of support for after hospitalization. Additionally, short-term therapy in conjunction with this healthcare has been shown to have long-term cost savings for the health system (Abbass et al., 2015).

### *Improve User Engagement*

**Make front-line level changes to facilitate easier access to mental health support**. Accessibility can be improved to accommodate those with neurodivergences by giving more options for contacting the person (e.g., texts, emails, or other technology). Advertisements can be used to inform the public of the availability of the resources. Brown (2017) found that

advertisements for mental health concerns and medication increased a person's perception of the prevalence, treatability, and controllability of the mental health concern. Gaiha et al. (2021) found that mental health awareness campaigns increased the person's knowledge of mental health symptoms, whether they are treatable, and where to look for support, thus increasing their treatment-seeking behaviour. Additionally, participants commented that their experience could be improved with more communications about waitlists, such as an online portal with estimated wait times, which can improve transparency for the mental health service seeker. Participants also noted the importance of practitioners providing hours outside the typical nine-to-five to allow more appointment accessibility.

### *Collaboration*

**Add more opportunities for client collaboration.** Participants noted instances where their input was not included in their treatment planning. This absence of collaboration included hospital treatment planning, discharge, and who they were referred to for psychiatry. Participants also had a negative experience when counselling-style activities were coercive. Another participant reported experiencing subsequent trauma when their cultural needs were not considered in treatment. Time and flexibility are necessary to improve collaboration. Further consultation with each institution and policymakers would be needed to determine how these fit with their system.

# Chapter 5. Conclusion

## Introduction

This study aimed to explore the pathways lower-income Calgarians take when seeking mental health support. Exploring this question led to a better understanding of the contexts of the barriers these individuals face. These contexts included common activities during different phases of the journey, information on what worked, issues encountered from the participant's perspective, and what opportunities for improvement are based on this information. This information was used to create a comprehensive journey map for industry stakeholders to use when considering strategies to optimize the accessibility of counselling for this population. This section provides a high-level view of the list of recommendations, how this information contributes to the field of psychology, the limitations of this research, and the recommended next steps.

## High-level View of Recommendations

Based on the findings and discussion in the previous chapter. The following is a list of recommendations broken out into systems, organizational, and individual levels.

### *Systems Level*

- Promote family doctors to screen and refer for mental health support. Continue with mental health modifiers for billings. Consult with family doctors who are apprehensive about providing mental health support to determine barriers to providing this care. Create direct or transparent referral routes for medical doctors. Fund family doctor's time for making referrals or fund for multidisciplinary assistance. Provide professional development for mental health care. Identify how this relates to nurse practitioners who have access to similar billing codes.
- Fund programming that is found most helpful by the users, including one-on-one counselling and higher acuity mid-to-long-term counselling.

- Reevaluate metrics for funding programming that require programs to be rigid in their structure.
- Promote funding for more multidisciplinary teams, such as primary care networks.
- Add counselling mental health interventions for psychiatric in-patients at hospitals. Include a direct line of referral to counselling at discharge.
- Add funding for time needed to collaborate with patients and clients, as well as time to follow up on referrals in both hospital and outpatient settings.
- Create systems that involve screening and assessing for mental health concerns in the early phases.
- Fund mental health systems navigators for the general public. Make them accessible in commonly used infrastructure such as libraries, schools, universities, and 211.

***Organizational Level***

- Reconsider pay bands and personnel choices for the staff working with populations with a higher acuity level. Examine practices that promote higher level retention and recruit those with the skill set to work with complex cases.
- Reevaluate policies for staff turnover and prioritize transparency with clients. According to the College of Alberta Psychologists' Standards of Practice (2019), when terminating a professional relationship, the client must be given a reasonable opportunity to arrange alternative professional services (section 9.15). What is deemed reasonable for individuals with lower income and limited access to support may differ from those with more disposable income. Therefore, consider implementing longer-term warm transfers during periods of staff turnover.
- Design programs that offer flexibility to allow clients and participants to access services tailored to their needs. Advocate for more adaptable funding structures to accommodate flexible service delivery.

- Educational institutions' decision-makers should use pre-established evidence-based techniques to promote mental health literacy. Provide time and resources to implement same.
- Educate staff (medical, educators, university) on the available mental health resources to which the staff member can refer individuals with mental health concerns.
- Educate staff (medical, educator, university) on policies, and what policies can be accommodated to different cultural interests.
- Add additional mental health staff development training for doctors and nurse practitioners.
- Budget for time needed for case conceptualizations and collaboration with clients.

***Individual Level***

- Choose to work with practices that have access to collaboration or on multidisciplinary teams.
- Add transparency when advertising for sliding scale or pro-bono work.
- Create options for program participants to disclose the best way to contact them.
- Reimagine strategies for assertive outreach.
- Educate self on the resources available. Add this to skills development training.

**Contribution to the Field**

This research contributes to the field of psychology in that it shines light on the issues encountered by low-income mental health system users at different phases of their mental health journey. The study highlights the specific barriers and facilitators that affect these individuals' ability to engage with mental health services. Additionally, it suggests changes that would matter to this group of individuals. Lastly, by using heuristic inquiry and journey mapping, the findings of this study provide a practical and holistic lens that can inform policy adjustment

and service improvements. These findings can inform practitioners, policymakers, and other stakeholders in making targeted interventions or guide further research for this population.

**Limitations**

This research is a small qualitative study that sought to gather ideas to direct further research. With a small sample size and limited age range, extending these findings to all low-income Calgarians is not appropriate. The data collected showed signs of saturation in this study in that there were no new major themes in the fourth and fifth interviews. In usability studies, five participants are key to begin this style of inquiry (Nielsen, 2000). This participant strategy is because these studies aim to improve the design rather than have an exhaustive list of weaknesses. Therefore, it is more pragmatic to start with a small study, make adjustments, and then test if those adjustments make a difference (Nielsen, 2000).

Nielsen (2000) argues that five users often find up to 85% of design flaws based on closed systems. I argue that the scope of this research involves a more complicated network of institutions over a longer period of time. The complex infrastructure comprising Calgary's mental health support makes it difficult to find and detail all major concerns and problems with just five users. However, the pragmatic value is that this is about improving the design rather than discovering all weaknesses. Therefore, the reader of this research should remember that with five participants, there is a ~85% chance that the main factors that facilitate or inhibit mental health support are evident in these interviews. However, there are a number of usability problems that were not likely found in this first round of interviews.

Another limitation comes from the characteristics and behaviours of the participant group. Those who volunteered to participate in this study may be skewed towards those who are more resourceful, have less stigma against mental health, and may already have more awareness of mental health. The study is also subjected to recall bias, as the participants may have had difficulties recalling past experiences ranging up to 15 years. Thus, the reader should be aware that the results of this study may not be generalizable to the low-income population.

**Recommendations for Future Research**

This research is a first-round probe into the usability problems of Calgarians seeking mental health support. Further directions would involve creating a workshop with subject matter experts. They would use the created maps to identify multi-level opportunities to improve the usability of the current system. Further usability testing can focus more on the opportunities that were identified and implemented to determine if the change addressed the concern, or if it leads to more concerns. A second user experience mapping study could also focus on the questions created by the subject matter expert group and examine the usability of our current system to move past surface-level problems in a deeper manner (Nielsen, 2000).

**Summary**

In this research, I aimed to answer the question: What are the pathways and experiences to seeking mental health support for people with lower income? The purpose of this study was to gain an understanding of how people with lower incomes arrive at mental health support, as well as to understand low-income individuals' experiences when they took steps to support their mental health and how it affected their pathway to mental health support. Using heuristic inquiry and journey mapping, five participants' experiences while seeking mental health support were analyzed and mapped. Key actions, information about what worked, and issues encountered were identified through the six phases: *navigating the unfamiliar, crisis, pipeline to medications, decision for further support, counselling loop*, and *disengagement*. Key factors that facilitated or created barriers to achieving mental health support included: mental health literacy, family doctors as gatekeepers, the use of systems navigators, types of support, acuity of support, collaboration, funding, sharing the burden of the load, user experience, assessments, continuity of care, and personnel structure were identified. Opportunities for growth and change were suggested based on these insights. This research adds to the body of research on barriers lower-income individuals face when seeking mental health support by adding context, saliency, and creating a simplified visual of the complex systems involved. This study has a small sample

size and should not be used as a report on all the problems encountered in seeking mental health support. Rather, it should be used as a starting point for changes, with consistent re-evaluation. Further research should connect this information with stakeholders in the system to provide nuanced recommendations and further opportunities for improvement.

Seeking mental health support is a difficult and multifaceted process, with the responsibility falling on those who are already struggling. While a complete system overhaul may be unrealistic, meaningful changes can still be made to make this journey more accessible for those with lower incomes. These adjustments can transform the path to counselling and mental health care from an illusion of choice into a genuine opportunity for support.

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## Appendix A: Index of Barriers

**Table 2**
*Access and Availability Barriers to Counselling*

| Category | Explanation | Sources Cited |
|---|---|---|
| Transportation | A person's access to safe reliable transportation. Including the costs of driving or transit. | Krupnick & Melnikoff, 2012; Santiago et al., 2013 |
| Childcare | Those with lower SES may not be able to afford child care while they attend therapy. They may also not have the social capital to have someone watch their child while they obtain treatment. Additionally, they may be the sole caregiver for their children. | Krupnick & Melnikoff, 2012; Santiago et al., 2013 |
| Employment Type | People who have lower SES are more likely to have jobs that are shift work, or sporadic hours. This makes it more difficult to schedule weekly counselling appointment. Additionally, their jobs are less likely to have paid time off for these appointments. | Dwight-Johnson et al. 2000; Krupnick & Melnikoff, 2012; Santiago et al., 2013 |
| Treatment Research | The person with lower SES may have not have the spare time needed to search for counselling treatment options. Additionally, they may not have the knowledge and understanding to find and obtain treatment in our current system. | Krupnick & Melnikoff, 2012; Santiago et al., 2013; |
| Scheduling | A person may have difficulty with time management and scheduling counselling appointments. | Krupnick & Melnikoff, 2012 |
| Cost | A person who has a lower SES has less expendable income to pay for counselling services. Counselling services may also be cost prohibitive. | Abbas et al., 2017; Krupnick & Melnikoff, 2012; Moroz et al., 2020; Santiago et al., 2013 |
| Location | The location of counselling services may be difficult to get to, especially when the person is using public transport or if they live in a location far away from the services. | Krupnick & Melnikoff, 2012 |
| Benefits | A person with lower SES may not have access to health insurance or benefits for counselling. This may be due to their employment type. This may also be due to the minimal inclusion criteria for public assistance benefits. | Santiago et al., 2013 |

| | | |
|---|---|---|
| Lack of Services | A person cannot apply for mental health services if they are full or not available. | Krupnick & Melnikoff, 2012 |
| Wait times | People with lower SES may have significant amount of wait times to access low-cost mental health services. This may interfere with their motivation to participate. | Moroz et al., 2020 |

**Table 3**
*Personal Barriers to Counselling*

| Category | Explanation | Sources Cited |
|---|---|---|
| Support Systems | Those who have less of a community and family support system are less likely to access to mental health support | Bonin et al. 2007 |
| Education | As education levels increase, a person is more likely to see a psychotherapist for their mental health concerns | Steele et al., 2007 |
| Autonomy | Those who choose to access mental health support are more likely to participate | Alang & McAlpine, 2019 |
| Competing Obligations | A person may have competing demands for their time and money. This can include the need to get to medical doctor's appointments, or put money towards credit card debt over mental health treatments. | Dwight-Johnson et al. 2000; Santiago et al., 2013 |
| Stigma | Stigma can be real or perceived. A person may have deep ingrained beliefs that push them away from psychotherapy, such as having a mental health concern is dishonourable to the family. The person may not want to attend psychotherapy because they are not able to hide this from their friends, family, or community. | Fikretoglu et al., 2022; Krupnick & Melnikoff, 2012; |
| Mistrust of Authorities | A person with lower SES may have a history of negative interactions with those in power. This can lead them to avoid therapists. | Krupnick & Melnikoff, 2012 |
| Cultural Differences | A person with a lower SES may not feel understood by a middle-class therapist. For example, the therapist may not understand their version of distress, or the amount of time needed to build trust. | Krupnick & Melnikoff, 2012; Lavell, 2014; Santiago et al. 2013 |
| Expectations | A person may have low expectation towards service providers, leading to them not wanting to access this support. | Krupnick & Melnikoff, 2012 |
| Power Dynamic | A person may fear being judged by the middle-class therapist. A person may have a bad experience if the therapist does not address social class differences. | Krupnick & Melnikoff, 2012; Thompson et al., 2012 |

| | | |
|---|---|---|
| Values | A person with lower SES's values may prevent them from seeking counselling. For example, they may see poor mental health as a burden to their families, therefore not acknowledging the problem nor seeking treatment. Or a person may value autonomy and have a preference to manage themselves. | Krupnick & Melnikoff, 2012; O'Donnell et al, 2017 |
| Labelling | Attaching the label of a mental health problem may feel like delegitimizing the instrumental problems a person is facing. | Krupnick & Melnikoff, 2012 |
| Managing with Medication | The person is already taking medication that is managing their mental health symptoms. | O'Donnell et al., 2017 |
| Recognition | The person may have difficulty recognizing that they have a mental health problem, or it's severity. Therefore, this person may be reluctant to seek care | Fikretoglu et al. 2022 |

**Table 4**
*Navigational / Structural Barriers to Counselling*

| Category | Explanation | Sources Cited |
|---|---|---|
| Poor User Experience | A person may have difficulty understanding how to access and obtain treatment cost services. Or they may have difficulties finding and accessing supports. | Moroz et al., 2020; Santiago et al., 2013 |
| Point of Entry | Those with lower income have a higher likelihood to seek mental health through a hospital or their primary care doctor. Doctors are more likely to refer a patient to psychopharmacology. Primary healthcare may not have full training in psychotherapy options | Bartram, 2019; Cutumisu et al. 2022; Krupnick & Melnikoff, 2012; Santiago et al. 2013; Wang, 2005 |
| Funding | Services may not be available or in best quality for people with lower SES due to lack of funding. | Moroz et al., 2020; Santiago et al. 2013 |
| Training | Psychotherapists who are lack training for those with lower SES as being treatment resistant. | Santiago et al. 2013 |

| | | |
|---|---|---|
| Deprived Neighbourhood | A person who is living in a socially deprived neighbourhood or lacks of residential stability are less likely to use health services. There are less psychotherapy options in deprived neighbourhoods. Additionally, there are less primary care options that could funnel to future mental health support. Different education that can lead to different healthcare choices. | Abbas et al., 2017; Giebel et al., 2020; Ngamini Ngui et al., 2012 |
| Education | Lower education is associated with less use of psychotherapy services | Ngamini Ngui et al., 2012 |
| Cultural Diversity | There is scarcity in therapists that speak the non-dominant languages. The lower diversity affects the availability of culturally congruent services | Krupnick & Melnikoff, 2013; Santiago et al. 2013 |
| Therapist Bias | Therapist are less likely to offer treatment to those with lower SES | Niemeyer & Knaevelsrud, 2023 |

**Appendix B: Advertising Poster**

# YOU ARE INVITED!

**Lower income Calgarians are needed to share their experiences of seeking our mental health supports.**

**WE ARE LOOKING FOR PARTICIPANTS:**

- Over 18 years old
- Have tried to access mental health support while living in Calgary
- Who identify as lower income.
- Willing to share their experiences

This research study aims to amplify voices of Calgarians in order to increase the accessibility of counselling services.

**HOW IT WORKS:**

1. Contact Christina (info below)
2. You will be asked a couple questions to determine eligibility
3. We will set up a time to do an interview in a Calgary Public Library of your choice
4. Interviews will take approximately one hour

**As a thank you for your time, you will be given a $25 gift card!**

**If you would like to participate in this study contact Christina Bassett, Master of Counselling Student, Athabasca University:**
**Via Email:**
**Via text or phone:**

Athabasca University

*This research study is being conducted under the supervision of Dr. Paul Jerry @*
*This study has been reviewed by the Athabasca University Research Ethics Board [REB File # 25660]. Should you have any comments or concerns about your treatment as a participant, the research, or ethical review processes, contact the Research Ethics Officer at 1.780.213.2033 or by e-mail to rebsec@athabascau.ca*

## Appendix D: Information Sheet

**Recruitment Letter**
Thank you for considering participating in this study. I am a Master of Counselling student, and I have been working with lower-income Calgarians since 2013. I am passionate about accessibility. It is important for all Calgarians to have access to the support they need for their well-being.

You are invited to participate in this project because you have used mental health services in Calgary and have a unique perspective due to having a lower income.

**Purpose of this study**
I have noticed that those with lower incomes were more likely to be taking medications and less likely to try counselling when compared to those with higher incomes. There are several reasons why this could be. What I want to learn is how these reasons relate to each of the steps you have taken when deciding on and pursuing your mental health support. This study explores participants' perspectives and experiences when they recount their pathway to mental health support.

**Why am I doing this study?**
The information we collect from this study can be used to inform counsellors and other decision-makers on what could be changed so that people can have more access to counselling.

**What will Happen?**
I want to interview individuals who have lower incomes and have accessed mental health support. This can be medications, counselling, or both. The interview would be about an hour long. It can be done in person at your convenience or via Zoom videoconferencing. The interview will be recorded so I can transcribe and analyze your responses afterwards. Your identity and the information you provide will be kept confidential.

**Benefits and Risks**
If you participate in this study, there are some things to consider. Seeking mental health help is hard, and talking about it may cause emotional discomfort. The questions are not meant to do that, but feeling this way is normal. You are always allowed to end the interview. However, there are benefits to the interview, too. Your answers will help counsellors, researchers, decision-makers, and others. We can use this information to find ways to make counselling more accessible for low-income Calgary. As a thank you for participating, you will get a $*** gift card after the interview.

**Confidentiality**
All information will be confidential, except when legislation or a professional code of conduct requires it to be reported. We will not use your name on any of the information that is recorded. All information will be stored on a password-protected hard drive. Any of your personal information will be kept separate from your interview files. This information will be kept for five years after completing the final report. Afterwards, all information will be deleted. The final report may contain quotes from your interview but not any information that can identify you.

If you choose to meet on Zoom, there is something important to know. Zoom is a service we do not control. We cannot promise it is completely private when information travels online. While it is not likely, there is a small chance that others, like government agencies or hackers, could see what you say. Also, even though we will not use your computer information to track you without

telling you, there is a slight risk with any online service that your data could end up on servers not controlled by us.

**It is your choice.**
Your participation is your choice. It is also your choice throughout the whole interview. This means that you can refuse to answer questions, you can end the interview, you can request for the recorder to be turned off, and within a specific time frame – you can ask for your information to be deleted.

You also have a choice if you would like to participate further. If you agree, you can see the results of this study and give me feedback. You can also request that the final report be sent to you when completed.

**A note**
Medications are an important tool to help you with your mental health. This study is not aimed to limit access to medication but rather to open up options for those who decide that counselling is the right support for them.

I look forward to working with you and learning from your experiences,

Christina Bassett
Master of Counselling Student
Graduate Counselling and Applied Psychology
Faculty of Health Disciplines
Athabasca University
Cbassett1@learn.athabascau.ca

## Resources

**If you are experiencing emotional distress:**

- **The Distress Centre** – 403-266-4357

To provide compassionate, accessible crisis support that enhances distressed individuals' health, well-being, and resiliency. You can also use their text or online chat. See www.distresscentre.com. They also offer access to free short-term counselling sessions for more complex issues.

**If you want to see a low-cost to no-cost counsellor:**

- **Access Mental Health** – 403-943-1500

A non-urgent service providing information, consultation, and referrals for individuals with addiction and mental health concerns. Mental Health Clinicians complete a clinical interview over the telephone to assess the individuals' needs. Mental Health Clinicians are familiar with Alberta Health Services and community-based programs and will explore all options to refer individuals to the most appropriate resources.

- **Eastside Community Mental Health Services** – Call 403-299-8699, Text 587-315-5000

offers immediate, no-cost mental health support from an integrated, ethnocultural team. Available on phone, Monday to Friday, 8 am to 11 pm. By text, Monday to Friday, 9 am to 10 pm.

- **Calgary Counselling Centre** – 833-827-4229, https://calgarycounselling.com/

They are helping people develop the skills they need to thrive.
You can register online anytime or phone between 9 am and 4 pm, Monday to Friday.

- **Insight Counselling** – 403-204-8280

Provides affordable and accessible mental health support to individuals who need it. Reduced costs based on a sliding scale, starting at $5.00 per session. Subsidies are available

**If you need more resources or mental health options**

- **211**

Access an entire network of community, social, health and government services.

**Information on different counsellors in your area (Most are full-cost)**

- **Psychology Today –** https://www.psychologytoday.com/ca/therapists/ab/calgary

**If it is an emergency or you are thinking of harming yourself:**

- **Please call 911 immediately**

## Appendix E: Interview Guide

### Interview Guide

### Pre-screening

1. **About the Study**

In this study, I want to learn about your experience in seeking mental health support. In my work, I support people with low to no income to connect them with mental health support. As a middle-income person, it is important for me to understand the unique experiences that those with lower incomes go through when they are seeking mental health support. I am looking to you as the expert in your own experience so that I can learn this valuable information. The information you share will be linked with your peers so that we can better understand your experience. These understandings will be made into a report that will be shared with other people in an academic setting. It will also be used by me and my future coworkers to improve how we support people with lower incomes.

During our interview, I want to understand how you got to your mental health support (or lack of mental health support). I want to know the steps you took, the decisions you made, what obstacles you came across, what helped you, and your feelings and experience throughout all of this. As I mentioned, you are the expert, I am interested in what you believe is important.

2. **Ask for their questions**
3. **Pre-screening Questions**

| | |
|---|---|
| Do you consider yourself to have a lower income? | |
| Have you sought out mental health support in the past? | |
| Are you over the age of 18? | |
| When you looked for mental health support, was this in Calgary? | |
| Are you willing to share your story for this research study? | |
| Would you like the information sheet emailed to you? | |
| Email: | |

4. **Location Choice**
    - **a.** In-person
        - **i.** Calgary Public Library location?
5. **Time**

| | |
|---|---|
| **Location Choice** | |
| **Date** | |
| **Time** | |
| **Best form of Communication** | |
| **Comments** | |

### Materials & Set up

- Informed Consent Agreement
- Information Sheet
- Set up two recorders
- Set up sound machine
- 2 pens, one highlighter, paper

**Preamble**

In this study, I want to learn about your experience in seeking mental health support. In my work, I support people with low to no incomes to connect them with support. As a middle-income person, it is important for me to understand the unique experiences that those with lower incomes go through when they are seeking support. I am looking to you as the expert in your own experience so that I can learn this valuable information. The information you share will be linked with your peers so that we can better understand your experience. These understandings will be made into a report that will be shared with other people in an academic setting. It will also be used by me and my future coworkers to improve how we support people with lower incomes.

During our interview, I want to understand how you got to your mental health support (or lack of mental health support). I want to know the steps you took, the decisions you made, what obstacles you came across, what helped you, and your feelings and experience throughout all of this. As I mentioned, you are the expert, I am interested in what you believe is important.

Before we dive into the interview, we have to go over a few formalities.

- Structure of the interview
    - 30 – 60 minutes
    - We will chat, and we will get a chance to sketch out your pathways
    - The recorders
    - There are no right or wrong answers
- Informed Consent agreement
- Gift Card
- Re-iterate ongoing consent
- Discuss safety
    - Steps they can take if they feel overwhelmed
    - Where security is located should they feel they need help
- Ask permission to begin recording

**Semi-Structured Interview**

| **Research Question** | |
|---|---|
| What are the pathways and experiences to seeking mental health support for people with lower income? | |
| **Study Purposes** | |
| • To gain an understanding of how people with lower income arrive at mental health support.<br>• To understand low-income individual's experiences when they took steps to support their mental health and how it affected on their pathway to mental health support. | |
| **In Plain English** | |
| I want to understand how you got to your mental health support (or lack of mental health support). I want to know the steps you took, the decisions you made, what obstacles you came across, what helped you, and your feelings and experience throughout all of this. | |
| **Semi-Structured Interview** | **Observations** |
| Introduction Questions | |
| How would you describe yourself?<br>*Tell me a little bit about yourself* | |
| What decade were you born? | |
| Could you tell me about your journey towards mental health support? | |
| I use the word *pathways and journey to mental health* a lot. I would like to know what language would you use for this? | |
| **Main Questions** | |
| Let's map out your journey towards mental health support. I am going to map out what you say. Here you are now. Here is a time before you started to seek out mental health support.<br>• Institutions encounters<br>• What happened in that interaction<br>• Actions<br>• Feelings (and intensity)<br>• Goals / Decision process<br>• Pain points and barriers<br>Facilitators | |
| On this map, what are the three things that were the most influential (helpful or hindering) on your pathway to mental health? | |
| What would you like to see changed? | |
| Supporting Questions (*optional*) | |
| • What prompted you to start seeking mental health support? – How did you first recognize that you needed or wanted support.<br>• Can you describe any challenges you faced while looking for mental health support? How did these challenges affect you?<br>• What was your original goal and why? What influenced this?<br>• How did your experiences change this take you towards or away from your original goal | |

**Journaling**

| |
|---|
| What was the Interview about? |
| What were the key issues? |
| What stood out? |
| What could be linked together? |
| What was the main concern stated? |
| Challenges and Successes of the Interview? |
| Assumptions and Biases? Role of Values, Beliefs, and Lived Experiences |
| Comments on the physical Environment and Logistics |
| Emotions |
| Other Comments |

**Observations Guide**

- Behaviour
- Conversation
- Context
- General mood

## Appendix F: Informed Consent

LETTER OF INFORMATION / INFORMED CONSENT FORM
Pathways to Counselling for Lower-Income Calgarians

[Today]

Principal Investigator (Researcher):
Christina Bassett
Master of Counselling Student
Athabasca University
Cbassett1@learn.athabascau.ca

Supervisor:
Dr. Paul Jerry
Program Director, Master of Counselling
Athabasca University
PaulJ@Athabascau.ca

**Funded by:**

You are invited to participate in a research project entitled 'Pathways to Counselling for Lower-Income Calgarians.'

This form is part of the process of informed consent. The information presented should give you a basic idea of what this research is about and what your participation will involve, should you choose to participate. It also describes your right to withdraw from the project. In order to decide whether you wish to participate in this research project, you should understand enough about its risks, benefits and what it requires of you to make an informed decision. This is the informed consent process. Take time to read this carefully, as it is important that you understand the information given to you. Please contact the principal investigator, Christina Bassett, if you have questions about the project or would like more information before you consent to participate.

It is entirely up to you whether you participate in this research. If you choose not to participate or decide to withdraw from the research once it has started, there will be no negative consequences for you now or in the future.

**This form tells you what you need to know about participating in this research project. This form tells you:**

- **What the research is about**
- **What you will have to do**
- **The risks and benefits of this research**
- **How your privacy and confidentiality will be kept**
- **Moreover, you can say "no" at any time.**

**It would help if you took your time reading this form because it is important to understand. If you have questions, you can talk to Christina Bassett.**

**Introduction**
My name is Christina, and I am a Master of Counselling student at Athabasca University. As a requirement to complete my degree, I am conducting a research project about how people access mental health support and what guides their decisions along the way. I am conducting this project under the supervision of Dr. Paul Jerry.

**Why are you being asked to take part in this research project?**
You are invited to participate in this project because you have used mental health services in Calgary and have a unique perspective due to having a lower income.

**What is the purpose of this research project?**
The research project aims to understand people's paths when seeking counselling or medical help for their mental health. This will help us understand the obstacles people encounter when seeking counselling.

**What will you be asked to do?**
In this research, you will participate in a one-on-one interview with Christina. She will ask you questions about your experience in finding mental health support. The interview will be recorded, and notes will be written down.

If you want, we can share the results of this interview with you, and you can give us your thoughts.

**What are the risks and benefits?**
When you participate in this study, there are some things to consider. Seeking mental health help is hard, and talking about it may cause emotional discomfort. The questions are not meant to do that, but feeling this way is normal. If it gets too hard, tell the interviewer. You can take a break or stop the interview if you want.

However, there are benefits to the interview, too. Your answers will help counsellors, researchers, decision-makers, and others. We can use this information to find ways to make counselling more accessible for low-income Calgary.

As a thank you for participating, you will get a $*** gift card after the interview.

**Do you have to take part in this project?**
As stated earlier in this letter, involvement in this project is entirely voluntary. Tell the interviewer if you want to stop the interview. You can do this at any time during the interview. If you want to stop the interview after it has started, we will only use the information you gave if you say it is okay. We will remove the written notes and delete the recording immediately if you do not want it to be used. You will still receive the gift card even if you stop the interview.

After the interview, you will have one week to remove your information. Afterwards, your information will be de-identified. This means that your personal information (name, age) and responses will no longer be connected. This makes it not possible for the researcher to remove this data.

**How will your privacy and confidentiality be protected?**

The ethical duty of confidentiality includes safeguarding participants' identities, personal information, and data from unauthorized access, use or disclosure.

- The interview recording will be kept on a secure computer with a password to protect it. The recording will also be turned into a written word transcript and saved on a secure computer with a password. After we finish the study, we will delete both the recording and the written words.
- Any notes written on paper will be scanned and stored on a secure computer. The paper notes will be destroyed. Only the researcher and the researcher's supervisor will look at this data.
- Only the researcher and the researcher's supervisor will access your information.
- Your data will be given a different name (we call it a pseudonym), so it cannot be linked back to you. When we study the data, we will group it by shared ideas, but your information will be mixed with others, so it is not about just you.
- In the report, the researcher might use quotes from your interview to help explain what we found. These quotes will not have anything that can identify you.
- The final report will include a "Journey Map" that shows how people go from wanting help for their mental health to getting that help. It is a general map that combines information from many people and will not point to you.
- <u>All information will be confidential, except when legislation or a professional code of conduct requires it to be reported.</u>
    - Some examples but not limited to:
        - I might have to share the information if a court tells me to. If that happens, I will make attempts to let you know about this.
        - Keeping everyone safe is important. If you say you are thinking of hurting yourself or someone else, or if you talk about child abuse, I have to tell the right people to make sure everyone stays safe.

**How will my identity be protected?**
This interview will be voice recorded, and written notes will be taken during the interview. Your name and other identifying characteristics will not be included in the data analysis or the final report. A pseudonym (a fake name) will label your information or quotes.

<u>Every reasonable effort</u> will be made to ensure your confidentiality; you will not be identified in publications without your explicit permission.

**How will the data collected be stored?**

- Your interview will be recorded on an iPhone. This will be uploaded to a secure computer. This recording will be transcribed into words and saved on a secured hard drive. The voice recording and transcript will be stored for five years after final thesis approval. Afterwards, records will be deleted.
- Any notes written on paper will be scanned and stored on a secure computer. The paper notes will be destroyed. Only the researcher and the researcher's supervisor will look at this data.
- Passwords will be used to protect your confidential data. When information is shared between the researcher and the supervisor, it will done over "share screen" over teams. This allows the supervisor to see the information, but the files will not be saved elsewhere.

**Who will receive the results of the research project?**
The existence of the research will be listed in an abstract posted online at the Athabasca University Library's Digital Thesis and Project Room, and the final research paper will be publicly available. It can be found here: https://dt.athabascau.ca/jspui/

**Who can you contact for more information or to indicate your interest in participating in the research project?**
Thank you for considering this invitation. If you have any questions or would like more information, please email me (Christina Bassett) by e-mail at cbassett1@learn.athabasca.ca or my supervisor, Dr. Paul Jerry, at paulj@athabascau.ca. If you are ready to participate in this project, please complete and sign the attached Consent Form. If the interview takes place over Zoom, you can give the interviewer your verbal consent.

Thank you.

Christina Bassett

**This project has been reviewed by the Athabasca University Research Ethics Board. Should you have any comments or concerns about your treatment as a participant, the research, or ethical review processes, please contact the Research Ethics Officer by e-mail at** rebsec@athabascau.ca **or by telephone at 780.213.2033.**

**Your signature on this form means that:**

- You have read the information about the research project.
- You have been able to ask questions about this project.
- You are satisfied with the answers to any questions you may have had.
- You understand the research project and what you will be asked to do.
- You understand that you are free to withdraw your participation in the research project without giving a reason and that doing so will not affect you now or in the future.
- You understand that if you choose to end your participation **during** data collection, any data collected from you up to that point will be destroyed unless you indicate otherwise.
- You understand that if you withdraw **after** data collection has ended, your data can be removed from the project at your request up to the [Cut off dates]
- You have read what this research project is about and understood the risks and benefits. You have had time to think about participating in the project and had the opportunity to ask questions and have those questions answered to your satisfaction.
- You understand that participating in the project is entirely voluntary and that you may end your participation at any time without any penalty or negative consequences.
- You have been given a copy of this Informed Consent form for your records, and
- You agree to participate in this research project.

| | **YES** | **NO** |
|---|---|---|
| I agree to be audio-recorded | | |
| I agree to the use of direct quotations | | |
| I allow my name to be identified in any publications resulting from this project | | |
| I am willing to be contacted following the interview to verify that my comments are accurately reflected in the transcript. | | |
| I would like to receive a copy of the completed report<br>Email: _____ | | |

_____ _____

Signature of Participant Date

Principal Investigator's Signature:

I have explained this project to the best of my ability. I invited questions and responded to any that were asked. I believe that the participant fully understands the potential risks involved in participating in the research project and that he or she has freely chosen to participate.

_____ _____

Signature of Principal Investigator Date

## Appendix G: Certification of Ethical Approval

Athabasca University

**CERTIFICATION OF ETHICAL APPROVAL**

The Athabasca University Research Ethics Board (REB) has reviewed and approved the research project noted below. The REB is constituted and operates in accordance with the current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2) and Athabasca University Policy and Procedures.

**Ethics File No.: 25660**

**Principal Investigator**:
Ms. Christina Bassett, Graduate Student
Faculty of Health Disciplines\Master of Counselling

**Supervisor/Project Team**:
Dr. Paul Jerry (Supervisor)

**Project Title**:
Pathways to Counselling for Low-Income Calgarians

**Effective Date:** April 25, 2024 **Expiry Date**: April 24, 2025

**Restrictions:**

Any modification/amendment to the approved research must be submitted to the AUREB for approval prior to proceeding.

Any adverse event or incidental findings must be reported to the AUREB as soon as possible, for review.

Ethical approval is valid *for a period of one year*. An annual request for renewal must be submitted and approved by the above expiry date if a project is ongoing beyond one year.

An Ethics Final Report must be submitted when the research is complete *(i.e. all participant contact and data collection is concluded, no follow-up with participants is anticipated and findings have been made available/provided to participants (if applicable))* or the research is terminated.

**Approved by:** **Date: April 29, 2024**

Frits Pannekoek, Acting Chair
Athabasca University Research Ethics Board

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Athabasca University Research Ethics Board
University Research Services Office
1 University Drive, Athabasca AB Canada T9S 3A3
E-mail rebsec@athabascau.ca
Telephone: 780.213.2033