A Narrative Exploration of the Experience of Racialized Youth Who Receive Mental Healthcare in Victoria, BC

by

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B.A.Sc. (Hons), University of Guelph, 2015
M.Sc., University of Victoria, 2018

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We acknowledge and respect the Lək̓ʷəŋən (Songhees and Xʷsepsəm/Esquimalt) Peoples on whose territory the university stands, and the Lək̓ʷəŋən and W̱SÁNEĆ Peoples whose historical relationships with the land continue to this day.

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Abstract

Background: *IBPOC* (Indigenous, Black, and people of colour) communities have faced and continue to face interpersonal and systemic racism across Canada, which in turn affects their mental health and their willingness to access mental healthcare. There is a well-established literature on barriers to accessing mental healthcare for IBPOC communities in Canada. However, much of the research to date does not centre on the voices of IBPOC consumers of mental healthcare, who may have experiences of racial and intergenerational trauma which impact their wellbeing and experience of receiving mental health services. This project highlights the voices of IBPOC youth who received public mental healthcare services between approximately 2010 to 2024 in Victoria, BC, as there is limited research exploring the narratives of this population in Canada. **Method**: The Collaborative Narrative Method (CNM; Arvay, 2003) was used in order to explore the lived experience of IBPOC youth (between the ages of 17 and 25) who received public mental healthcare in Victoria, BC, which included a period of time when they were mature minors (i.e. between the ages of 13 to 18). The aim of this study is to understand and co-construct their stories, centered around their voices. Individual interviews were conducted with five IBPOC youth, who henceforth will be referred to as the Co-Investigators. Both the researcher and Co-Investigators conducted two readings of the transcripts (the first reading for the accuracy of content, the second reading with the research questions in mind). **The** narratives were written collaboratively between the researcher and Co-Investigator, with the Co-Investigator having final editorial power. **Results:** The five narratives explored each youth's mental health story, including their needs and preferences for supportive mental healthcare, while taking into account the complex intergenerational dynamics that set the context for their lives. **Discussion:** The researcher identified themes across the stories and discussed them with all the Co-Investigators together at a joint meeting. The identified themes have been organized into five Acts. [Act I] reflected the importance of understanding the complex and nuanced context of each Co-Investigator's life. [Act II] explored the experience of living through the discrepancy between how the Co-Investigators perceived themselves compared to how they were perceived by mental health professionals. [Act III] identified the meaning that Co-Investigators have made of their experiences including how they exercise their agency, how isolated they are, and their belief that collaborative care between an IBPOC youth and their mental health providers is possible. [Act IV] is composed of the recommendations that the Co-Investigators suggest for service providers in the community based on what they would have wanted from their mental healthcare experiences. Finally, [Act V] is an exploration of the researcher's observations about the study. **Impact:** The CNM approach facilitated the intentional attempt to level power dynamics and for IBPOC youth participants to have their stories heard and documented the way they wanted them to be shared. Importantly, the results of this study can inform local policymakers and contribute to creating a culturally-attuned mental healthcare experience for IBPOC youth in Victoria, with the ultimate goal of dismantling systemic racism in mental healthcare.

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Dedication

For my family and my community.

Situating Myself

I would like to start by saying that I am very grateful to be sharing my personal account from the traditional territory of the lək̓ʷəŋən–speaking peoples on whose traditional territory the university stands, and the Songhees, Esquimalt and W̱SÁNEĆ peoples whose historical relationships with the land continue to this day. I will always be grateful to have lived, created relationships, and studied on this land as an uninvited visitor. I hope that by sharing some of my story, it will help you understand why I believe this research to be so important.

As both a therapist and a curious person, I often ask others how they identify. In the spirit of narrative inquiry, I hope that you will allow me to share some of my story, especially in the context of this research project. I am a second-generation Korean immigrant who is a settler in this country called Canada. My family has a history of intergenerational and historical trauma due to the colonization of Korea by Japan (officially from 1910 to 1945). As the country and people were recovering from colonization, they entered another period of unrest due to the Korean War (1950-1953). Many Koreans reflect on this time with sorrow in their hearts as one people became separated into two due to outside forces.

These historical events have shaped my people, including my family. My paternal side of the family was split across the Korean border; my relatives in North Korea were never heard from again. Due to the war, most people were living in poverty and my family was no exception. As a young man, my paternal grandfather would buy trinkets in South Korea and cross the DMZ (the Korean Demilitarized Zone) into North Korea under the cover of night to sell his wares to save up money for university. It was an extremely dangerous way to make a living, and I am very grateful for the privilege of having grown up comfortably in comparison. My family has always valued education and saw it as a way to overcome poverty. This extreme poverty and need to survive has undoubtedly affected the way that the generations before me related to one another, and crucially, affected how they parented.

Fast forward several decades to the present-day, and South Korea is prosperous and successful for such a small country (e.g., K-pop, kimchi, Samsung, etc.). South Korea is one of 37 members of the Organization for Economic Cooperation and Development (OECD), which represents 80% of world trade and investment (OECD, 2021). However, taking a closer look at the mental health of the people of South Korea reveals the cracks in the façade: South Korea has been ranked first in suicide mortality among the 37 OECD country members since 2003 (Kwak & Ickovics, 2019). I cannot draw firm conclusions around why this phenomenon is occurring in modern Korean society. However, for my family members, I can see how the intergenerational and historical trauma that they personally experienced has affected their mental health including my grandparents' generation in particular, and then on to subsequent generations.

A few years ago, while speaking with my aunt (who has lived in Canada for over 30 years), I candidly asked in my broken Korean if there was a word for 'anxiety' in Korean. At the time, I was interested in how Koreans in Canada discuss or address mental health. At first, she did not understand what I meant by 'anxiety' and asked me to elaborate. She then responded that she had never thought about trying to translate that idea, and that as far as she knew, there was no word that conveyed this meaning in Korean. From what I know (and please take this with a grain of salt, as I will not pretend to be fluent in Korean), the closest approximation to 'anxiety' is 'geokjeong' (걱정) which is closer in meaning to 'worry.' Perhaps 'buran' (불안) would also fit. I would also argue that the Korean pronunciation of 'stress' (스트레스) could convey a meaning closer to the idea of 'anxiety.' In essence, sometimes mental health definitions cannot easily cross cultures.

Speaking of crossing cultures, though I lived most of my life in Canada, I also lived in the Philippines during that mysterious period that developmental psychologists call 'middle childhood.' It was a formative experience and I learned a lot about the world through observation. I attended an international school that was run by white American Evangelical Christians, and it was a very interesting microcosm within the context of a country that has an extremely long and complicated history of colonization.

Even from a young age, I understood that culture, power, and history were extremely important to the human experience. Being an ethnically Korean child, with a Canadian passport, going to a school with white Americans (who could not understand that someone could be Canadian and not be white or live in igloos), in the Philippines (a country which has its own unique relationship to whiteness, Americans, and Koreans, interestingly enough), was certainly an experience that left its mark. While I adored the country and its people, I was left with many mixed experiences during my time in the Philippines that made me question my identity.

We moved back to Canada just in time for me to enter junior high school, and living in Toronto was a direct contrast to my experiences in the Philippines in many ways. Here I was, going to school with people just like me (racialized immigrants) again! In most spaces, no one would bat an eyelash when they saw me. No one questioned my ability to exist. It was exhilarating.

In many ways, moving to Victoria for graduate training reminded me of my time in the Philippines. Living in Victoria has been both an amazing opportunity and a culturally isolating experience. This time in my adulthood, I found myself once again experiencing what it was like to take up space in predominantly white spaces, and to negotiate tensions between my personal values and the values of a white Euro-centric society.

Lastly, I have personally experienced mental health problems in my own life, and I have tried my best to navigate what all of that means to me: communicating with loved ones (or not), accessing mental healthcare (or not), reflecting on the experience of the mental healthcare system as a person of colour (or not), and the list goes on. When I think about the kind of mental healthcare that I would have needed, it is radically different than what I received and what is currently offered. I genuinely believe that we now live in a time where as a society, we are more ready for change than we have ever been. My hope is that this research will bring us one step closer to that change.

Situating this Study

Throughout this paper, the term ‘IBPOC’ (Indigenous, Black, and people of colour) will be used when referencing these racialized groups. Since the concept of ‘race’ is socially constructed, people of colour are subsequently ‘racialized’ – an active process that is done to them (Carter & Pieterse, 2020). The use of the term ‘IBPOC’ is not to erase the vastly different experiences of these peoples, but rather to highlight them and to shed light on the different ways in which each group is oppressed. Further, the term brings these communities of colour together in shared experiences of racism due to being racialized in a predominantly white settler country.

Canada is a product of colonization that was intentionally built from the belief that those who were not Anglican and white were second class citizens. In particular, policies were enacted in order to assimilate and “educate” the Indigenous peoples from whom this land was taken (Davin, 1879; Ryerson, 1847). When examining the origins of our country, it is juxtaposed with the current reputation that Canada has promoted: a country that welcomes multiculturalism and diversity, and accepts many immigrants and refugees (Government of Canada, 2021a). However, when critically examining the experience of racialized people in Canada, it is clear that many of these racist and discriminatory beliefs still exist to this day.

Chapter 1: Introduction

The mental health of Indigenous, Black, and people of colour (IBPOC) individuals in Canada is a complex issue that is steeped in history (e.g., colonialism, slavery, immigration policy) and has multiple intersections. Racism occurs both historically and presently at interpersonal, institutional, and societal levels. Discrimination and racism in daily interactions, as well as via systemic racism, have contributed to the degradation of mental health across IBPOC communities in Canada (Government of Canada, 2020; Hilario et al., 2018; King et al., 2009; Logie et al., 2013; Noh et al., 2007; Taylor & Richards, 2019).

The experience of racism is a pervasive stressor that is associated with lower levels of health and psychological well-being (Carter & Pieterse, 2020; Tummala-Narra, 2020). For example, Indigenous youth are 5 to 8 times more likely to die by suicide than non-Indigenous youth in Canada (Statistics Canada, 2019a). As well, IBPOC Canadians, especially Indigenous people and Black Canadians, are more likely to be criminalized for their mental health problems, and for police to use excessive force against them – even during a mental health crisis – than their white counterparts (Borshuk & Eljdupovic, 2019; Cenat, 2020; Chan & Chunn, 2014; Gur, 2010; Oriola et al. 2011).

Despite experiencing mental health problems, Canadian immigrants from communities of colour are less likely to seek professional support compared to their white counterparts (Chiu et al., 2018). Although a number of studies have explored the issue of barriers in access to mental healthcare for IBPOC individuals in Canada (Beiser, 2009; Chen, Kazanjian, & Wong, 2009; Donnelly et al., 2011; Fung & Wong; 2007; Kirmayer et al., 2007; Kirmayer et al., 2021; Thomson et al., 2015; Healey et al., 2017), few qualitative studies have explored the experiences of IBPOC individuals who have actually received public mental healthcare in Canada, and even fewer have done so outside of major metropolitan areas.

This introduction will provide a summary of the literature of the experience of mental healthcare for IBPOC people in Canada, including both accessing and receiving care. It will also highlight the gaps in the literature in discussing relevant and important considerations when addressing IBPOC mental health in a Canadian context.

An Attempt to Define 'Youth'

Further, there is a significant gap in research on IBPOC youths' experience of the mental health system in Canada. This is especially problematic given that IBPOC youth may require tailored services due to their experiences of navigating multiple cultural and generational complexities. 'Youth' represents a particularly sensitive period in development because experiences at this point in the lifespan can have substantial developmental cascades that affect the rest of one's life, which highlights the importance of early intervention.

As Masten and Cicchetti (2010, p 491) described:

> *Developmental cascades* refer to the cumulative consequences for development of the many interactions and transactions occurring in developing systems that result in spreading effects across levels, among domains at the same level, and across different systems or generations. Theoretically these effects may be direct and unidirectional, direct and bidirectional, or indirect through various pathways, but the consequences are not transient: developmental cascades alter the course of development.

There is no universally agreed upon age range that defines 'youth.' This lack of agreement amongst researchers reflects the fluid nature of this period of development – a period of life that negotiates the gap between the reliance of childhood and the independence of adulthood. Erik Erikson’s (1950, 1967) dominant lifespan theory of developmental stages posited that the period of ‘adolescence’ occurs from the beginning of puberty until the late teen years. Arnett (2007) argued that ‘emerging adulthood’ – during which the individual navigates developmental challenges as they ‘transition’ to adulthood – seems to lie between the ages of 18 to 29 years. Similarly, the United Nations uses the age range of 15 to 24 years for statistical purposes (United Nations, nd).

This research project considered the concept of ‘youth’ loosely and broadly, understanding it to generally mean a period of the lifespan that bridges childhood and adulthood, and which can occur between the start of puberty to approximately the end of one’s 20s. The focus on this period of development is because of how these developmental cascades can have far-reaching impacts on a person’s social, emotional, and academic development. If we can understand how a youth’s developmental cascades unfolded, we can use this information to inform early intervention.

Important Considerations When Trying to Understand the Context of IBPOC Youth’s Mental Health Concerns

This section summarizes important considerations when addressing IBPOC youth mental health in Canada. Given that there are few Canadian resources on IBPOC mental health in general, some of the following literature review will reflect the experiences of IBPOC adults, which also highlights the need for continued research on IBPOC youth mental health.

Racial Trauma

The issue of IBPOC youth’s mental health is extremely complex and involves a number of intersecting dynamics. As described earlier, since the concept of ‘race’ is socially constructed, people of colour are then ‘racialized’ – an active process that is done to them (Carter & Pieterse, 2020). An interesting expression of racism then, is that the process of racialization occurs as a result of one’s perceptions, which are often based on observable physical characteristics. This explains how members of a society who were born and raised within that cultural context, may still experience racism against them.

In recent years, American scholars have focused on *racial trauma* or *racially-based traumatic stress* (RBTS), with evidence accumulating that experiences of racism can lead to symptoms that are similar to those experienced in post-traumatic stress disorder. These symptoms can include intrusive thoughts, arousal, avoidance, emotional distress, a loss of self-worth, and difficulty with relationships (Carter & Pieterse, 2020; Comas-Díaz & Hall, 2019).

However, a clear distinction between RBTS and DSM-5 trauma and stress disorders is that the experiences of racism do not fit neatly into the DSM-5 criteria of traumatic events (Carter & Pieterse, 2020; Comas-Díaz & Hall, 2019). Usually, experiences of racism involve a sudden and emotionally shocking experience that creates anxiety, and is often compounded upon by previous experiences of racism (Carter & Pieterse, 2020). Further, racial avoidance, aversion, or hostility may be communicated by direct and indirect means including actions, coded language, and symbols.

Moreover, racist experiences are different from other stressors that can cause trauma (Carter & Pieterse, 2020). For IBPOC youth, early life experiences of racism can result in traumatic responses that can have subsequent impacts on their development including their identity formation, mental health symptoms, and connection or disconnection to their communities. Researchers and clinicians who are active in this line of work have called for a re-working of interventions to adequately address experiences of racism through psychotherapy.

These interventions would involve acknowledging and incorporating theories like the socialization of racism and corresponding cognitive appraisals, which can directly support youth to overcome stressors associated with IBPOC identities (Metzger et al., 2021).

Emerging literature in Canada addresses how racial trauma has been overlooked in the Canadian literature and Canadian society as a whole. Williams and colleagues (2022) sought to fill a gap in the research and conducted a scoping review of the Canadian literature, focusing on race-based stress and how it impacted the following groups: Indigenous people in Canada, Black Canadians, Asian Canadians, Muslim Canadians, queer IBPOC in Canada, and immigrants and refugees to Canada. Their results demonstrated how reported events of racism led to mental health symptoms of trauma (e.g., depression, anxiety, hypervigilance, cognitive distortions, isolation and a diminished sense of belonging, reckless and/or self-damaging behaviours, reduced positive affect, intrusive thoughts, etc.). In a qualitative study with eight Black immigrant youth from the Greater Toronto Area, researchers found themes such as: experiencing discrimination and othering, wrestling with identity issues, and finding that youths' mental health and identity were impacted by socio-political and historical factors such as the 'global valuation of Africans' (i.e., the narratives told about Africa and Africans that justified the colonization of Black peoples; Olawo et al., 2019). Researchers are also beginning to highlight how IBPOC youth in Canada who are transgender or nonbinary are especially vulnerable to experiences of discrimination, violence, or negative outcomes compared to their white transgender or nonbinary peers (Chan et al., 2022).

Intergenerational and Family Dynamics

Racial trauma is intricately linked to intergenerational and historical trauma for IBPOC communities in North America. In Canada, attention must be given to intergenerational dynamics including but not limited to: different levels of acculturation within families, intergenerational and historical trauma, as well as intergenerational resilience.

Regarding different levels of acculturation within families, acculturation researchers tend to distinguish first-generation immigrants and second-generation immigrants by place of birth (i.e., second-generation immigrants born in host country; Abouguendia & Noels, 2010), though some researchers go by age (e.g., second-generation is defined as immigrated before the age of 12 years; Berry & Hou, 2017). Acculturation research has shown that there are often significant differences between generations and between individuals with regard to the balance between retaining ethnic cultural practices or beliefs and adopting host country norms (Costigan & Dokis, 2006). Often, due to acculturation differences within families, there can be added difficulties in intergenerational communication, such as greater conflict when there is a larger difference in acculturation between parent and child (Abougouendia & Noels, 2010; Costigan & Dokis, 2006; Tardif & Geva, 2006).

In reviewing the mental health literature, it seems that there can also be a lack of consensus regarding terms and nuances. For example, some studies with a focus on mental health problems in IBPOC individuals essentially collapsed multiple generations of immigrants into one generation by considering first, second, and third, etc., generations as if they were all immigrants with the same shared experiences (e.g., Berry & Hou, 2021). Other studies assumed that second (or further) generation immigrants were more acculturated to Canadian culture than to their heritage culture (e.g., Kirmayer et al., 2007). Many identity and acculturation researchers would object to both of these assumptions, suggesting that acculturation experiences need to be examined in a more nuanced way regarding immigrant mental healthcare in Canada.

Another factor that disproportionately impacts IBPOC communities in Canada is intergenerational trauma, which is the transmission of trauma from one generation to the next. Intergenerational trauma affects the children and grandchildren of the individuals who were the initial victims, and can be experienced as both individual and collective trauma (Bombay et al., 2009; Menzies, 2008). One clear example of this effect is how the Canadian government caused Indigenous peoples to endure significant trauma for the purposes of assimilation, segregation, and "integration" into mainstream Canadian society (Menzies, 2008). As a result, there has been a movement toward promoting healing from intergenerational trauma within Indigenous communities, with Indigenous scholars sharing which approaches have worked well for their communities (Hadjipavlou et al., 2018; King, Smith, & Gracey, 2009; Kirmayer, Simpson, & Cargo, 2003; Marsh et al., 2015; Menzies, 2008; Reeves & Stewart, 2017; Rowan et al., 2014). Unfortunately, there is less guidance in the literature on how to address intergenerational trauma in other communities of colour in Canada. When considering collective and historical trauma, scholars around the world have noted the tendency for there to be "silence" in families around trauma that parents have faced, especially when there are no cultural scripts or appropriate contexts to speak about the events that have occurred (Bokore, 2013; Chou, 2019; Lijtmaer, 2017; Sangalang & Vang, 2017). It is clear that IBPOC youth who have experienced intergenerational or historical trauma and desire effective mental healthcare services will need clinicians who are attuned to these complex dynamics and nuances.

When considering intergenerational dynamics and intergenerational resilience, the role of supportive and nurturing parenting despite adverse life experiences must also be discussed. IBPOC communities who have lived through genocide, slavery, war, and other traumatic experiences have displayed immense resilience in the face of immense hardship. Researchers have begun to explore intergenerational dynamics of resilience around the world (Atallah, 2017; Denov et al., 2018; Shevell & Denov, 2021; Woods-Jaeger et al., 2018). Stories of resilience for communities of colour in Canada should also be explored as an important pathway to mental health and wellbeing.

Demographic Factors That Affect IBPOC Mental Health Experiences

There are relevant demographic factors that must be considered when addressing IBPOC youth mental health in Canada. According to Statistics Canada (2019b), more than 20% of the current Canadian population were born outside of the country, with the most migrants coming from India, the Philippines, and China. When we factor in generational immigrants and refugees (i.e., second generation or more), as well as some Black individuals who are descendants of slaves and Indigenous individuals, the proportion of IBPOC individuals in Canada is significant (at 27% of the population), and deserving of attention (Statistics Canada, 2019b). Furthermore, 37% of Canadian children (15 years of age or younger) have at least one parent who was born outside of Canada. It is problematic to assume that mental health services designed for white Canadians (settler Canadians who appear white and who come from European backgrounds) would be equally effective for IBPOC Canadians (Bracken, 2002; Herati & Meyer, 2020; Jones et al., 2021; King et al., 2009; Kirmayer, Simpson, & Cargo, 2003; Murray et al., 2010; Reeves & Stewart, 2017; Stewart, 2008).

In Canada, most of the research on cultural adaptations being conducted with immigrant and refugee groups are in the major metropolitan areas of the country (e.g., the Greater Toronto Area, the Greater Vancouver Area, Montreal, Edmonton, Calgary, etc.), and for good reason. These areas are usually where immigrants and refugees settle when they arrive in Canada (Beiser, 2009). In these cities, there can sometimes be a sense of a ‘strength in numbers’ and many specific enclaves for IBPOC groups exist. For some, it may not be necessary to learn English fluently due to the ability to stay within their enclaves for nearly every facet of life (Beiser, 2009). Diversity and inclusion are often thought to be non-negotiables in clinical care due to the volume and proportion of clients who live in those areas. Research should also include exploring lived experiences of IBPOC individuals who live in non-metropolitan areas of Canada.

Past research has shown that living in more racially diverse neighbourhoods is associated with a stronger sense of belonging in Canada for IBPOC individuals, and that sense of belonging is associated with positive well-being and lower rates of depression (Chiu et al., 2018; Wu et al., 2011). This demonstrates that where IBPOC individuals live has an impact on their mental health and wellbeing. In the Greater Vancouver Area, which is British Columbia’s largest metropolitan area, approximately 51% of the population identifies as IBPOC (calculated as the percentage of the population that identifies as ‘visible minority’ and/or ‘Aboriginal’; Statistics Canada, 2019c). In contrast, only approximately 20% of the Greater Victoria Area population identify as IBPOC (Statistics Canada 2019d). It is imperative to understand the experience of IBPOC youth who do not live in the major metropolitan areas of Canada (i.e., Toronto, Montreal, and Vancouver), such as Victoria, BC, as they may struggle more to find a sense of belonging.

Many IBPOC individuals have been born in, raised in, or live in more rural areas across the country (Statistics Canada, 2009; Statistics Canada, 2020). For instance, about 60% of Indigenous peoples in Canada live in rural and remote areas (Statistics Canada, 2017) due to implications of the Indian Act and reserves (i.e., the displacement of Indigenous peoples away from their traditional land and territories to artificial boundaries constructed by the federal government). Rural mental healthcare is already difficult to obtain for white Canadians (Boydell et al., 2006; Haggarty et al., 2010; Reume-Zimmer et al., 2018). Given the intersections between socioeconomic status and IBPOC identities (Block et al., 2019; Hou & Picot, 2004; Statistics Canada, 2015a), it is likely that this reduced access in rural areas compounds with socioeconomic status, so that those who are IBPOC in Canada are more likely to be limited to public or free mental healthcare. Oftentimes, public mental healthcare resources have long waiting lists and are not immediately available when problems reach a crisis point – which is usually when IBPOC individuals seek care (Chiu et al., 2018; Donnelly et al., 2011).

Important Considerations for IBPOC Youths' Mental Health Care Services

The following review of the research includes literature from the experiences of IBPOC adults due to a lack of research focused solely on youth, which again highlights the need for continued mental healthcare research with IBPOC youth in Canada.

Current Mental Health Approaches to Working with IBPOC Individuals

While he was the Minister for Health in British Columbia, Hon. Adrian Dix commissioned an in-depth investigation into allegations of racism and discrimination in health services (including mental healthcare) that were provided to Indigenous peoples across the province (Turpel-Lafond, 2020). The report, *In Plain Sight*, was released in November 2020 and detailed harrowing accounts of Indigenous people treated in dehumanizing and racist ways in both interpersonal interactions and through systemic racism (Turpel-Lafond, 2020). This begs the question, when care is provided and "made accessible" to vulnerable groups, is the experience of the care actually helpful or is it harmful?

The idea of needing to tailor, adapt, or modify existing assessments and interventions with racialized or ethnic minority groups is not new. As our understanding of possible adaptations progresses, our terms and goals for care also evolve. For a time, many considered the standard of ethical care to be *cultural competence*, which is understood to be an ongoing process in which a provider attempts to work within the cultural contexts of the client through cultural awareness and knowledge (Campinha-Bacote, 2002; Kirmayer, 2012). However, the North American literature has identified that *cultural humility* is a more appropriate goal to work toward. Cultural humility is understood to be the lifelong commitment to self-evaluation to redress power imbalances between clients and clinicians with an openness to cultural diversity (Kirmayer et al., 2021; Kumas-Tan et al., 2007; Tervalon & Murray-Garcia, 1998). *Culturally responsive care* is an emerging term that broadly encompasses any cultural adaptations made to services (Delfish & Chadha, 2025; Huey et al., 2023). To build further on these ideas, *cultural safety* is the notion of actively acknowledging the oppressive systems in which IBPOC individuals live and operate, and working to address these imbalances in health service provision. The ultimate outcome of cultural safety is reducing and mitigating harm by consciously striving to avoid re-enacting oppressive dynamics, to challenge government policy and community attitudes that have the potential to negatively impact IBPOC individuals, and to work toward collaboration and healing (Durie et al., 2009; Johnstone & Kanitsaki, 2007; Kirmayer et al., 2021).

For the purposes of this paper, the term *culturally-attuned care* will be used to describe a desired quality within the helping clinician or system to support IBPOC individuals. Culturally-attuned care is more than the act of adapting the content of interventions to be more culturally appropriate, and it is more than being open to different worldviews. It is the spirit of aligning with the client while being actively responsive to their cultural needs. It is a reflexive and flexible process that is centred on what the client needs, promoting their autonomy. This requires creating a space that feels *culturally safe enough* for the client to express and explore what those needs would be if the clinician is not already meeting them, with the understanding that the clinician will do their best to meet those needs once voiced. *Culturally-attuned care* will be used as an umbrella term, and can include adaptations, modifications, new innovations, and more, with the key distinction being the spirit of the approach of the clinician and the system.

As an example, when considering psychological assessments, clinicians and researchers have been active in objecting to the use of standardized assessment tools with IBPOC populations (Thomson et al., 2015). The Cultural Formulation Interview (CFI), which was formed in partnership with Kirmayer and colleagues at McGill University, was developed and researched many decades ago and has been included in every copy of the Diagnostic and Statistical Manual – 5th Edition since 2013 (APA, 2013; Lewis-Fernandez et al., 2016). What sets this tool apart from mainstream clinical tools is that it asks the client, from their worldview, what they believe is the reason behind their problem(s), and how those in their community would understand their problem(s). By focusing clinical attention on the client's perspective and social context, it can improve clinical communication by enhancing rapport, allowing for the collection of new cultural information in a short period of time. This approach also elicits clients' perspectives on what caused their symptoms, leading the client to reflect deeply, gain insights into their problems, and feel more understood by their clinicians (Jarvis et al., 2020). Situating the helping relationship in this way can help to level power dynamics that can be compounded when serving younger clients, including IBPOC youth.

Identified Barriers to Accessing Mental Healthcare for IBPOC Individuals in Canada

One of the first conversations about IBPOC mental healthcare in Canada in the literature revolved around barriers to access. Indigenous peoples, Black Canadians, and immigrants and refugees in Canada under-utilize mental health services compared to white Canadians (Chen et al., 2009; Fenta et al., 2006; Fung & Wong, 2007; Hadjipavlou et al., 2018; Hilario et al., 2018;

Kirmayer et al., 2007; Thomson et al., 2015). Scholars have identified a number of interrelated barriers to accessing mental healthcare for IBPOC in Canada.

First, stigma toward mental health and mental illness is an important issue in many ethnocultural communities across Canada (Chen et al., 2009; Donnelly et al., 2011; Fenta et al., 2006; Kirmayer et al., 2021). Often mental illness is regarded as something that brings shame not only to the individual but also to those who are connected to the individual, such as their immediate family, extended family, their community, and even their people group (Chen et al., 2009; Donnelly et al., 2011; Fenta et al., 2006; Kirmayer et al., 2021).

Second, a different understanding of mental illness may lead some to believe that mental illness is ‘incurable’ and an affliction that the individual and the family will need to live with for the rest of their lives, further adding to the stigma of mental illness in some communities (Chen et al., 2009).

Third, some IBPOC individuals have a fear of the unknown consequences of being diagnosed with a mental illness, such as being deported, separated from family, or losing their children (Donnelly et al., 2011).

Fourth, mental health problems can present differently across cultures and thus they need to be explored and understood in each cultural context. Groleau & Kirmayer (2004) highlighted this phenomenon through their study of Vietnamese-Canadian clients who were experiencing psychosomatic symptoms that could not be explained or treated by Western medicine. The participants had a sophisticated understanding of two expressions of distress in their culture (i.e., *phong tâp’* and *uâ’t u’ć*), which provided a deeper understanding of how their symptoms developed and therefore informed treatment.

Fifth, the lack of clarity about how to navigate the mental healthcare system is a significant barrier to accessing care for IBPOC individuals (Thomson et al., 2015). For example, many people do not know who they should contact or how to contact someone if they are struggling. Oftentimes, mental health issues will worsen to the point where services must then be accessed in a crisis situation (Chiu et al., 2018; Kirmayer 2004). Family doctors or emergency departments are usually the first point of contact when IBPOC individuals seek support for mental health problems in Canada, especially given the greater somatic presentation of mental distress in these groups (Chiu et al., 2018; Kirmayer et al., 2004; Saunders et al., 2018). Perhaps the complexity of the public system is another reason why most IBPOC in Canada access mental healthcare through private, specialized, non-profit organizations (Hilario et al., 2018; Van Ngo, 2009).

Sixth, the "lack of knowledge about and understanding of mental health" by IBPOC individuals in Canada has been discussed in the literature as a significant barrier to accessing mental healthcare (Ganesan et al.,, 2011; Thomson et al., 2015). However, the wording of "lack" implies a limited ethnocentrism in itself. For instance, if certain symptoms of mental distress are not present or are not interpreted in the same way across cultures, then who is the party that "lacks" the knowledge? An approach such as *Two-Eyed Seeing* is much more appropriate when trying to conceptualize mental health across cultures (Carter et al., 2017; Martin, 2012). Two-Eyed Seeing places equal value and emphasis on two or more perspectives, holding the dialectical and honouring the tensions between them, understanding that both perspectives can be true and have equal merit (Martin, 2012).

Finally, the literature identifies a number of considerable barriers which can significantly affect the experience of receiving mental healthcare for IBPOC youth and their families. These barriers include: a lack of language translation and an overdependence on family members to translate, a fear of not having confidentiality, a lack of visible IBPOC individuals on the clinical team, culturally insensitive or incongruent interventions, mistrust of Western biomedicine, the decentering of socioeconomic needs, fear of stigmatization by healthcare providers, and the ethnocentric attitudes and beliefs of providers (Donnelly et al., 2011; Jones et al., 2021). Culturally insensitive interventions include those that have underlying ethnocentrism in interventions and practices (e.g., an assumption that Cognitive-Behavioral Therapy will work for everyone; Jones et al., 2021). Further, when socioeconomic needs are decentered, addressing socioeconomic needs is not seen as key to treatment and recovery (Jones et al., 2021). Donnelly and colleagues (2011) argued that the solutions to these mental health problems can only be derived if we listen to those who are receiving current mental healthcare services.

Current Recommendations For 'Cultural Adaptations'

Most of the literature on cultural adaptations to mental health treatment come from an American context. For instance, Griner & Smith (2006) conducted a meta-analysis of 76 (mainly American) studies and found an overall positive effect of culturally adapted mental health interventions with effect sizes of "moderate" magnitude. They found the following cultural adaptations resulted in better outcomes: adapting individual treatment to group format, vice versa, or combined; mixed-race versus same-race intervention groups; longer length of treatment; cultural content incorporated into the intervention; therapist-client ethnic matching; non-English services; cultural/multicultural paradigm of the clinic; involving cultural consultants; outreach recruitment; staff sensitivity training; and using referrals to external services (Griner & Smith, 2006).

Healey et al. (2017) also conducted a systematic review on this topic with mostly American studies (31 in total), and found three major areas of adaptations: adaptation of content, changes to the way that services were delivered, and consultation with the community to create changes to service delivery. Healey and colleagues (2017) did not find consistent evidence supporting the implementation of any specific type of adaptation or increased efficacy with any particular cultural group.

Finally, Rathod and colleagues (2018) summarized 12 meta-analyses on the topic of culturally adapted mental health services, and concluded that there is a significant gap on comprehensive reviews that provide direct guidance to policy makers and clinicians. They called for further research into the process of adaptation to discover which approaches are helpful and which are not.

Studies on specific topics, such as Rowan and colleagues' (2014) meta-analysis of cultural interventions to treat addictions in Indigenous populations, are a promising start to this literature. Furthermore, Measham and colleagues' (2014) presented a series of case studies from Canada which highlighted the importance of supporting a community wrap-around approach to mental healthcare for refugee children (e.g., including the family, school, community health clinic, etc.), taking the time to understand a family or client's reluctance to receive the suggested care, and rolling with the strategies that the family and client already find effective as a way of promoting strengths.

Overall, these kinds of cultural adaptations take significant intention and resources. However, these adaptations must be prioritized, as not providing culturally adapted care may contribute to harm (Wendt et al., 2015). Unfortunately, mental health service delivery is rarely informed by the perspectives of IBPOC individuals who receive them (whether the service is culturally adapted or not). Thus, there is a missed opportunity to understand what IBPOC clients perceive to be the gaps or inadequacies in care. Mental health service providers are important sources of information; however, there is a need for greater focus on the experiences and perspectives of the IBPOC youth themselves who are the recipients of mental healthcare.

The Need for Lived Experience and Expertise

While lived experience should not be the only factor that shapes policy and service delivery, changes to mental healthcare in Canada should be developed via a partnership and collaboration between those with professional expertise and IBPOC youth with lived experiences of mental illness. Studies have highlighted the importance of understanding the perspectives of those individuals with oppressed and marginalized identities in order to better understand the psychological and sociopolitical factors that affect their mental healthcare use. This can include learning more about which supports would address these complex needs, why there are high levels of dropout after care is initially accessed, and what can be done to address the high level of dropout in the first place (Donnelly et al., 2011; Fung & Wong, 2007; Jones et al., 2021; King, Smith, & Gracey, 2009; Kirmayer et al., 2021).

Hilario et al. (2023) specifically reviewed how the impact of racism on adolescents is explored and discussed in the literature. They highlighted the importance of understanding the impact of racism on adolescents, and found that racism in healthcare services was often expressed through the quality of treatment and care toward racialized adolescents. Gajaria et al. (2021) highlighted that systemic racism needs to be addressed in the mental healthcare of Canadian children and adolescents, and specifically that more research needs to be conducted with racialized young people in Canada in order to address this gap in knowledge. This would result in improvements to the experiences of Canadian racialized youth in accessing and receiving mental healthcare. From an Indigenous perspective, researchers who have reviewed the current Canadian literature on mental health services for Indigenous youth in Canada, have found that research is conducted through a lens of medicalization, and using lenses of intersectionality and cultural safety could offer a more balanced cultural counter to traditional Western approaches (Weerasinghe et al., 2023).

We need to hear directly from Canadian IBPOC youth about their experiences so that we can understand whether the current general mental healthcare services – as well as culturally sensitive and attuned approaches – are working in Canada. Qualitative research can provide IBPOC youth with the space to communicate their stories and can help facilitate a fuller and richer exploration of their experiences, rather than through the restrictions of quantitative research. Without this kind of research to add to the body of evidence, it will be difficult to advocate for policy and systemic change, and even more difficult to understand how the changes should be implemented. We need to understand how the policies and systems that shape the social fabric of Canada have affected the daily lives of the most vulnerable, and how IBPOC youth cope and make sense of their everyday experiences (Spencer, 2007; Velez & Spencer, 2018). In essence, an important approach to help understand the lived experience of IBPOC youth living with mental illness is to conduct qualitative research that highlights their voices.

Edwards (2025) presented data from an art-based research project that focused on identity for six Black Afro-Caribbean youth living in urban areas of Southern Ontario. Edwards specifically wanted to use art-based research to resist colonial ways of conducting research, and instead wanted to use a modality that could acknowledge the cultural, historical, and racial context that shapes people’s lives without misrepresenting or distorting the knowledge and realities of Black people. Edwards asked the participants to create ‘identity maps’ and was able to capture profound and nuanced findings such as: colourism at individual and system levels; the harms of European standards of beauty; a desire and preference to have race and ethnicity be central to their identity because it allows them to feel a sense of connectedness to their Black identity; concern and awareness of how they are stereotyped, discriminated, and racialized against for being Black; needing to adopt 'safety behaviours' and hypervigilance to avoid unwanted negative attention that could result in being criminalized because of being Black; feeling racial pride and resilience by being Black in a society where being Black is met with ongoing racism; and how they are "resisting and decolonizing colonial constructs of Blackness through their construction of positive messages of what being Black entails (Edwards, p 37)." It would be difficult to fathom such rich and decolonial research findings resulting from traditional quantitative research methodologies.

Examples of Qualitative Research That Explore Culturally-Attuned Care in Canada

A few studies have been conducted in Canada that provide a qualitative analysis of culturally-attuned care and highlight the lived experience of IBPOC individuals who have received this care. Hadjipavlou and colleagues (2018) explored the experience of 37 adult participants from at least 20 different Canadian First Nations. The participants were part of an Indigenous program for mental health and well-being that featured the inclusion of Elders in the direct care of patients in an inner-city primary care clinic. All but one participant described substantial benefits from their interactions with Elders, and no one reported being negatively affected. There were five main themes that were identified from the interviews: experiencing healing after long periods of searching and feelings of desperation; strengthening cultural identity and belonging; developing trust and opening up; coping with losses; and engaging with ceremony and spiritual aspects of care as a resource for hope.

Reeves & Stewart (2007) explored the experience of 6 Indigenous adult men who had accessed services at Anishnawbe Health Toronto, a culture-based community health centre, to facilitate healing from sexualized trauma. The participants discussed the ongoing mistrust of the medical, educational, and religious institutions within communities, and the degradation of their mental health as a result of systemic racism and colonialism. The program focused on psychoeducation around colonization; exploration of Indigenous cultural values, teachings, and traditions; engaging in spiritual healing; and addressing isolation and identity issues. Anishnawbe Health Toronto offered community circles and healing events such as weekly sweat lodge ceremonies, medicine picking, and seasonal fasting trips, with the intent of bringing the community together. The men shared that though they were initially hesitant and sometimes resistant to receiving services (especially if mandated), the ability to build relationships between clients and counsellors, and allowing for the healing process to be a lengthy process, helped them to speak about and acknowledge their trauma. Further, they shared that having a culturally safe place to explore their traditions and spirituality was central to their healing.

As well, a few researchers have explored the experience of IBPOC individuals who receive services from the traditional mental healthcare system. Donnelly et al. (2011) conducted an exploratory qualitative study to increase understanding of the experience of the mental healthcare system for immigrant and refugee adult women in Calgary. Their approach was informed by the ecological conceptual framework and postcolonial feminist perspectives. In contrast to the Hadjipavlou et al. (2018) study, the women received care through general mental health services, rather than specific culturally adapted services. Interviews revealed serious incongruencies between the worldviews of the participants and the values within which the mental healthcare system is embedded. For example, the majority of the participants had concerns regarding the clinician-client relationship. The women identified a few critical provider-specific components that were needed for them to continue using the available mental healthcare services: providers who genuinely care about them and are interested in their stories, providers who spend adequate time with them, providers with awareness of the women's cultural backgrounds, and providers with an awareness of the impact of the migration process. Without these elements, the women stated that clinicians would not be able to build trust and rapport with them, leading to disappointment and distrust of the Western healthcare system, and ultimately, the termination of services. This study revealed and explored some of the many pitfalls of care that is not culturally-attuned.

Other examples of culturally-attuned care providers or those working toward providing culturally attuned care in Canada include: San'yas Indigenous Cultural Safety Training delivered by the Provincial Health Services Authority of BC, Indigenous Focusing-Oriented Therapy training offered through the Justice Institute of BC, ACCESS Open Minds using the pre-existing Fish Net Model in the First Nation community of Eskasoni, the Cultural Consultation Service out of the Jewish General Hospital in Montreal, the Cross-Cultural Mental Health Clinic at Vancouver General Hospital, and the Hong Fook Mental Health Association in Toronto. Continued research is needed in order to know which services are working, which services are not adequately serving mental health needs in IBPOC communities, and to share knowledge with the wider community about how to deliver effective services.

Examples of Qualitative Research That Explores Youth Experiences of Mental Health Services in Canada

Researchers are acknowledging and acting on the significant need for further exploration of youths' experiences of using Canadian mental health services. Researchers know that there has been an increased focus on the mental health needs of youth, but there is still a lack of research that focuses on the mental health needs that youth themselves identify (Barbic et al. 2019; Jenkins et al., 2017; Lal et al., 2017; Slemon, 2019). There are few published articles that use qualitative methods to explore youths' perspectives on mental health services in Canada. Below is a curated selection of studies that used qualitative methods to explore the lived experience of youth with mental health problems in Canada.

Islam and colleagues (2017) explored the mental health challenges and barriers to accessing mental health services for 10 South Asian youth in the Peel Region of Toronto, Canada. A social determinants of health and intersectionality lens were used to guide this research project. A thematic analysis of the interviews revealed several major themes: differences in what was emphasized across worldviews (e.g., psychotropic medication, spirituality, etc.), a lack of targeted mental health outreach to South Asian youth, a lack of education about mental health in schools, long waiting times when accessing mental healthcare, and social stigma within the South Asian community (e.g., community knowledge of an individual's mental health problems subsequently affecting marital prospects). The youth also voiced recommendations for improving mental healthcare services for youth in their community. Their recommendations included: schools taking a more active role in normalizing help-seeking for mental health issues (e.g., guidance counsellors being more proactive, increasing the number of staff from racialized backgrounds), increasing free or low-cost services with professionals who are trained in working with youth, offering services in convenient community locations, increasing the number of South Asian mental health professionals, increasing representation of South Asian youth in mental health promotional materials, and offering mental health programs that do not use the term "mental health" (e.g., sports/arts programs that foster connection and build resilience) so that parents will not object to their child attending a mental health program. The youth also discussed the complexities of navigating relationship dynamics with their parents, including differences in acculturation and in coping with mental health problems. The youth recommended that leaders within the South Asian community (such as religious leaders, politicians, celebrities, and others) could take a more active role in promoting mental health awareness and combating stigma in their parents' generation. This study highlighted the importance of understanding IBPOC youth perspectives and the value of asking the youth for meaningful and logical recommendations that can be implemented in their communities.

Salami et al. (2021) conducted a youth-led participatory action research study to understand access to health care for Canadian-born and immigrant Black youth in Edmonton, Alberta. They conducted individual interviews and café-style focus groups with a total of 129 youth. Their findings highlighted that there are key barriers that affect access and the use of mental health service by Black youth, such as a lack of cultural inclusion and safety, a lack of knowledge and information on the mental health services available, the cost of mental health services, geographical distance, mental health stigma, and 'limits of resilience'. The idea of limits to resilience was an interesting concept. They explained it is because Black people in Canada have historically faced struggles and trauma that prompted them to create a culture of independence, resilience, and self-sufficiency, which meant that mental health struggles are a threat to these qualities. Therefore, Black youth are expected to manage their mental health struggles privately and on their own. One recommendation the youth made to address this barrier was to be careful of an overemphasis on hardiness and self-sufficiency, while still honouring and highlighting the importance of resilience. In a subsequent article based on the same interviews and conversation cafés, Salami et al. (2022) discussed how anti-Black racism and microaggressions affected the mental health of Black youth, particularly how they internalized the anti-Blackness and felt ‘othered’ by white people outside of the Black community. Youth also discussed how they experienced a generational gap between their generation and previous generations, both in the sacrifices that previous generations had made for the youth, and also a lack of openness from them in understanding mental health problems.

Mai (2024) conducted semi-structured interviews with five IBPOC youth in British Columbia to gather their recommendations for anti-racism and mental wellness programming in high schools. Using thematic analysis, seven themes were constructed from the interviews. Particularly relevant themes uncovered were that youth felt that their wellness was deeply connected to culture and identity, the need for an intersectional approach, the need for the program to understand the importance of family and the broader cultural community, and the desire to see more IBPOC individuals represented at various levels of the healthcare system.

Sheikhan et al. (2023) used focus groups with 22 youth living with mental health challenges to understand the barriers to early intervention among youth seeking mental health services in Ontario, Canada. Though this study was not focused on IBPOC youth, an interesting theme that came out of this research was that youth described feeling a constant negotiation between feeling ‘sick enough’ and ‘not sick enough’ to receive services, which affected their help-seeking behaviour. A recommendation by the authors was to propose early intervention models of care so that youth know that they do not need to be ‘sick enough’ to receive care.

Lal et al. (2017) wanted to understand how mental health and related services support and hinder resilience in young people diagnosed with first-episode psychosis. Seventeen youth from Vancouver, BC, between the ages of 18-24, were interviewed. While the intent was for each participant to be interviewed twice, a total of 31 in-depth interviews were conducted. Lal and colleagues (2017) used a blend of grounded theory and narrative inquiry research methods. The researchers stated that there was a diverse range of socioeconomic and ethnic backgrounds represented in their sample, with 7 participants identifying as racialized (First Nations, Asian, or Latin American). They identified several themes about the services that were experienced as enhancing resilience, as well as several themes that were experienced as hindering resilience. Relevantly, one of the latter themes identified was service providers 'being out of tune with needs' when interacting with participants, and participants not being understood by their clinicians, which led to supports that were not effective or meaningful. This study highlighted that more attention is needed from policy, research, and practice about the systemic factors that impact services and recovery. The authors touched on the idea that their methodology and focus of the study (i.e., 'well-being') contributed to a richer and deeper understanding of the youths' lives, when compared with other studies that investigated similar topics using qualitative methods. Specifically, they raised the point that their participants discussed themes of spirituality, physical health, and morality, while previous studies did not find these themes.

Jenkins et al. (2017) focused on gathering youth perspectives on substance use prevention and harm reduction. They used an ethnographic approach to bring the 'youth voice' to the literature on mental health and substance use. They conducted 86 interviews with young people aged 13-18 across three communities (urban, suburban, and rural) in British Columbia. Researchers recruited youth through schools with permission from the respective school boards and interviews were conducted within the school building. The authors did not discuss a theoretical framework from which they operated, other than using a multi-site qualitative analysis that used thematic analysis on interviews within each site first, and then a between-site thematic coding and analysis. The researchers noticed a pattern of young people's experiences of substance use being shaped by geographic, socio-cultural, and political contexts, and especially in relation to their peer groups and the broader community. The strategies that youth used reflected their specific contexts. Findings highlighted that harm reduction approaches need to be contextually relevant and responsive to the lived experiences of youth.

Tying it Together

There is a need for more scholarship on how to culturally adapt interventions and how to engage with communities to partner in developing innovative interventions so that policy makers and clinicians can implement these important changes to current practices. Many studies do not give detailed accounts of the positionality of the researcher or how relationships were formed between researchers and participants. Though experienced clinicians have created changes and innovations in their practices, only a few have been able to translate their knowledge to clinicians across Canada.

Further, there have been calls for partnerships and collaboration between systems, such as families, schools, and communities, in order to provide effective care to youth who are immigrants and refugees in Canada (Herati & Meyer, 2020). Further to this point, the coordination and collaboration between schools, communities, and families must also extend to include government policy and mental health services. True community work requires extensive time, investment of resources, levelling of power dynamics, and willingness from stakeholders.

In addition to hearing from the experts, we also need to hear from those with lived experience. We need to hear from IBPOC youth who have accessed mental health services in Canada. Together, through collaboration and partnership, we can create innovative solutions that can actually meet adequate standards of care. According to Kirmayer et al. (2021):

> The clinical setting can be seen as a space of negotiation between different cultural systems of knowledge and practice and different value systems. These reflect not only the ethnocultural backgrounds of the patient and clinician but also the implicit values and ideologies that structure medical knowledge and the healthcare system. (p. 211)

Clinicians must actively level the power dynamics in the provider-client relationship, provide opportunities for youth with lived experience to speak, and then respectfully listen to what these stakeholders share. Incorporating clients' knowledge together with the expertise of clinicians will only create a stronger and better mental health system for all.

The Current Study

The aim of the current study is to explore the experiences of IBPOC youth who received mental health services in Victoria, BC (the Greater Victoria Area; a mid-sized Canadian city), with the goal of understanding their mental healthcare experiences, the meanings made about those experiences, as well as their preferences and priorities for high quality mental healthcare.

This qualitative study explored the lived experience of IBPOC youth who received or are receiving mental healthcare in Victoria, BC. This study explored their lived experience through narrative methodology (specifically the Collaborative Narrative Method), which centred on the youths' voices and empowered them as Co-Investigators in the study.

These voices will be presented through five narratives followed by a discussion exploring each individual's context (including intergenerational dynamics, histories of colonization, and social location) and the meaning they have made of their experiences of receiving mental health services in Victoria.

Chapter 2: Methodology

Epistemological Approach of Social Constructionism

The epistemology of social constructionism posits that knowledge and understanding are co-constructed between an individual and other people (Bruner, 1987; Reissman, 2005). Meaning is a construction that occurs within an interchange between humans and their social world. Social constructionists posit that as humans, we actively participate in the meaning-making and interpretation of life through social interchange, whether through broader discourse or more intimate conversation. Social constructionists are interested in what is happening between people as they come together to discuss and make meaning of their experiences.

When considering the topic of this study and how an individual youth understands their interactions with a mental health system, it is imperative to acknowledge the unique perspective and meaning-making processes that the youth is undertaking in their cultural context and in relation to their environment. Individuals construct their own meanings of their world, therefore, no two people will have the exact same understanding of it. Each person has a uniquely constructed perspective that is carried every day to understand and make sense of their experiences.

Narrative Inquiry: The Study of Human Experience Through the Interpretation of Stories

A personal narrative, as understood in sociology and psychology, usually refers to longer accounts of one's life that is situated in one's own context, and is typically relayed to a researcher via an interview or conversational format (Reissman, 2005). Narrative analysis does not make claims outside of the specific context in which that interaction occurred – in other words, for that specific individual, at that specific point in time (Polkinghorne, 1995).

Narrative researchers posit that humans understand and organize their lives through the stories they tell themselves (Bruner, 1987; Polkinghorne, 1995; Reissman, 2005). Narrative researchers would go so far as to say that not only do we understand and interpret what happens to us through stories (as stories are a reflection of our realities), stories actually begin to shape how we take in new experiences (Bruner, 1987). Therefore, stories allow us to structure our realities (Bruner, 1987).

Story-telling is inherently situated within social constructionism, as the act of telling a story and listening to a story involves other people. How a person tells a story shapes the interaction and the knowledge that is created: the information they choose to share, the information they do not share, the meaning they have already made and try to explain overtly, even the passivity of the orator's voice which may allow the listener to come to their own conclusions. For instance, if a group of individuals listens to a person sharing a story, each individual may take away a different meaning of the story. They may find different parts of the story uniquely salient to them, disagree with certain parts, or engage with the story actively or passively. Social constructionism posits that since knowledge is socially constructed (Burr, 2003), there is room within this perspective for multiple realities that may conflict with one another.

The research methodology of narrative inquiry is situated within social constructionism as it is interested in understanding human experiences through the telling, recording, and interpretation of stories of an individual or small group. Narrative inquiry is a natural fit for understanding race-based interactions as it allows for the possibility that each person's lived experience and meaning-making is uniquely their own. Further, since narrative inquiry acknowledges that stories are lived experiences, it is possible to gain a deeper understanding of a type of research ‘puzzle’ rather than a research question (Johnson & Christensen, 2019). As Johnson & Christensen (2019) explained, “Narrative inquiry encompasses time (the passing of time as well as the experience of time), social experiences (personal and social dimensions), and place (specific situations and geographical locations).”

Narrative researchers are interested in operating from a place of these kinds of questions: What is the *story* I tell myself about my experience? How do *I* understand the story I tell myself about my experience? How do I communicate this to *others*? What meaning do *I* want them to take from it? What meaning do *they* take from it? What meaning do *we* create of it?

In narrative inquiry, there is an understanding that the researcher and the participant are *both* contributing to the development of the narrative, and that the story is an active construction between the two parties. Both parties are jointly involved in developing the narrative of events. Therefore, it is impossible for the researcher to be a neutral, unbiased party, as they are actively contributing and jointly making meaning of the experience of the participant as well.

As such, it is imperative that researchers engage in a process of *reflexivity*. That is, the researcher must intentionally reflect on their own meaning-making of being a part of the research process so that they, in turn, are aware (as much as one can be) of how it may affect the research process. This involves having clarity on the personal and practical justifications for why the researcher wants to conduct a narrative inquiry.

Justifying the Use of Narrative Inquiry. There are several reasons for why narrative inquiry is a fitting choice for this research topic. Narrative inquiry is a form of research practice that is cross-cultural and also honours cultural understandings and honours the importance of relationships (Barton, 2004; Chou, 2019). Studying narratives is a way to explore social change and personal identity (Elliott, 2005; Chou, 2019). There is a precedent for using narrative forms to understand and retain relational history, lived experience, and cultural knowledge, particularly areas of lived experience that are especially sensitive and private.

For example, narrative forms have been used to understand the experiences of families of Holocaust survivors (Bar-On, 1995), to inform the mandates put forth by the Truth and Reconciliation Commission for Indigenous Peoples of Canada (Truth and Reconciliation Commission of Canada, 2015), to explore individuals' experiences with specific social phenomena such as not conforming to a gender binary (Mair, 2016), to explore the understanding of fatherhood (Larsen, 2021), and to understand the intergenerational transmission of various phenomena within families of particular cultural diasporas (Chou, 2023; Ortiz, 2025).

Storytelling can also be a form of resistance or an act of advocacy (Solorzano & Yosso, 2002; Chou, 2019). It can allow for stories to emerge that may challenge dominant narratives or dominant ideologies (Milner, 2007; Chou, 2023). Telling one's story is an act of agency, an act of choice. It is a way to speak back to the powers that initially defined their experiences.

Narrative inquiry allows participants to discuss their experiences of using the public mental healthcare system as young people, without any constraints on how to talk about it or how to frame it. It allows for the participant to share their story from their unique perspective, no matter their cultural or racial background. It provides a way to discuss the act of being racialized without automatically centering on the white experience or automatically operating from a place of maturity being influenced by age. This method allows their experience to be the centre of their story, which is a different way of approaching research with young people or racialized people compared to current literature which tends to favour quantitative methods. Narrative inquiry can be a way of returning agency and power to participants through the research method itself.

Narrative research can also be used as a way of gathering information about peoples' adverse experiences in a way that is thoughtful and proactive about the possible risk of re-traumatizing or harming them. By speaking about the topic at a pace that is within their control, having agency over what they discuss and how it is discussed, and choosing what they do or do not want to include, the hope is that the participants' risk of being harmed is mitigated, even if the risk can never be fully eliminated. The purpose of this research is not solely to produce narratives, but also to commit to ethically centering on the well-being of and the relationship with each participant (Caine et al., 2013; Clandinin et al., 2018).

It is possible that by speaking about their adverse experiences through exploring the personal meaning they have made about their journeys and building a coherent narrative (Keats, 2009), the process itself may be helpful to their healing and well-being. By sharing their story in a way that feels right to them, it may serve the secondary aim of it being a therapeutic or cathartic process. Though this method is not psychotherapy, this act of social construction – that meaning is constructed in the space between people (Guterman, 2006) and having someone listen to their story and value it as important, and then construct it into a coherent story – may itself be an empowering process.

A common critique of narrative methods is that the results are not generalizable or replicable. In actuality, the narrative research method intentionally considers the richness of the complicated, numerous, nuanced, and inexplicably linked intersections of various facets of a person's life. This includes within relationships, intersections of systems (e.g., how public policy impacts how healthcare is delivered, and what the experience of interacting with the healthcare system is like), internal meaning-making, and re-interpretation. These nuances would be nearly impossible to capture for each participant using quantitative research methods. With this understanding, it becomes clear that generalizability or replicability of findings is not a relevant or applicable facet to this research methodology.

My Personal Justification: A Critical Theory Approach to Understanding the Experiences of IBPOC Youth in Mental Healthcare

I understand that my personal beliefs and viewpoints are influenced by critical theory (Kincheloe & McClaren, 1994). If social constructionism posits that our understanding of the world is influenced by the historical, political, social, and cultural contexts we live in, then critical theory extends this assumption. It asserts that narratives derived from positions of power will result in the continued perpetuation of dominant discourses (Solorzano & Yosso, 2002). Groups with power will continue to maintain their own knowledge's legitimacy that may intentionally or unintentionally reproduce oppressive systems based on race, gender, class, or culture. A critical theory approach using narrative inquiry acknowledges this understanding of how narratives are maintained and perpetuated via social constructionism and seeks to dismantle it by purposefully highlighting narratives that may be counter to the dominant discourse. It seeks to amplify voices that may be silenced because they do not have the privilege of being in positions to be shared.

My values of anti-racism and liberation, as well as my belief that power cannot be understood without social and historical context, were a large inspiration for this project. My intention is to amplify the voices of IBPOC youth because historically, their voices have not been viewed as privileged and thus have not been shared in research. To this end, the exploration of the lived experiences of participants are understood to be shaped within power relations, and co-constructed together with me through narrative inquiry – specifically, the Collaborative Narrative

Method. It is my hope that this work will challenge, critique, and improve the current mental healthcare system.

The Collaborative Narrative Method as a Way to Understand Lived Experience

The Collaborative Narrative Method (CNM), developed by Arvay (2003), is a narrative inquiry method used to explore the lived experience of participants in a way that emphasizes the participant's active and continued construction of their reality and meaning-making. The CNM is a qualitative method that blends narrative inquiry with collaborative and participatory research practices. The CNM can accommodate the positionality of understanding how a person is living within the power structures and relations they are embedded within. Indeed, within this method, it is understood that the social world is where power relations reside, and that meaning is dependent on who is speaking to whom, and which power dynamics reside within the relationship. Researchers who use this methodology are guided by the belief that this narrative inquiry results in co-constructed knowledge produced through the interaction between the researcher and the participant. Using a lens that is structured in this way allows us to have a deeper understanding of how a youth makes sense of their experiences and interactions within the mental healthcare system, while acknowledging that the act of telling their story is an internal interaction between their present self and their past memories.

Given the collaborative nature of this methodology, participants are referred to as *Co-Investigators* as they are active and equal partners in the research process of constructing the narratives. A central tenet to this approach is to intentionally level the power dynamics found in traditional qualitative research, which – intentionally or not – usually privilege the researcher's perspective, since researchers tend to have control over the research questions, the information-gathering process, and the final product, including knowledge translation. In CNM, while the researcher forms the basic research questions and the general structure of the information-gathering process, the Co-Investigators are invited to take the discussion in whichever direction it makes sense for them given the context of their lives. They are encouraged to actively contribute to the content and framing of their story, and to have continued and final editorial power over their narrative. Reflexivity is central to the approach, as the researcher must scrutinize and examine how power relations are attended to both within the research relationship and when constructing the resulting narratives.

There are seven stages within this research process as described by Arvay (2003):

1. *Setting the stage.* Before the research formally begins, the researcher meets with the Co-Investigator to engage in a pre-interview dialogue to discuss the research process. Though the researcher decides the aims and questions before this meeting, the purpose of this first meeting is to develop rapport, begin the conversation regarding the research questions, explain the research process, outline the roles and responsibilities of each party, articulate the researcher's own values regarding the research, and to explain the philosophical values that the research design is rooted within.
2. *The performance.* The research interview is understood to be a joint interaction between the researcher and Co-Investigator. Stories are invited, and the researcher holds dual-consciousness in being both a performer in the story as the narrator, and reflecting on the story as a researcher. Together, the story is constructed and meaning is built. Upon completion of the performance, both the Co-Investigator and the researcher are asked to write down any thoughts about the interview process.
3. *The transcription process.* Transcription is understood to be an interpretive practice in CNM for two reasons: 1) past events cannot be exactly reproduced and, 2) the

transcription process is understood to be another construction of the story. The interview is transcribed twice by the researcher who was a part of the performance (rather than outsourcing the work). The first transcription is considered a rough draft, with great attention to detail (e.g., noting pauses, silence, laughter, tone of voice) and adding in relevant information from field notes (e.g., the Co-Investigator discussed a heavy topic with incongruent body language). For the second draft, the transcript is re-transcribed into *stanza form,* as described by Reissman (1993), where tone of speech and pace are marked. During this second draft, *narrative episodes* are identified. Narrative episodes are the places in the text where the stories begin, end, or are continued later on, in order to understand the temporal sequencing of the storyline and to understand how the plot unfolds.

4. *Four collaborative interpretive readings of the transcript.* Both the Co-Investigators and the researcher complete four interpretive readings of the transcript together: reading for content, reading for self as the narrator, reading for the research question, and reading for relations of power and culture.
5. *The interpretive interview.* This stage involves a collaborative interpretation of the text together with the Co-Investigator. Each person listens and responds to each other's interpretations, and the discussion is audiotaped or documented in writing. Any meanings, ambiguous parts of the narrative, and cultural implications of the interpretations are discussed.
6. *Writing stories.* The research narrative is a result of drafting the interpretive readings into one sequential narrative. The stories are written as first person accounts, which are

coherent and revelatory of the storyteller’s intent. The narratives are understood as a joint construction between the researcher and the Co-Investigator.

7. *Sharing the story.* The story is shared with the participants and the public.

The CNM has been used to study a number of complex and varied phenomena such as exploring the narratives of people who identify as having a non-binary gender identity (Mair, 2016), capturing the narratives of intergenerational dynamics of Chinese-Canadian families (Chou, 2019), exploring the experience and perceptions of pleasure in sex for gay, bisexual, and queer men (Gendron, 2023), exploring young women’s narratives of self-objectification and sexual pleasure (Beyer, 2022), and exploring narratives of shyness and friendship in female adolescents (Tan, 2014).

The CNM informs the presentation of results as narratives because the key elements of the CNM are to preserve each participant’s voice, capture their experience by co-constructing a narrative, and situate the narratives within time, place, and the individual’s context (Arvay, 2003). A narrative allows for these elements to be upheld while allowing for the power and compellingness of the stories to be heard (Arvay, 2003; Ospina & Dodge, 2005; Riessman, 2008).

While this research project stayed mostly true to the original CNM, there were slight changes that were made to the method in order to lower barriers for Co-Investigators. These changes will be discussed where applicable in the research procedures section to follow.

Research Questions

Given the relevant literature and theoretical perspectives reviewed previously, the following research questions guided the research process:

1. What are the narratives of IBPOC youth who have experienced the mental healthcare system in Victoria, BC?
    a. How do they experience the mental healthcare system in Victoria, BC?
        i. Who do youth perceive as important in their care/support?
    b. What meaning do IBPOC youth make of their experience of the mental healthcare system in Victoria, BC?
    c. What do IBPOC youth want and need from their mental healthcare?

Research Procedures

Relational Ethics. Given that the topic of this research project is very personal and sensitive, there was a plan in place to care for the Co-Investigators in case they became triggered or distressed through the research process. There was also a rationale weighing the pros and cons of asking individuals to make themselves vulnerable in this way, which was discussed with each Co-Investigator while 'setting the stage.'

The purpose of this study was to share the stories of young people in a way that felt as safe as possible given the potential vulnerability of their stories becoming public. In order to mitigate harm against the Co-Investigators, what was included in the final narratives was wholly under their control and power (i.e., the Co-Investigators held final editorial power). Further, I endeavored to create a sense of safety during sessions with the Co-Investigators through developing rapport and encouraging self-determination and agency in their research decisions. As discussed in the ethics protocol, I ensured that the Co-Investigators knew that they could withdraw their participation at any time and that only pseudonyms would be used in the final narrative. I ensured that the Co-Investigators were aware that there might be risks with making their story public, even while using pseudonyms (i.e., there might be other identifying information in their stories). My hope was that the Co-Investigators' beliefs were aligned with my own: that by sharing their stories, the possible benefits would outweigh the costs.

As registered psychologists, Drs. Erica Woodin and Fred Chou agreed to provide one debriefing session with the Co-Investigators as necessary, with parameters stated during the informed consent process of the study. I also provided the Co-Investigators with a list of community resources if they wanted to access mental healthcare (both private and public resources).

Inviting Co-Investigators. The plan was to recruit five to ten IBPOC youth within the range of 16 to 30 years of age who were born in Canada (e.g., second (or greater) generation immigrant/refugee status, Indigenous peoples, Black individuals, etc.), and who self-identified as being racialized. To be included, the Co-Investigators had to have accessed public (free) mental health services in the Victoria, BC, area at any point during the age range when they would be considered to be a 'mature minor' in BC (i.e., 13 to 18 years of age). Five Co-Investigators were included in the study, and at the time of the story-sharing meeting, they ranged in age from 17 to 26 years old. The researcher met with each Co-Investigator on a rolling admissions basis.

This age range was chosen to recruit youth who had a greater chance of being connected with their nuclear families at the time that they accessed public mental healthcare and were likely still in the process of identity formation and exploration. Further, this period of adolescence is often a time of negotiating and discovering autonomy, while also having greater say over their access to care if they are deemed to be "mature minors" (i.e., able to provide consent to care for themselves).

The planned sample size was in line with the reasoning that narrative analysis is better suited to smaller sample sizes because of the time-consuming and detail-oriented nature of the method (Arvay, 2003; Reissman, 1993). Given how time-intensive and demanding the CNM can be for both the researcher and the participants, the sample size was limited. Further, the sample size was restricted in order to provide significant and meaningful honoraria and compensation for each participant (a total of $125 for each participant). As well, narrative research is incongruent with the idea of generalizability or replicability of results in any case, as the purpose is to deeply explore and understand the meaning and context of each individual's reality, which cannot be generalized to another person's individual context and lived experience.

The criteria requiring participants to be born in Canada was to acknowledge the difference in experiences for first generation immigrants compared to the experience of subsequent generations. For individuals who are born in Canada, they may have more cultural knowledge of dominant norms and may have a greater understanding of how to navigate Canadian systems given the differences in acculturation that can occur between generations of newcomers (Abouguendia & Noels, 2010; Berry & Hou, 2017; Costigan & Dokis, 2006; Kirmayer et al., 2007). This may mean that their experiences may have more to do with racialization than with cultural differences as compared to first generation immigrants.

English language fluency was required as the only language that I speak fluently is English, and also given the heavy requirement of language familiarity with the selected research method. Potential Co-Investigators were required to live in Victoria, BC, in order to provide the opportunity to conduct the research in-person, and for the Co-Investigators to be immersed in living in the context of Victoria in the past and present. It is possible that Victoria's demographic makeup may have important implications regarding a sense of belonging for the IBPOC youth who grow up there, given that previous research has found that racially diverse areas are positively associated with a greater sense of belonging (Chiu et al., 2018; Wu et al., 2011).

Exclusion criteria included people who have active psychosis, mania, or other severe mental illness that was currently impairing, as it would not make sense to prioritize a research study before their own wellbeing. Potential participants were asked to self-identify this either before or during the initial consent process, and the researcher's clinical judgment was also used when needed.

Recruitment was conducted from May 2022 to December 2023 on a rolling basis. Strategies included posting flyers in public areas of the university and city, university and community email listservs, reaching out to relevant campus clubs, sharing about the project through word of mouth to personal and professional contacts, giving announcements at the beginning of undergraduate classes to explain the project and to introduce the researcher, and through paid advertisements through the social media platform Instagram.

One Co-Investigator was recruited through word of mouth, another Co-Investigator was recruited through a community email listserv, and three Co-Investigators were recruited through paid Instagram advertisements.

Stage 1: Setting the Stage. Before the research formally began, I had a conversation with each of the Co-Investigators to introduce myself, to share more information about the purpose of the research project, and to discuss the research process. The main goals of these conversations were to give the potential Co-Investigators a sense of my identity, to begin the conversation regarding the research questions, to explain the research process as well as consent, to discuss what they could expect of me and what would be expected of them, to share my own reasons for why this research topic was important to me, and to explain how the research method was purposefully chosen to amplify the voices of young people who wanted to share their story.

Most importantly, we discussed how to present the stories in the way they wanted them to be shared with the world.

During these conversations, I disclosed aspects of my identity to reduce my power. I located myself as a younger racialized person, a second-generation Korean immigrant, and as someone who lives with mental health issues and has accessed and continues to access public mental health services in Victoria, BC.

I explained how participation at all stages was completely voluntary, and that the Co-Investigators could choose to stop participating and remove their story from the project at any stage without consequences. Given the Co-Investigators would have a history of mental health concerns, I explained to them that they could limit their involvement in the study to adjust to their life circumstances. For example, after completing the narrative interview, should the Co-Investigator no longer be able to commit to the study methods, they could choose their level of continued involvement (e.g., consent to allow their narrative to be included, consent to the researcher continuing with the 2 readings with editorial power of the Co-Investigator, etc.). It was explained to Co-Investigators that their confidentiality and anonymity would be preserved, and that they could choose the level of any potentially identifying information to present in their stories.

All Co-Investigators (except one) participated in this ‘setting of the stage’ via phone call (usually about 30 minutes) with the researcher. The Co-Investigator who declined the phone call opted to receive the information via email instead.

Stage 2: The Performance. Semi-structured interviews were conducted in order to better understand the experiences of each Co-Investigator as they navigated the public mental healthcare system in Victoria, BC. While originally the hope was to offer to meet in-person, during the process of recruitment, I had to physically relocate to Treaty 6 Territory (Edmonton, AB) for a clinical psychology residency year. As such, all meetings with Co-Investigators were conducted virtually over Zoom. All story-sharing meetings were audio-recorded, and notes were taken during and after the meetings.

I provided the Co-Investigators with a list of questions that could be discussed throughout the meeting (see Appendix A). However, given that each person's context and lived experience is different, I explained to the Co-Investigators that not every question would need to be asked of them, and that they could choose to take the conversation wherever it made sense to them in the telling of their story. I made it clear that the stories that arose in the interview would be prioritized. For some story sharing meetings, the prompts were largely disregarded, and the participants were able to take the conversation in whatever direction they wanted to go in.

While approximately 1-1.5 hours was planned with the Co-Investigators for this story-sharing meeting, these meetings often went much longer (they ranged in length from 1.5 to 3 hours). In total, 5 Co-Investigators participated in the story-sharing meetings, resulting in 9.75 total recorded hours of dialogue. The average time for each interview was approximately 1.75 hours.

Stage 3: The Transcription Process. Interviews were transcribed verbatim. Intentional focus was paid to the perceived themes and intended meaning of the Co-Investigators that was captured in the interviews, rather than the way or the structure of how the story was told. I completed 4 out of 5 of the transcriptions based on a rudimentary Zoom automated transcript. Although it was labour-intensive, personally transcribing the data allowed me to be repeatedly immersed in the stories, which gave me a deep and detailed understanding of them.

After a verbatim transcript was created, it was transformed into a revised transcript by removing all identifying information and leaving prompts for the Co-Investigators to consider (e.g., if clarity was needed, if they wanted to include/exclude certain parts of their story if it would be somewhat identifiable through deduction, etc.). These de-identified transcripts were provided to the Co-Investigators for consideration.

Stage 4: Collaborative Interpretive Readings of the Transcript. The original CNM required participants to engage in 4 interpretive readings of the transcript. However, given that most of the transcripts were well over 50 pages in length, asking Co-Investigators to engage that many times with the lengthy document was not practical. To lower the burden on the Co-Investigators, we completed 2 interpretive readings of each transcript.

The first reading was to read for accuracy of content in their story. The Co-Investigator was invited to make changes to the transcript to make the content clearer, to expand or explain the temporal sequencing of the narrative episodes, or to make corrections. Ultimately, the goal was to ensure that the transcript was true to their story. They were also invited to consider which parts of their story they wanted to include and which parts they wanted to exclude, especially if any information could be used to triangulate their identity.

The second reading involved keeping the research questions in mind, and reflecting on their story in relation to the research questions.

Stage 5: The Interpretive Interview. The next stage involved a collaborative interpretation of the text with each of the Co-Investigators. Each person listened and responded to the other’s interpretations. Detailed notes and audio recordings were kept of these discussions. Meaning, ambiguous parts of the narrative, and cultural implications of the interpretations were discussed. Co-Investigators addressed the research questions in their reflections and discussions.

While originally 1-1.5 hours was budgeted for these meetings, these meetings often lasted up to 2 hours due to the investment and passion of the Co-Investigators. All of the Co-Investigators found that they wanted to continue the meetings beyond the planned amount of time.

Stage 6: Writing the Stories. The research narrative was a result of summarizing the two interpretive readings into one text. All Co-Investigators were invited to write their own stories, and all opted for the researcher to draft the narrative and were comfortable with taking on the role of editor.

The stories were written as first-person accounts, and intentionally incorporated the meaning-making and reflections the Co-Investigators shared during the interpretive interview. Stories were written by staying as closely as possible to the transcript in order to preserve the voices of the Co-Investigators. This method is consistent with the spirit of the CNM, as this procedure serves to limit the researcher's power to change the meaning of the narrative. Some Co-Investigators continued to edit their story in great detail beyond the intial narrative constructed from their transcript, while others were largely happy with how their narrative read when based off the initial narrative.

The Co-Investigator was invited to edit the narrative draft and had the final say regarding the presentation and content of the narrative. It was sometimes difficult to decide what to include in the stories for a number of reasons such as privacy concerns, potential for backlash, a desire to protect or not traumatize the reader, and more. The decision of what to include and what not to include in the narratives was always left in the hands of the Co-Investigator. This was a conscious decision made, again consistent with the values of the CNM, in order to not censor the Co-Investigator or to remove or dull any parts of their narrative due to the researcher's own discomfort or possible disagreement. Some Co-Investigators did decide to remove some parts of their narrative for their own reasons, and others decided to intentionally leave in some elements of their story as a way of speaking to power.

How the final narratives were constructed were highly dependent on the stories themselves, how they were told, and what the Co-Investigator wanted as the final editor. While most narrative methodology instructs narratives to be plotted according to time, participants were allowed the freedom to orient their stories in ways that felt more natural to them, which speaks to the importance of allowing each person the ability to share their story the way they want it to be shared. While for most Co-Investigators that meant sequencing the narrative according to time, for others, there was less emphasis on constructing their story this way.

Stage 7: Sharing the Story. The story was shared with the participants, and now are being shared with the intended audience: you, the public.

The Co-Investigators Meet: Themes Across the Narratives

While the results and product of the CNM and this research project are the narratives themselves, it can be helpful to condense such rich and vast knowledge into themes. The purpose behind creating these themes was to make the knowledge generated from the narratives more translatable and accessible to stakeholders (such as policy-makers, researchers, training programs, and the public). Since many of the Co-Investigators had asked if the others would be willing to meet as well, co-constructing themes across the narratives was added as a post-hoc procedure to facilitate conversation and meaning-making between co-investigators.

Given this was a post-hoc procedure, it was explained to Co-Investigators that their level of anonymity and confidentiality would change (from their initial consent at the beginning of the project) once they participated in this group. Separate consent forms were sent out and signed by each of the Co-Investigators, acknowledging this new level of risk (see Appendix C). Interestingly, this desire to meet one another continued from the start to the end of the research project. This joint meeting was another layer of attempting to level power dynamics and include checks and balances in how their stories were being interpreted.

Once all the narratives were written, the researcher compiled common themes that arose across the narratives and presented them to the Co-Investigators all together. The themes presented to the Co-Investigators were drawn from the completed narratives, rather than the raw data. This was an intentional decision made by the researcher to only draw from what the Co-Investigators were comfortable with making public – from the stories that they wanted to present to the world.

Given that this process was a post-hoc procedure, theme generation was not guided by a specific coding analysis in order to prioritize timeliness and ease of accessibility to the content of the themes for the Co-Investigators. Instead, the researcher reviewed each narrative and wrote dwn a list of themes, then compared across the lists of themes to see which ones appeared across two or more narratives. The writer chose the themes that appeared the most frequently across the stories to present to the Co-Investigators. Please see Appendix D for the original list of themes generated by the researcher.

Next, the Co-Investigators were invited to meet each other in-person to discuss common themes that arose across the narratives. This was to ensure that these themes resonated with the Co-Investigators and were representative themes across their narratives. Presenting the themes to the Co-Investigators served as another layer of member-checking and peer review. Some of the themes were changed or amalgamated based on the Co-Investigators' feedback and co-construction, or were explained in further detail with examples from their own stories. Some new themes were identified and brought forth from the Co-Investigators, particularly the themes regarding recommendations for service providers.

The generation of themes is not necessary nor is it a part of the CNM as the results of the method are the narratives themselves. However, given that one of the main aims of this project is to inform community stakeholders about the Co-Investigators' experiences, themes were generated to help facilitate discussion and knowledge translation. While an established coding methodology was not used for this post-hoc procedure, the co-constructed nature of developing the themes as a group continued to be in line with the spirit of the CNM even if theme generation itself was not included in the original method. This allowed for the discussion of themes to be informed by the perspectives and voices of the Co-Investigators themselves, rather than the researcher alone drawing conclusions about the meaning and implications of their stories.

Evaluating the Trustworthiness of the Research Process

Trustworthiness

The goal of the study was never to represent the absolute truth (Polkinghorne, 2007; Reissman, 2008). Rather, the aim was to take a position where the narratives are based on life events that are told from the perspective of the individuals who lived them. This is inherently an interpretation of reality. In line with that aim, there were specific steps taken to ensure the trustworthiness of the study given this position, guided by the recommendations set out by Loh (2013). First, *member checking*, which is the process where the product is taken back to participants to offer them a chance to provide more context or a different interpretation, was intentionally woven throughout each step of the research procedures. Co-Investigators were continually asked throughout the research process if the story still felt true to them (i.e., multiple readings of the transcript, discussion meeting, editing process). At each step, they were asked to consider which parts of the story they wanted to be represented and if there were any parts they wanted to add, take out, or emphasize. Co-Investigators were given a potentially unlimited number of opportunities for member-checking through the editing process. The Co-Investigators had multiple points of interaction with the research process in order to ensure that the constructed product was as close to a triangulated representation of their interpretation of their reality as possible (i.e., through multiple interviews with the same Co-Investigator, two readings of the transcript, analysis of their narrative, etc.). *Thick description*, which was embedded throughout these narratives, is the concept of providing contextual details to further understanding and helps to facilitate the utility of the research, as it is only possible to apply any generated knowledge to a different but similar context when the knowledge is contextualized. Supervisory committee members served as a form of peer review, as I sought out their feedback and expertise on the research design and how to approach the generation of themes, especially as the latter is not a part of the CNM. The joint Co-Investigator meeting served as an additional form of peer review, to see whether the identified themes pulled from across the stories resonated and made sense to them given each of their varied experiences.

Reflexivity: The Researcher's Role and Location

In addition to reflecting on the opening statement about my own social location, throughout this project, I engaged in ongoing self-reflection as directed in the CNM manual (Arvay, 2003). I journalled about my process as a researcher and noted personal reactions and reflections I noticed in response to the meetings with the Co-Investigators or when thinking through research decisions. This helped me be aware of where I was situated both as a researcher, and personally as 'Pauline' in my own work life as a clinical psychology resident and eventually as a clinical psychologist. I considered the themes and reactions that I generated, and also considered the quality of my emotional energy for each meeting with Co-Investigators. In order to be able to bring my full ability to be present with the Co-Investigators, I made the conscious decision to drastically limit my clinical workload on the days I met with them.

Due to my own life circumstances, parts of the dissertation were delayed. I was often repeatedly surprised by how all of the Co-Investigators remained invested throughout the process, which told me a story of their belief in the importance of the project and how the relationships we had built were meaningful and authentic. The Co-Investigators expressed messages of support and encouragement to me throughout each stage of the project or when I let them know how life events had delayed my progress. This truly added to the sense that this project has been a co-construction between the researcher and Co-Investigators. I continue to be grateful to them for their belief in me and in this work.

Analysis of Power

In order to guide the research process an Advisory Committee was formed, made up of community stakeholders such as IBPOC people with lived experience of using the mental health system, IBPOC and white mental health clinicians in the community, school counsellors from local school boards, and leaders of community services. The role of the Advisory Committee was to provide feedback on the structure and methods of the proposed study and whether the study would be addressing a need in the community. The Advisory Committee agreed that this project was addressing an important need in the community to better the mental health service experience for IBPOC youth in Victoria. Many of the members helped guide the process of recruitment (e.g., advising on who to contact or where to go to spread word of the study, how to word flyers or emails, what would be culturally sensitive, etc.). A follow-up meeting will be planned with the Advisory Committee in order to hear their insights on what they perceive would be effective methods of knowledge translation back to the community. The hope was for power dynamics to be further levelled by including racialized people with lived experience to guide the rationale, approach, and structure of the research.

The CNM was chosen for the purpose of attempting to level power dynamics inherent in any research process. Despite this, I was aware throughout the process that I was still the person in a position of power. I was the one holding the data, writing the stories, and using the research as a means of fulfilling my own degree requirements. I know that I am in a privileged position, not only because of the research relationship with my Co-Investigators, but because of my own social location as a middle class, well-educated researcher, and trained clinical psychologist. While I continue to acknowledge and work to reduce my power, I know that these efforts will never be able to fully level the power differential between me and the Co-Investigators.

Chapter 3: Results

Five Co-Investigators participated in the study. At the date of the story-sharing meeting, their ages ranged from 18 years old to 25 years old. All Co-Investigators had accessed some form of free public mental health service in Victoria, BC, at some point between the ages of 13 and 18 years of age. The Co-Investigators identified as IBPOC and racialized and were all born in Canada.

The stories are presented with great effort taken to preserve each person's voice. Given that the stories have been written and presented to intentionally represent the Co-Investigators' own perspectives on the events that have happened in their lives, there will inherently be opinion woven in with their telling of events.

Due to what the narratives revealed, it inherently caused tensions between giving voice to the Co-Investigators and considering what would best serve the needs of the community. As with any work that provides critiques of real people and systems, it can be difficult to walk the line of providing honest feedback while not demoralizing people who are engaged in good and important work. It was not the intention of any of the Co-Investigators, the researcher, or the committee members, to single out specific places or people but rather to provide examples of situations in which IBPOC youth did or did not reeive the type of support they needed.

Overall, Co-Investigators wanted their forthrightness to be a catalyst for meaningful change. Some elements of the stories may be jarring to certain readers. Some elements of the stories may be encouraging to certain readers. Co-Investigators intentionally wanted to highlight both their adverse experiences and their profound moments of feeling seen and heard. The goal of the research method and the Co-Investigators, is to compel the reader to engage with the stories in meaningful ways. The hope is to "call people in" to create positive change, not to maliciously expose negative interactions. The Co-Investigator's hope is for service providers to be able to learn from these experiences. Speaking as a fellow professional, any of us can make mistakes or blunders. What matters most are the actions we take after we learn of them to repair relationships with our clients.

This chapter shares the stories of the five Co-Investigators: Hassan, Tonia, Fen, Raven, and Felix. The stories have been written collaboratively with their final editorial say.

Hassan's Story

Hassan (he/him) was 25 years old when he shared his story. His description of his racial identity was "Part-Arab." The date of the first interview was on September 19, 2022, and the date of the follow-up discussion meeting was on January 21, 2023. Below is his story.

PART 1: BIRTH AND BACKGROUND

I was born and raised in Victoria, so I've lived my whole life in Victoria. My parents met at UVIC and got married a few years later. My mom is French-Canadian from Eastern Canada and my dad is Arab. So it's always been me trying to figure out, who am I? That identity crisis is always there. Even to this day, I'm still trying to figure out who I am.

My mom grew up Catholic and moved around a lot growing up. In the case of my dad, he was living in a war zone but then he came to Canada to Pearson College on a scholarship. All of that affects my story.

My maternal grandparents, my uncle, my aunt – they're Catholic. Not only are they Catholic, my uncle is a Catholic priest. My grandparents are very staunch Catholic. Very religious. And so my mom always had stress when dealing with them. She didn't grow up Muslim. She *chose* to be Muslim. She *converted*. And that was a very controversial thing for my [maternal] grandparents and my uncle. She got along better with my [maternal] aunt because she wasn't as religious. My mom even became depressed and later on she developed psychosis. The big fights happened around when I was born, and I didn't even know that she had a brother until the end of my elementary school years because she had such a bad relationship with him. It took a really long time to get over the fights and the conflict and the religious battles in the family. It was disconnected and still to this day, it's stressful to visit with her family. Any time my grandparents, aunt, or uncle would come visit, there was something missing. A puzzle piece of actually feeling like you're a part of the family. It just wasn't there. And to this day, it's still fractured and broken. And no matter how much my dad or my mum would try to say we have similarities, like how my dad is a religious guy and trying to get along as best as he can and respect them – in return, my parents didn't always get respect. There was always that tension from my mom's side of the family, you know, we don't get along so well with them but they're in Canada.

And then for my dad's side, they're not here but they really care about you. And when my mum went to see my dad's family, she fit right in! They were so nice to her, they respected her; it was a totally different experience. She even told her mom, "These people have furniture, they wash, they're friendly," because my grandma is just very racist. She had very racist ideas about my dad. She had watched some strange movies with bad stereotypes in them and it validated what she wanted to think, even though it was so far from the truth.

My dad's family is probably in the most troubled part of the region, an area that is closed off from the rest of the world. So it's very hard that I was never able to go to visit them because of the situation. I went there once when I was a baby but I don't remember that visit. Growing up, I wanted to help but I couldn't do anything about it. Things just kept getting worse and worse. And so now, I just have to live with the fact that I need to do the things in my life that I want to do, but at the same time I'm always concerned about them. It definitely affects my mental health because sometimes I'm just sitting down and thinking about the situation and I can't even wrap my head around it because it's so awful. My mental health – there's always that trigger there. Any time there is serious conflict going on there, bombs – it affects me.

And it’s hard because I don’t really know them, but I wish I did. They want to get to know me too. I’m like that weird cousin that lives halfway across the world who they don’t know! I got excited when I found out that some of them spoke English, because I thought they only spoke Arabic. Historically, the way for my dad to connect with people back home was by paying a premium for long-distance calls. When I got Facebook, I realized that my relatives were on there and I thought that I should try connecting with them.

I look like them! That’s part of the problem too. When I look at myself in the mirror, I see that side of the family. I don’t look as much like my mom.

PART 2: GROWING UP IN CANADA AND CATALYSTS

There were really three things that contributed to my mental health spiraling down. One, I didn’t really have a lot of friends growing up and I already had a lot of anxiety to begin with. Second, money was always tight in my household. The third thing was that my sister developed an eating disorder and that really took a toll on the family.

Social anxiety was a contributing factor because I didn’t know how to talk to people and get to know them properly. But honestly, some of the people I was around in school were not that interested in me somehow, and I wonder if there was an element of that they didn’t know what to do with me because I was *different*. I wasn’t “Canadian.” I visibly looked different. When I was really young, I only had two good friends. One of them – I can’t remember what happened – but they just didn’t seem that interested in me anymore as we got older. So I only had one friend left, and I got disconnected with that one friend and then I was pretty much alone. It was very difficult because I was in French Immersion from kindergarten to grade 12, and there weren’t many boys. And so trying to make friends was not easy when you only have like five other people to choose from. And if you don't get along with them, then that's a big problem.

I was alone for a long time, and even with all my anxiety I tried to make in-roads with other people, but I still somehow just didn't connect with them. Even through high school when I was going through therapy, it was like other people didn't really want me there. I was just too weird. I was too different.

In college, it was very hard to make connections with people because I tend to be very sincere and I want to have good conversations, but a lot of people are just not interested in that. People are busy with other friends, other things – and they're not really that interested in getting to know somebody who wants to care about them and care back. They want passive friendships. So it's very hard because my parents are bringing me up in a certain way, to be a certain person, and I think I'm gonna be a good person by doing things that way. And then when I'm not accepted, it's tough. It's really tough.

Growing up, there was financial stress in my family. A better way to put that is probably stress from my dad. And a big part of that was financial stress but he also had stress at work, and then stress from the situation where his family is. He was also volunteering and he had to deal with all kinds of very stressful people. And so it was just a lot of things. We had just moved into a house from an apartment. Most of the stress had to do with finances because he seems to be very anxious about spending money, but there were other factors there. It really fed into my own mental health issues because I can feel people's anxiety since I have anxiety myself. My mom was always stressed because of the religious tensions with her own family and she developed depression because of it, and then psychosis later on when I was in high school.

I think I was in Grade 4 when she started dealing with depression. For her, psychosis came along when I was in Grade 10. I think that was due to the stress of dealing with my sister and even me too. She ended up in the hospital when I was in Grade 10, and then at some point she stopped taking her pills and she ended up in the hospital again when I was in Grade 12. It's really hard to be in your graduating year and your mom is in the hospital. It's still hard but it's different now that we're older. My sister and I handle it differently.

The very first person I talked to about this stuff was my middle school vice principal who did some counselling. This one time I had written something in my Grade 6 class, and my teacher noticed what I wrote. She was concerned and so she referred me to them, and I had a crying kind of meltdown. I talked to them and felt better after that. I felt like I could actually talk to somebody about things. But that wasn't enough.

And then the following year, I had more sessions with the school counsellor. And I think even into my Grade 8 year, I was having some sessions. But it didn't really get to the root of my problem.

Also, my sister is younger than me. When she was in Grade 4, she started having some weird eating habits. Before that, she had been overweight on and off. So I guess she decided to take it into her own hands to eat healthy and then it went out of control. She wasn't eating a lot of different things and so her body became skin and bones. Eventually we had to go to the doctor, and the doctor said, "She has an eating disorder. She needs to drink milk, and she needs to see the special people from Child and Youth Mental Health who deal with eating disorders." Obviously, this had a big effect on me too. And the interesting thing is that if it wasn't for her getting sick, I might not have gotten a referral to CYMH for myself.

PART 3: ACCESSING CYMH

We had no idea that this place – CYMH – existed! We didn't know that there was help out there that you didn't have to pay $300 an hour for! We were shocked that there was actually help that was government-funded and that they could actually help you. I was really relieved that there was somebody who could help me, and I didn't have to pay a premium. The cost was very prohibitive. Because for years, we knew there were services but we always thought, "Aw that's too expensive! Can't do it! Gotta figure out another cheaper way." It just wasn't working. We were stuck.

As my parents started talking to the lady that was helping my sister with the eating disorder, they started figuring out that I had problems too and it wasn't just my sister. My sister had a lot of anxiety, unstable friendships, and then they started talking about me, and it's like, "Well he's got problems too!" I got a referral from the doctor and once that was in place, I was in the system. I had my first appointment with a counsellor there, and that's how the whole journey started.

I was in Grade 9 when I first accessed services at CYMH. I wanted to do it. I was determined to solve my 'friends' problem. That was initially what I wanted to fix. I felt like my life was not going very well and my parents said that maybe CYMH could help with that. I felt like it was a risk but I was willing to take it because everything else I had tried didn't work. And my long chats with my mom while going for a walk was not going to solve it because she's not a psychologist. CYMH was the first time I could really talk about what was going on with me, and not just about my problems with friends. Talking about relationships with friends was a big part of the work I did with the school counsellor, but maybe they sensed other things in me.

I saw three different therapists there over the course of Grades 9 and 10. I also had a psychiatrist who was in a different place and they had their own practice. The initial therapist was a counsellor. I think the second one I had was a student. And then she referred me to somebody else because she was leaving. It was hard because my mental health was so volatile and fragile at that point in time. It's hard to trust people when you have to keep telling your story over and over again. I was a little reluctant. You're delving into a lot of information to this person that you don't even know. Yeah, it's confidential but it's… a strange feeling. It's kind of like blowing the lid off a jar that's tightly sealed. Because for so long, that's what I was doing – keeping it all sealed – because I didn't know what to do or how to deal with it. I felt like I had to re-explain my story again with each new person and that would take a number of sessions and then I'm working with them again, and then it's like I'm finally getting somewhere.

In high school, I had a counsellor and he would connect with the therapist and the psychiatrist. And he helped me with the individual education plan so that I could get educational assistance in some of my classes. And he was someone who helped me with course stuff (like timetables), but I also talked to him about other stuff too. It was really like if there was some way he could help, he would try to help. I repeated myself a number of times with him and my therapist but it kept them connected.

I did individual therapy with the counsellors and the psychiatrist prescribed me medications. I tried them, but they didn't always work. The therapists… they definitely tried to help me as much as they could, but it was pretty much just for anxiety. Maybe some social anxiety. I think I also did a social anxiety group, Reducing Anxiety and Panic – I tried that group for a few weeks and then I was just too depressed to do it. It was very hard on me.

It was a very scary time in my life because I couldn’t do my schoolwork, I was anxious, I was depressed, I was starting to have thoughts of harming myself. I was just really in a – I felt like a lump. I’d go to school and have such high levels of anxiety. It was just debilitating. And it was just like nothing was getting anywhere. I had one teacher that really sparked my anxiety because she was very... negative and didn’t really care about my mental health. She cared more about how I wrote an essay. That lady *really* triggered me. She made me feel inadequate. She was older and grumpy. She actually had problems with other students because she was a French Immersion teacher but she would make a lot of mistakes with her French. Eventually other students complained to the administration about her.

And we tried to have a counsellor from CYMH and one of my parents and the teacher to talk together. And this teacher was not cooperative. She phoned on the wrong day and then said, “Why didn’t you show up!” Well, we had made an appointment, and she didn’t follow that appointment! She was really rude about it, so my mom just told the counsellor to forget about it. My mom has always had social anxiety, and it could have played a part in not asserting herself with people. But she definitely told my therapist that this lady (the teacher) was out to lunch. This was maybe about 6 months before my mom ended up in the hospital the first time.

The thing that really made my mom want to help me with that was that she speaks French herself, and this was a French Immersion class. That class threw me off for many many years to come. It was a wreck. It de-motivated me to do my school work and gave me a lot of anxiety, a lot more than before. Because I couldn’t do my school work, it definitely made me have serious thoughts of suicide. I had given up hope with school because of that experience. And I don’t think I’ve ever really regained it back.

And what didn’t help was the previous semester I had a lot of work to do, and I felt so burnt out. She was the kind of teacher that would give you a whole project to do for the next day. I thought she had lost her mind. I had a teacher the previous semester joke about that and I was like, “I’m never gonna come across that because it’s so crazy.” And then there you go! And nobody handed it in the next day because nobody had time to do that! This was in grade 9. Academics was my whole life pretty much.

Academics – that was success. Nothing else really matters because you just have to get down to work and do your stuff. That belief – it’s a combination of negative self-talk, but mainly I think it comes from my parents. Just the values that they shared with me. Especially my dad. Knowledge and school is like a reward. It gets you somewhere. Otherwise you’re not worth much. For my dad, academic success was everything because it gave him the opportunity to escape a war zone. So it’s like he’s passing it on to me.

Unfortunately for this teacher, all the smart kids were in that class so they weren’t going to let her get away with what she was doing. And actually, she didn’t finish the full semester. I don’t know what happened, but eventually she left. I was sick for a few days with a cold. When I came back to school, we had a new teacher for a few weeks. She was a student teacher from the previous semester and she was really nice. She cared about the students.

My first CYMH therapist didn’t always know what to do with me. She tried to help me as best as she could but I found out what my real problem was later on. It wasn’t anxiety specifically. Therapy wasn’t working so well. I was trying to deal with the anxiety I had, and I definitely had anxiety at that point in time! I think back to that time now and laugh – but it was serious anxiety at that time. I eventually had to stop taking some of my medications because my mom was like, “You look like you’re going to do something to hurt yourself.” And so we talked with the psychiatrist and eventually I just took melatonin. I needed that for sleep but otherwise I wasn't on anything. The psychiatrist was good. My dad had some concerns and he addressed them. The psychiatrist said, "Don't worry! I'm not here to give you pills just so I can get a pretty laptop. I really care about the person I'm treating and I'm trying to help them as best as I can. And stories are stories but don't worry, I'm not one of those stories." He was good. But again, he didn't always know what to do with me. Sometimes it almost felt like he was pushing to see if I met criteria for other mental health diagnoses. No one had done a thorough assessment. It was just talking. It was a lot of talking.

For what I knew at the time, it was a good experience. It was definitely helpful but it didn't address my needs. I needed help that I didn't even know that I needed. The professionals at the time also did not know what I needed.

But then at the end of the day, maybe it wasn't helpful because they didn't really deal with the problem that I was having. Because they didn't know. They didn't know what I had and they couldn't deal with it themselves. They had to get somebody else to help. Ledger was the start of that help, but ultimately outpatient services at Anscomb was the key.

PART 4: EXPERIENCING QA

The summer after Grade 10, I had a change in services. The day after Grade 10 was done, I ended up at the hospital – Ledger House – at Queen Alexandra. I was fed up with feeling awful. I wanted to do something about my mental health because what I was doing just wasn't working. I needed something… better. The people at CYMH thought I could really benefit from a stay there. So that summer, I stayed there for about two months and they watched me and assessed me and I talked to them. And eventually I figured out what was really wrong with me.

The stay was good. There were some interesting moments because you're dealing with other kids that have mental health issues and sometimes you end up in some weird situations. But overall, it was a good experience. It kept us busy and most of the time I was able to come home for the weekend. I got to have visits with my parents. The time away from home was worth it because I wanted to get the help that I needed. I really needed a change. Most of the staff on the unit were pretty good. I could tell that they cared about me, they wanted me to progress. They wanted to understand what was going on with me. And they loved the fact that I was so honest with them. I just wanted to be as honest as possible.

One thing that I took away from the experience there is not hiding my dad's side of my identity. I was too scared for so many years to associate with that part of my identity. I was worried about racism, politics, negative connotations. There was one person in particular – a nurse – who told me to stop suppressing that. They said, "That's where your dad's from, that's where he comes from. If people are going to make bad comments about it, that's their problem, not your problem. You're just showing who you are." They said, "This is a part of who you are, and nobody can take that away from you. You need to associate yourself with that part of your identity too, not just your mom's side." They said, "Don't hide this, because it's your right to be who you are." It was no big deal for them to say that, but for me it was a *big deal*. It was a part of me that I hid away because I was scared for so long. So since then, I can say that I'm part Arab.

The other huge piece that came out of my stay there was that they discovered I had OCD. So that's where my anxiety was coming from. It was my OCD. And that was a whole different ball game of treatment! I mean, there are anxiety components involved, but this is so different! All I knew about OCD before was like the hand washing and the germs. I had watched the Cat in the Hat movie, and there's this guy, and he just kept nuking his hands with hand sanitizer, and I thought, oh that's OCD? So I'm one of those? But that's not exactly what I was doing. But it made sense because handwashing was a part of it. In Grade 5, we did a unit on how to wash your hands properly, and that stuck with me, and so I had to keep washing my hands all the time after that. I think that's when it started. When my head started having obsessions, and then I did all these compulsions, and then it just…spiraled.

It was funny, a few months before I ended up in the hospital, I saw something on TV about some people with OCD. And I was like, "Oh my goodness! That's me! I'm doing what they're doing! But I didn't really think too much about it. So I made sure I brought it up when I was in the hospital. But I just hope that they…would have looked into it because they were already going to look into it, not because I brought up something that I saw by chance. I actually spent an unusually long time at Ledger House. Most people were there for maybe about a month? But I was there for two months. I think maybe because of staffing shortages? People were away, and also…maybe because I just really needed the help. I needed more assessment done. And so they kept me for longer, and I wasn't in any rush to leave. I was just like, keep me here as long as you need! Because even if it goes into the school year, I want to get the help that I need so that I can get myself out of this rut. It was funny. Somebody who actually had OCD was helping me with the OCD at Ledger. One of the nurses – so she knew how hard it is – what you had to do to get it under control.

My parents also had some appointments with them when I was at Ledger. The parent support started then. Ledger was a good start but it wasn't everything.

It was definitely a turning point for my development because I didn't feel held back anymore. Of not knowing what was going on with me. I could move forward, rather than keep taking steps back. After I finished the two months at Ledger, I came out with a better understanding of what was going on, and then they referred me to the Anscomb program at QA.

I got a new psychiatrist who continued the medication that they started at Ledger, and I also got somebody who knew OCD. I worked very hard on my OCD, and I got the right medication. Things weren't perfect, but they were working a lot better and more smoothly than they were before. I kind of started understanding myself and getting the self-awareness of who I was, where I was coming from, what I was thinking, and what to *do* in different situations.

I had two therapists. I started off with the one who went on maternity leave, and so I had another one for a while. And eventually the other person came back from maternity leave and so I went back to them. But I had the same psychiatrist the whole time. The experience at Anscomb was a lot better because it really jived with what I needed and what I could do. I felt a sense of relief that I was in good hands. That they actually *understood* me.

There was also a social worker who helped my parents too. For a period of time, whenever I went there, my parents would be there and talk with the social worker. And then I would talk with the therapist. At some point I was working with a student on social anxiety. That student was working with my therapist (the original one who went on mat leave). With the student, all the things we were talking about, I already knew and was unconsciously applying it. But since I wasn't always applying it consciously, it was good to reinforce it.

The original therapist was the one who really knew OCD and who I had the most momentum with. The social worker support with my parents really helped them gain insight into OCD. I guess Ledger was trying to reinforce those things and trying to elaborate on things. So Anscomb was more for what are we going to do to keep this ball rolling. It was really eye-opening because my parents finally knew what to do with me. They had noticed some weird things that I was doing and my dad would get frustrated with me, and say. “Oh you need to toughen up. Why are you doing this stuff?” “I don’t know why I’m doing it, I just feel like I need to.” So at Anscomb, it kind of woke them up to the pattern and what was really happening. And my mom didn’t know what OCD was either. You know you hear things in Hollywood but you don’t know what it is. Which is really unfortunate. It was so relieving when my parents understood. It was revitalizing and refreshing.

I’ve often thought back to my time at CYMH. What was the expertise of the CYMH clinicians? Did they have expertise in OCD? If they did, how come they didn’t pick up on mine? When I was going there, OCD was still considered an anxiety disorder. So maybe that’s why they were just treating my ‘anxiety’, including social anxiety and some depression.

At CYMH, they’re good, but if they don’t understand you, there’s not much they can do. If mental health services can assess people better from the start, people probably wouldn’t be there as long, and it would put less pressure on the system because it would be more resource efficient.

I have good feelings toward QA. They really helped me move forward. If it wasn’t for them, I might not have graduated high school. I was with Anscomb until my first year of college when I aged out of the program. At that point, I went to the Adult Mental Health program at the Royal Jubilee. I’ve been there since.

PART 5: ACCESSING ADULT MENTAL HEALTH

Since both places are a part of Island Health, I kind of got gradually phased into the program at Adult Mental Health. So they actually let me stay at Anscomb for about 6 months longer. They made a bit of an exception for me. And then my care was eventually transferred over. I was fully transitioned to the new psychiatrist, and then the specialized mental health treatment group that I was going to. The transition was kind of hard because it was a new place. But my mom was already receiving services there, so she kind of showed me around so it wasn't so scary.

I didn't get a case manager until a few years after I started going to Adult Mental Health. They kept asking me whenever I went to the psychiatrist (who was the only person I was seeing there), who's your case manager? I didn't have a case manager! Why do you keep asking me if I have a case manager? It was because everyone else did! So eventually, I got one, and I think *that's* when my care became a lot better. The psychiatrist and the case manager worked together and they helped me with the things I needed. That's how I got the referral to the Mental Wellness Day Program. I didn't have the connection — the psychiatrist didn't think to refer me. And then my case manager said, 'Hey do you want to do this coffee group?' Sure, why not! I got a recovery coach with the Coffee Group at the Day Program.

The case manager was my gateway to the Day Program Groups. Funny, my mom had done those groups when she got out of the hospital the first time. But I never thought that I would be doing them and that I'd still be doing them now.

The psychiatrist and the recovery coach are a crucial connection, because that's how I get into these groups. That recovery coach retired in September, so I have another guy now. The coach is there to help in your recovery in ways that your psychiatrist or case manager can't. Sometimes the roles overlap (case manager & recovery coach). Anybody who goes through the Day Program gets a recovery coach. Recovery coaches lead a lot of the groups and they get a lot of training, and they may be OTs.

So I was able to start groups there, and later on I worked individually with a couple psychology students who I knew already from the specialized treatment group. At first, I was just doing the OCD group with no individual sessions. And so it was just the group and my psychiatrist and that was my support. I liked the group. Thinking back, I had an impact on others in my OCD group by what I shared which is nice to reflect on.

In September 2017, I was told that it seemed like the specialized group wasn't working for me, which felt surprising to me. And they wanted to refer me to an in-patient program at Sunnybrook in Toronto. How it was communicated to me was by the group facilitator taking me into a room after the group and he was talking to me for a little bit. I guess he kind of asked me about my parents and where they were from. Almost in like a way, he was almost blaming my dad's culture and the way that they do things that kind of covers up or deals with mental health problems properly. Not that I disagree with that, it was just the context was a little bit off.

I was like, I need to talk to my parents about this, I need to think about this. And then eventually, I was busy with school, and I got a case manager, and then that kinda slowed down that idea.

After that conversation, it felt like I didn't trust him as much. I still respected him, but I was worried that he was going to come up with a comment that was kind of off. I don't think he meant to be nasty. I think he was genuinely trying to help. But it came out wrong. I can see why he would think like that, but that's not always how it works.

I'm hypersensitive about people criticizing where my dad's from, and it all ties into mental health, and it actually encourages my OCD. I told him, no, family is an important part of the culture and they're tight knit, and they're not necessarily trying to cover it up. But I do recognize the political situation.

There was a day, when I was the only one who showed up to the group, and the student at the time (by then, the third student I had worked with) was like, ‘Hey, how’s it going. What’s happening with you?’ And I told her everything. She was like, well I think we really need to have one on one sessions to talk about some stuff. Her boss approved of it. He said, if that’s going to help you, then go ahead. So now I had the group, my psychiatrist, and the student. Things had seemed to be going better, but it was short-term and she was limited in what she could do to help me. And so I worked individually with that student for a few months, and then I worked with another student for about four months, and then there were two years where I did not have any individual support again. When I finally started working with a student again, that got cut short because of the pandemic.

We could talk about things, but the students were limited in what actions they could take to make that happen. They had to report to their boss. And that’s the thing that really got me. We couldn’t make the progress I needed because they weren’t a regular employee, they were bound by certain terms and conditions. If there was something very serious, they couldn’t deal with it. It had to be their boss. And their boss was the facilitator of the group. I was told by the students ‘I can’t do this, I can’t do that.’ Some really simple things, they were bound to the terms of the practicum. They wanted to help me, but they couldn’t. They felt restricted by whatever policies were in place there. Combined with how the group facilitator had made assumptions about my family and my mental health, it just showed me that he didn’t really understand where I was coming from.

On top of that, I found changing therapists is really hard for treating mental illness. It’s hard for them to understand what I’ve tried before, what I haven’t tried. What my situation is like. Losing momentum. Going back to square one every time. I mean the previous person can explain things to them, but you never really know until you get to know the person.

The first two students I worked with were IBPOC [of a different racial background than Hassan], and so they were racialized. One of them, his girlfriend was from where my dad was from. I actually felt quite comfortable with him. I felt like I didn't have to explain myself the whole nine yards. The other 3 students I worked with, they were white. So it is kind of harder to explain things. It wasn't like I had a problem with them, but it was just — I guess what I'm getting at — with mental health services, I have to explain myself a lot when I'm racialized. What I was often met with was curiosity, so it wasn't all bad. A lot of the time, what I get is assumptions (not just from mental health clinicians), just assumptions that I'm a certain way or that I do things a certain way. And it's not true. I'd rather see curiosity than assumptions (making assumptions like my grandma).

It's not like I could look for services elsewhere. People drive from the Malahat, just to come to this group. It's like the only specialized group that we know of. And if you didn't do this group, you'd have to pay a premium to see a specialist at a private clinic. I didn't think too much about it because there's nothing else! It was just, 'I gotta go with this.'

I didn't know how the system would deal with somebody who is racialized. If there would be a different way of looking at me. Racism and discrimination are subconsciously at the back of my mind in my care. I would definitely complain if there was something really serious that had happened to me. But it's always a thought in the back of my mind…If my name was John Smith, they might not think much about it. But I have a different name, it's not a name that everybody has. They might subconsciously think something different that maybe is not so healthy, just by looking at my name in my file. Would that affect my care? When I talk to people, it takes some time before I can be open and honest with them. Because I wonder, are they gonna be talking like my grandma? I know the system has things in place to make sure that it doesn't happen, but the fact that that's where it starts from is hard.

PART 6: THE PANDEMIC

I was *really* making headway with my OCD, and then March 2020! The whole thing fell apart, and it's just like *everything* to do with my OCD that I had worked on, it was just like thrown out the window. Flushed down the toilet. Have to start from scratch again, and everything around you is encouraging OCD. There's germs everywhere, you don't wanna catch the virus! My whole world fell apart. I didn't know what to do. I didn't go to the grocery store for the first month of the pandemic.

I was still connected with my psychiatrist and my case manager. There was the group but it was on Zoom and it wasn't the same. Even now [late 2022], it's still on Zoom! The facilitator of the group moved on, and then the guy who replaced him who was covering for him until somebody else came along, he's also leaving! So now they've fortunately found somebody to replace both of them who knows these mental health issues well, but these changes in the mental health system…when it's so fragile, and then something changes, it's really hard.

INTERCONNECTEDNESS OF SYSTEMS

I could have used more help at school, but they didn't have enough funding. The school and CYMH working together was not a great experience. It wasn't helpful. (The story about the teacher - that wasn't the school counsellor involved with that. That was the therapist directly with the teacher). Anscomb was more helpful. I think that the system is overwhelmed and exhausted.

REFLECTIONS ON RELATIONSHIPS, FAMILY, CLOSENESS

It didn't really feel like I could talk to other people ~~a~~bout this stuff other than my therapist and psychiatrist. I guess I would've wanted to talk to my parents more about it but I didn't always feel comfortable. It would have been nice to talk to my aunt about it but she—I just don't know how receptive she would have been to it. I was scared of starting fights, or creating tension, or that they wouldn't understand what I was talking about.

Going through college now, I try to go back to doing things the way I did them before this Grade 9 teacher. But it didn't go as planned because my OCD is pretty bad. I tried *so* hard, but I just couldn't do things the way I wanted to do things. I wanted to focus on academics, do things exactly the way they wanted, the whole notion of doing your best. But no. That's not good enough, I need to try my hardest. That's the culture that's being fed to me. Try my best really means try your hardest. I just feel like I'm never good enough. I'm always going to be judged if I don't do perfect. The standards are very high. The stakes are very high. It's almost about bragging rights within my dad's family, to show off. He's pretty much the only one that's not in that area. Everybody else is still there.

I refer to it as 'payback time.' To payback my parents for all they did for me growing up. I'm proving to them that I am worthy of being their son, and that they should value me as their son. I know in my college years, I tried to take it less seriously, but I just couldn't! It was all in or you're out. It was crazy to me that people were saying to step back and not be so hard on myself (some of my therapists, but mainly my parents). It seemed to me that they were still being hard on me, so why would I listen to their advice when that's what you're wanting from me?

REFLECTIONS ON RELIGION AND MENTAL HEALTH

To be fair, there are Canadian people, like my grandparents, who seriously suppress mental health. It's taboo to talk about it. They don't want to talk about it. Religion? Yes. Mental health? No way.

When there's stigma toward mental health, sometimes people will use religion to suppress it. Everything seems to surround religion. A lot of people don't really understand what their religion wants, and so they think that stigma is helping them be more religious. When actually the religious teachings in general seem to be about helping mental health. I think there's a misinterpretation. I know that being Muslim, there are definitely people in my Muslim community who do not understand mental health. And they become very very religious, but the root of their problem was actually mental health. They cover it up with religion. As my mom says, "they sweep it under the rug." And that's what my Catholic grandparents did to my mom growing up. Like somebody with schizophrenia, they can't use religion to make them well! What I'm getting at is that some people might think that schizophrenia can be treated with religion. It's kind of like extinguishing, put out the fire kind of thing, with religion. I know sometimes imams have talked about mental health, but people's feedback is not receptive. They just want to push it away, hide it. Like trying to put him, the troll, back under his bridge.

REFLECTIONS ON RACISM AND RECOMMENDATIONS

There can be awkward situations that come up for racialized people with mental illness in the system. Speaking about Victoria, if you're not white and you have a mental illness, it's kind of like you're a black sheep. Visibly different. Foreign.

I just found that sometimes as a racialized person, people didn't always understand where I was coming from. I had somebody tell me, kind of blame my mental health problems on the way that my…because of where my dad's from. And I told them, no, people look after each other, and it's close knit, and they care about the family. I think what they were trying to get at was that my family structure was trying to suppress mental health. But that's not the way I saw it. I mean, I can see why in some cultures that might happen, there's a lot of stigma. Even though my dad's family is in an unfortunate situation, I don't think that's what they're trying to do. So when that person said that to me, it just kind of opened my eyes. Like wow! Being able to understand other cultures…I think Canada is still trying to understand other cultures. And so the mental health system, is one thing that's affected by that.

Canada is still trying to understand non-British cultures, so the mental health system is based on British culture. Unconsciously what I mean when I say white, is British. The roots of Victoria's culture is British. I think my dad is always mindful of the fact that it's so British. Because the British did a lot of damage in his homeland.

It's hard for the system to deal with all these cultures and bring them together in Victoria for a mental health system. A one size fits all approach maybe doesn't always work. That's kinda what the mental health system has been. Everybody goes through this way because it has worked for Canadian people, but other people — if it doesn't work for them, well tough luck!

The comments from the group facilitator made me feel like I needed to prove myself. My dad's side of the family is *not* just a bunch of extremists. Because I feel like that's what people are getting at. They're trying to imply that. It's not like they're just bluntly calling me a terrorist, but they're um, yeah…I don't think he meant it in a bad way, but it came out — I don't know, it almost felt like a threat for me. Because of my upbringing and all of the negative connotations of my dad’s heritage. As a racialized person, it feels like I represent that region of where my parents are from, and I need to be this dictionary or encyclopedia, and people have these unrealistic expectations or assumptions. And if they find something bad, they just want to take it, turn it up, and use it against you.

What doesn’t help, and maybe what I was getting at earlier with regards to elementary school and being different, is that I *look* visibly different. It’s not something I can hide. I’m always conscious of what I’m doing, or what I’m saying, or how I’m doing things. You never know what’s gonna come up. And knowing how some people are nowadays, they’re ready to come after you and put you in the media and shame you and guilt you and put a negative image to you. And you can’t get rid of it after that.

Fen’s Story

Fen (any pronouns) was 19 years old when they shared their story. Their description of their racial identity was ‘South Asian’, ‘Punjabi’, or ‘Brown.’ The date of the first interview was on March 3, 2023, and the date of the follow-up discussion meeting was on May 30, 2024. Below is their story.

POLITICS

Sometimes it's like the world’s gone to shit. We can write a letter to our government. Nooo. Systematically it doesn't work like that. Like you can yell at them all they want. But *they* still have this barrier between the privilege of being the politician and the money they get from lobbying. It's just ridiculous. And they’re just like, oh, yeah, we can just write to our government or stand by the Parliament. But no. I feel like we need to approach it in a *way* completely different way. I think, not full anarchist, ‘cause like that's not gonna work out. Because everyone's completely different. So I don't think even having one main idea of following of a social system would even be beneficial. There's so many different things going on. Someone’s identity in politics is very prominent. Yet I don't think that it should be.

We talk about politics outside of politics, and really get to the fact of the systematic control that exists in government right now, and the fact that we should relinquish it a bit and gain more autonomy. Especially within our health care system, it’s really important, and mental health systems as well. They go hand in hand. Our food systems, I feel like it should be more localized. But not just disregard the fact that we do live in a capitalistic society. So we need to have that money, like we don't need to have it, obviously you can do without it. But, like. I'm thinking it could be completely different, and not to go full-fledged anarchy, but like definitely kind of reclaim the power that you give into these systems. From people who have exploited it from you.

That's my idea of like how I would kind of play it out is, privatization, but not necessarily privatization in the sense of like, where capital is the barrier between accessing health care like they do the States, but like, not banking on government systems to help you out. ‘Cause they don't.

For example, the mental health thing of like, ‘Oh, yeah, we're here for you.’ Like I get the ads all the time, I know I’m mentally ill. I don't need to be reminded on my Snapchat story, but thank you for that. Or Bell ‘Let's Talk.’ All these like corporation-backed access to mental health care virtually, and but people who often talk about it like, ‘Oh, yeah, because you should try this or you should try that or look at this new thing,’ they don't necessarily have the current experience to say this is a valid and acceptable response to our mental health care crisis. The fact that they kind of promote this and no one really talks about the fact how there's long wait calls--long wait times. We need specific things. And there's so many things that go into it that these health care systems like…

I found one that worked for me. But if it weren’t for my parents' private health care insurance – like in Canada, you get to claim ‘free healthcare,’ but like healthcare as an encompassing thing? If you're fully bleeding out like, yeah, they would help you. Maybe not all. They're not going to help you equally compared to other people with different races and what not. But they're going to stop the bleeding.

Mental health is such a thing that's like invisible. We always talk about that. That you can be smiling, and during dinner one night and next night, you know, we have to call help lines, and the next day go to school, and the next day…No, so it doesn't even play out in that sense of how mental health should be approached.

I've learned a lot more with the help of my doctor, my therapist, and people. I just talk about mental health issues. And we're like, oh, yeah, I have BPD (Borderline Personality Disorder), too, but I'm like, it's more of an ADHD thing than the actual BPD thing.

People look at me and think I identify as female. You look like a woman, and like you're not gonna get the same treatment of ADHD, as if you were a 7-year-old white boy. ADHD treatment is preferentially set up for young white children, especially white boys. Like generally for females or minorities, there's less of a mental health community. It doesn't even exist.

And like my mom was mad at medication. She doesn't like me taking my medication. I just got a refill. It's amazing. It's just like weed as well occasionally. So she doesn't like anything, and doesn't believe in mental health. That's a whole thing. Like you go talk to the parents. They'll say, 'I want to make sure you're safe or come back home. I'm worried for you.' But the facts are the same at home as I am here. I just have more my comfort here than I do at home. All these problems don't come from the location. It isn't the point. You just have to give up the power. You just have to be like, 'Okay, yeah, my mom is not going to accept this, but I need to do what I need to do.' And kind of just work through it.

I'm just a bit older too now. I'm 19. So like I'm still learning 'adulting' and like how to be an individual free willed person. I could try a whole bunch of different things, and it's just so long and tedious, and I have my hopes up so high sometimes and I just get absolutely crushed. It's quite in a public way too, many times. Just to try and make a phone call to my doctor's to try to make an appointment like, 'Hey? I need to see you.' They're like, 'Are you a patient? I'm like no, but I think I am, like I'm not an official patient, but I think the doctor team is like—' 'The doctor's not taking you -- come as a walk in patient.' That's 4 hours there. In the middle of my day, between 7 am. Because by noon you cannot get a spot.

And no one talks about that when it comes to politics, because there's so much power, so much emotion in our current political system that it's becoming more of a fight of who's right rather than what needs to happen. Like I want to be right. I want my religious values backed on this. I want my privileged identity to be the forefront of my policies, and not know that that's my privilege. They don't talk about it in a sense, it's kind of like a whole game of cat and mouse.

'They won't assign me labels'

UVIC claims they have this amazing CAL Centre. Centre for Accessible Learning, right? I'm like great, you know, I used to press on in a way that had recently been really regulated, like I've been okay. Like been getting by. But sometimes I'll have a week, and I just won't get out of bed. And I'll have a week where I'm really high energy. And I don't want to do any school work. I just want to…Hmm. Not necessarily manic, but like definitely high energy in the sense that I can't control it. Like an emotional regulation thing which is very common in BPD, but guess what! Also in ADHD and Autism! Isn't that crazy! So crazy! That I need to get a diagnosis for CAL to give me the things that I need.

And it's so weird because you go and you wait, and then you have to like, defend your mental illness! Which is so stupid because I'm an adult with bodily autonomy, and I can communicate to you my exact emotional needs and what I'm thinking. But the fact that I'm not a medical professional, and have a lack of access to medical professionals who can diagnose me with the correct things that I feel like I need to be validated on? Literally impossible, and it's super expensive.

So teachers are like-- Oh, yeah! Go to CAL! Right? No. Why can't I tell you as a human being, as an adult, that, ‘Hey, I know this exam is gonna take me more than 2 hours. I need time to process things a bit longer, and I have really bad distraction issues.’ Like why can't I look at you and just be like – ‘Hey, can you just give me another hour for this exam?’ But no, I need to justify it, defend it, write my academic concessions, say that I am mentally ill. And it's getting so annoying because it's the same story every time. And like professors that I have repeated, with other people in a different class, but with the same professor, they just know at that point, and they're just like: Expect my work Wednesday, and it's done with respect to myself of like I'm proud of my work that I give you. And everything like that.

So the fact that… UVIC claims...a lot of universities claim this, because obviously they don't want the case of the kid killing themselves in their room. But it doesn't actually…if they actually tried as a student to go through the process of achieving these mental health services, they would understand that, wow, it's really fucked up.

And it doesn't work since UVIC leadership can just write in their little emails like we at UVIC acknowledge the territories that we are on, and mental health, and everything else that you want to throw at people without acknowledging the actual human interaction between these systems? It doesn’t work. Because you could approach the system through the lens—or create a new system. It's a newer system of mental health access services. If a white man approaches the system, and me as a brown person, we will have completely different interactions with it.

Inaccessibility of treatment

So like therapy is fucking expensive. Even with the sliding scale, sometimes people don't want to claim a sliding scale as an option for themselves. They don't want to put themselves in the position of like, ‘Oh, yeah, can I? Can I get the sliding scale option of the lower—" Obviously, when you approach that with people with sliding scales, generally people who have sliding scales understand it, but it’s just like, I wish we didn’t need a sliding scale. I wish you can come and be like, “Hey, this is what's going on.” But obviously because of the system that we have been in and like rent, and they have families, and they’re pushed out—anything from professors to doctors to—literally myself, my family, like. I understand that they have a support system that they need to provide for. So it's not even like I'm hating the therapist for giving the rate of $150 for a session, or I’m hating the doctor for the 4 hour wait for a call. It’s not the person that I’m frustrated with.

I have gotten very mad at doctors and receptionists. I feel so bad for them because I will call with a lot of emotion and a lot of anxiety, and it's not communicated the way I'm planning in my head. The response I'm gonna get, how they're gonna treat me—I lose my shit. I get really frustrated because it's almost like I could have had everything I've wanted. And it's taken away at any given minute, because you said you're too full, or it's too expensive, or the wait time is 2 months, but you’ve been thinking about killing yourself yesterday! You know, like it's ridiculous. And—if we just approach things on a more holistic scale of medication access, access to information, access to conversation. It's not even about having a system, but just like talking to your friends.

And I'm South Asian. So I've talked to my Punjabi friends about mental health, and realizing that the traits of BPD are very common amongst older Brown sisters. Who have younger siblings because they systematically had to be a parent. That emotional nature and emotional nutrient that they needed from their mom and dad. Because they had to work because—see it's—you keep going back—

And then you kind of get into that whole aspect of you're a first or second generation immigrant in Canada, and you're starting to understand mental health as communicating-in-English mental health. And that's a whole other aspect. Using the words that they were kind of given to us instead of finding a feeling that'll fit for us? Like why—Because it's the same thing about queer people and labeling. I don't have labels – I don't believe in it, because if they say ok, you're non-binary right. I'm like, okay cool. But that's—like you gave it to me. You gave me a space that's non-binary, out of the 3 options: man, woman, non-binary. But the thing is, I think I'm not non-binary, but I'm non-binary because you gave me 3 options. I am not an option. I am myself.

What is it with—the minute I got rid of labels, I realized my gender sexuality as fluid, which made it so much easier to get ready in the morning. Like the most miniscule st thing of waking up in the morning, getting dressed, not needing to achieve something that literally cannot be achieved because they make money on you. Not achieving it? Creates this—…and then you get dysphoric, and you're just like, oh, my god! Like you're telling me to shave my body hair. Okay, I hate shaving my body hair. So I'm not happy with it. With having freshly waxed legs. And I start growing my leg hair out, and I'm like, oh, my gosh, okay. I feel a lot less dysphoric! So it's a whole aspect of different things of what people are telling you to do.

And with mental health, they're like, do your yoga. Do your breathing techniques. Do you grounding exercises. Those help, but so does socializing. So does just honoring your sleep, and taking the time off. Treating mental illness like a physical illness, is very important to me, Because, if you go, it's just, ‘I’m feeling sad.’ Well I’ll just go on my whole day and be overwhelmed. No, take that time and acknowledge it, like, sit with it? Don't ignore it or brush it off. And I think that's the thing. You don't treat physical illness with mental illness like that, and even physical illness. Partially medical systems still don't respect you how you need to be respected. So yeah, it's kind of like a right/your information that you need for your thing. I'm just like…*privatization.*

I would never have said that I would want a privatized health care system until I went through our public health system and realized that I'm privileged enough to afford privatized medical health care. And if I were to get private medical health care like how they have it in the States? I'm not familiar with it, but you go and you pay when you need to see a doctor—we don’t have that right. That's what I need to do. But it's not going to be the same, for my friend whose mom is a single mom. They can’t afford health care through privatization. But my experience—I need a doctor to sit with me for—God— at this point like 5 years. Yeah, and work through medications and work through things.

Hospitals

And the worst feeling ever though, has to be going into the hospital—I've been to the hospital multiple times. I'm very anxious. A nauseous person. So I have vomiting spells. My heart rate gets really bad. I have palpitations. I've had heart monitors on, and late night emergency calls like several times in like a couple of months. It's ridiculous! You sit there for 6 hours. You're crying, you’re a mess, and when they look at you, they're like— ‘Oh, yeah, your result is back. They're fine. You're good to go.’

I’m trying to gaslight myself! And saying like, ‘Okay, am I—actually in my heart—like going to die? Like my heart going to explode out of my chest?’ Or is it—the same, I think, with my brain, and then like my vomiting. There's so much to take in when they say, ‘No, you're fine.’ You should be happy, that you're not fucking dying. But it's the fact that, like, it stops there.

While you wait the 8 hours in the emergency room, along with a lot of people who are homeless, especially in British Columbia in major cities. That is a whole other thing— the fact that people who need assistance are trying to find the hospitals because hospitals legally cannot reject you. Are they sick? Yes. Are they sick in a way where they need to seek emergency medical attention? No. It's because they can get a fork and knife. They can get a place to sit. Dry, warm. Wi-fi service. Safe. Because there's police officers, security guards, a system in place. You're with professional people. Yes. Would you rather go to a homeless shelter where there's inadequate health, cleaning services? There's people who are not mentally—mental illness needs to be addressed properly. You're a woman and have children, and that's not a space where you need to be. I'm like sitting here in the waiting room like, ‘Hi, Daddy, I'm not feeling good!’ I’m with my father and there’s a lot of people, especially in Surrey. I know there’s a much denser population on the Mainland. But that's the whole conflicting part. And then their results. They have to get blood tested. They have to be addressed with their concerns, right. Even with the concerns. I'm not denying them that they're real, but I feel like—Like using the washroom where they can do whatever they want to do. Like access to anything. It's very important that they have that. But like, they get their blood test. I get a blood test. I have a current medical emergency, and they are left without housing, in a situation right? My blood test is going to take 10 times longer, because everyone else in the queue has to get blood tested. And they probably want to be treated with respect. ‘Cause I’ve seen security guards get upset at homeless people, or people who are just seeking out just a space to be in the hospital because of their own mental health issues. And there’s the people with—who are on the streets often have—and there’s like the whole correlation to that, but that they react badly because the cops and security guards don't act responsibly, because they're not trained in mental health services. And you can’t really treat someone like that with a stranger. Like I cannot go to a person that's having a mental health crisis inside a hospital who is homeless while being ill. The power dynamic is not there. Like I volunteered a lot, so I know my safety and stuff. But in that situation, I am vulnerable. And so the whole safety aspect, and then I'm just dying, and they're like you're fine, and they give me a shot and are like go home.

Victoria

It's much smaller here. I went to Royal Jubilee several times, and it's the same waits. I'll be waiting the whole night. And to be told I'm fine. Or I was actively throwing up in one of the isolation rooms, and no one was around. I was by myself. I can send you some photos of what the quarantine room looks like. Because it's literally just a bunch of random chairs, and like a portable with a heater. Which I understand, because I was showing symptoms. I didn't have COVID, I just had COVID-like symptoms, so they had to separate me.

There were people there. They were sleeping, too. Not a lot. There was maybe 2 or 3 people there that one time. And yeah, they were just trying to sleep. They get rejected from the hospital being very—you have to be quite destructive—and they might have had a pass of being disruptive. I feel like to reject someone from the hospital is like the lowest one can be. Because, like the hospital, is the center for emergencies. Like you walk in the door, and they have to treat you with respect. Then when they don't. Yeah, sometimes they don't even get the basic respect that they deserve as just regular human beings with or without a mental health crisis being in that space. It's just come to a point where you're just sitting there, and I'm scared. I can't go without my dad. I mean in Victoria I did go without my dad, but I can't. I don't want to go without my father, I freak out. But going to the emergency room? I don't want to be in that space. It's crazy. Victoria is a lot calmer.

Speaking out from the Surrey experience, people with substance issues, and not necessarily like hard drugs, but alcohol. Generally, there's a large influx of people who are alcoholics, and they say, ‘Oh, my God, my heart is going to die.’ But they are just shit-faced and it was honestly quite traumatic. It was really bad to see all of them scream, and people going in and out, and going through your own anxiety crisis too. Like my heart rate is increasing.

To have time to go and sit down and wait in the middle of the night. So I understand why we have to just start treating, even the Victoria system, medical systems here emergency rooms as more of a walk-in clinic. If I really needed to go see a doctor. Cause walk-in clinics—I don't have time. It's in the middle my day, and that doesn't work.

THE STARTING POINT

So you can go back to like my mom and my grandma and colonization. You can go that far back. I'm not obviously going to go into the deep history of the British colonization of India, but it did start there. It started when colonization happened and we were forced to starve, and we were neglected, on every single aspect of our holistic medical approach to our bodies, our souls, and our minds. So we could say that's the starting point in time.

MY STORY

But for me, I was probably like 5 years old, and my dad would send me to the playhouse, like those free, open gym spaces, and I would not even talk to a single kid. I would just sit in the little fake kitchen, talking to myself, playing my little server, serving game and what not. I was a very shy kid, I didn't really want to do much. Crazy social anxiety, but it was never noted. I don't think they picked up on that because I was a very great student. I was engaged in class, I was a teacher’s pet even, and I was very very inattentive and I masked it very well. I realized that I found patterns that I can now say back to when I was 5, 6 years old, and for second grade, where I copied the perfection matters of what my teachers expected of me. And I just kind of acted upon that. What that kind of looked like was, I talked to kids who maybe were also socially awkward and didn't really have a place or things like that. So I ignored my own mental health issues—Or I wouldn't ignore myself—I was 6 years old, and nobody knew it existed. But people around me have kind of disregarded that by saying I'm quirky. I'm old soul-ed, I'm just kind of eclectic and eccentric. Which I am, and I take this as valid characteristics. But these link to mental health issues that I’ve had, stemming from literally everything.

So example, me and my mom don’t have a great relationship. She was born and raised and grew up in Hong Kong. She grew up without the Western view of relationship, society, and that's honestly not—no harm against her, for not growing up in the western space. My dad did. So I have both kind of back and forth, and it's a communication between me and my mom, but, like my mom's brother, has noted that he has severe mental illnesses. He has no wife, no children. He's narcissistic, manipulating, things like that. That are attributed to certain untreated and unsupported mental illnesses. Because there are ways to like properly talk that out and realize, are you being snarky and mean and manipulating? Or are you just Autistic and not understanding social connection between people in this conversation? So that’s a whole other— But when I started living with my own mental health issues and identity and trying to figure it out, I'm like learning what these symptoms look like for me. I noticed it a lot in my mom. Well, in a sense it kind of worked out in a way. I've kind of reconfigured my relationship with my mom, to not be so angry at her. Because my stimming annoys her, her stimming annoys me, type situation. I realize that like I like to fidget with things. She likes to control noises like chewing. Anyway. It's things like that.

So I noticed things that would trigger each other. And then her sibling—her brother, kind of being more introverted and very strange. And then I don't know enough about my grandma, just because I don't speak the same language as fluently, so talking my mental health within generational gaps. I wish I could speak Punjabi, which I don't. Communicating what depression is—I can just imagine that would not contextualize what we're talking about over the conversation. Because they have feelings that you feel, but in English we have words for that, and Punjabi, we don't.

Or we do, but it's not in the same connotation of how we correlate with the emotions we feel, and how you want to speak it to each other. So my grandma probably also has her own issues and what not but I can’t speak on that. My dad has high-functioning anxiety, so I picked up a lot, probably ADHD too, and he's very analytical. So I often come back to how I feel like I could be autistic too. I have yet to get diagnosed, and I believe in self-diagnosing to the extent of where you can pick up on your traits and kind of formulate that in your own opinion, and use facts and non-medicinal resources to implement into your life. Timing, scheduling, clocks. I'm a very visual time person. I need to see the time passing to understand that my task does not need 4 hours to do dishes. I need 15 minutes, you know.

So back to my mom and my dad, and kind of picking up their habits that they somehow figured out a way to manage through life? I don't know how, because I am *struggling*. Trudging by. But it was kind of interesting to see that, and realize that they're hurt, and you’re just—I get stuck in the crossfire. And then through that, mental illness gets passed down. Like the way they may have approached situations, like I don't know, loud noises, music, screaming, crying, pitch, a tone of voice even. My mom used to say to me all the time, ‘Oh, your voice is so annoying like can you talk regularly?’ Maybe my tone of voice was just not meant for her brain. Her sensory input was…yeah, we didn’t have a way to communicate. And it's often approached with anger. So now I don't show emotion at all, except for happiness and contentness. It’s so much more difficult.

Social location

Victoria is very white and very privileged. It's also very conservative. It is predominantly queer in my area, and in Central Victoria, right by UVIC, it’s gay students going to a very gay school. I know that everyone's gay. I'm saying academically, it's queer. But the minute you leave that space, and it doesn't quite relate to that.

Example. Newer parents nowadays, I work with kids, especially in the summer-time. I'm a camp counselor and that’ll literally give me like the inch of credit I deserve to talk about family and children, because again I'm not a professional, but, like you can't achieve the whole thing. But I feel that…having the words to say ‘mental health issues’, understanding that they stem way back and they started very young. Like the minute—probably early, too, but like socialization, I've picked it up and can verbalize it by the time of like first, second grade.

I was sitting outside of my classroom door on the wall for the whole recess until I went back inside. Head between my knees, and no one was like, ‘Do you want to go back inside?’ I was a happy, nerdy little kid, and I respect that, and I want to honor that kid forever. But as I grew up, I realized that it was much harder to deal with complex issues such as relationships, emotional maturity, dealing with your parents, independence, and adulting, and that whole ‘you are now being your own person and not relying on anyone else for the support.’

Out of thirty first-graders you’re not gonna notice the one kid who loves reading, and is kind of peculiar, and being a little bit off, you know? Like it's out of character, but the connection is that this is untreated, undiagnosed issues. And I excelled. Then I burnt out because I was tired, and I'm still so tired. And not tired in the sense of I can’t sleep, but it's hard to—doing. Interacting with the world takes too much time in my life. It costs everything. To continue on that emotional labour.

I'm not receiving that from my parents. My medical system. Some people around me who are in denial about using this kind of language. But then, the more I advocate for myself. I talk to people who are advocates. I follow people on social media who promote the sort of encompassing way of approaching mental health. Then I start to learn that, I’m not a weird kid. I was a weird kid, like I was reading—in like fucking third grade. It was weird. But it was in a way that it could have been approached and noticed. Noticed and respected. I identified it in a way where I could be quite successful in my space now.

The journey of living through symptoms

Working through my challenges, there's this big disconnect when you approach mental health services: Hi. My name is Fen. I feel stressed. I don't sleep. I eat too much. I don't eat too much. You know the whole DSM-5. And then you look at me. Okay, cool.

And then you sort of have a grieving period. The grief of the fact that you could have had this life, right? I went through that, and I still go through that period of time where I'm just like, I could have been like my brother. I could have been a normal, normal child. I could have been successful in social situations. I could have had friend groups and relationships, and…but maybe not. Because I do have these undiagnosed issues, so it probably wouldn't have played out like that. But the fact that I could been supported in a way where I could have lessened some of the negative implications of our lack of social services. It was really heartbreaking to realize like, oh, my god! I lost time! I lost energy. I lost feeling and emotion and trust and validation. And it's—it eats you away when you sit there, and when you're having an episode of a negative mental health crisis, that adds on a whole extra weight. Now you've been acknowledged, but you've been left to kind of reel in the fact that you've lost, or you can't even remember your childhood in a sense, because you were dealing with so much trauma throughout that period of time that wasn't interpreted as trauma. Because we think of trauma as like gory, intense things. But sometimes trauma can slide in there and you don't understand that's the way. But the kids not playing with me during elementary school is my trauma! Like there's definitely an issue, but we don't see it as trauma— they think a car accident, or death of family member. The most severe trauma is the only valid trauma that you can have.

And then I feel bad because I have the same mentality of like, okay, someone who is crying right now deserves more attention or more immediate attention than I do. But I am going through a lot, too. So when I approach school systems and I'm like, ‘Hey, guys, l-o-l, we're not slaying the day away. Realistically I’m gonna off myself in two days if you don't like acknowledge what I'm feeling.’ So like I'll just cope with humor too. It kind of makes it a little fun and Gen Z shit, you know, but whatever. But then the kid will come down the staircase of the elementary school sobbing. You know? That visually needs more attention. So the therapist will be like, ‘Hey, can you come back after school tomorrow? I'll give you a call.’ Put it on the form and fill it out right. And I get restacked in that pile, even though I come for immediate attention. But I can't book my counselor. But actually, can you ignore this kid, who is like having a full-on visible breakdown while I’m having an inside breakdown? And deal with me first? When I can’t express my emotion?

Yeah, and it flips the other way around, too, that if people are more visibly emotional that… maybe they get attention and support, but they're not getting it through what they need to get.

But mine's internal, and theirs is external, so they often get priority, and they have been prioritized over me several times and I used to be upset. Like the system does not work. So yeah, 5 years old, seeing the playground, not doing anything, being weird, being angry. I had a lot of anger issues, a lot of dysregulation, and it just got played off as—I'm just a bitch.

Not really, Pop. The lighting is wrong, and I'm hungry. Why? Cause I forgot to eat. Why? Because I had swimming practice is at 6 o'clock today, and I’m 5 years old. I will not necessarily forget to eat—but I don't communicate to eat. Well, that's how I ended up being overstimulated. If they knew this and I could see it in kids today, especially the whole other factor of technology…I can acknowledge. I'm like, ‘Hey, you're having a rough day. Do you want a fidget toy—okay cool here.’

People don't learn at all. They continue to trudge by, have unhealthy issues with themselves, with substances, including food and the gym. That's a real issue. I'm so passionate about how addiction is not only substances of—like drugs, but also shopping, clothes, watching TV. Like doing things in an extensive amount is addiction, and people don't understand that. So untreated.

And you get back in the system. And now you're a person of power. With untreated mental illnesses who has been ignored by systems and just made their way along. And now you’re a part of making personal decisions for your family, friends, partners, government even, jobs, if you are a manager, and not understanding that, like someone, can't come into work or has to leave work early. And it's not an excuse to bum off work. They genuinely cannot get out of bed. They cannot shower, you cannot eat, or you just literally are the wrong temperature. I get this a lot—I'm the wrong temperature, and I need to like reconfigure everything before I leave the house.

I felt it, but I didn't have the words to communicate it. I didn’t know that was anxiety. I didn't know that was overstimulation. I didn't know why I hated hugs so much, and culturally it got played off as me being rude. So I was mean. My dad would say to me, ‘You’re such a nice and beautiful girl! Oh, my god! But sometimes you're just so angry!’

Girl! Hate to break it to you like fucking 10 years later, but maybe it's no surprise. I'm definitely throwing it out there. I'm not denying it, and I feel like it’s a confirmation that I was Autistic or ADHD. It’s probably both at this point. It's encompassing. I don't even need a label it's just like, tell me no. And I can find out what the correct solution is.

I used to hang out with supervisors during lunch. People who volunteer to monitor school grounds so the staff could have their legal break. And I would walk with them around the school, helping other kids out. Being empathetic is a very key point of Autism that not a lot of people talk about—is having this passion to help people. And yeah, I was just a helpful kid who just really needed that support of the system. ‘Cause I didn't know what kid to play with. I didn't have a lot of friends. I wasn't like on the playground. Wasn’t athletic. My Nat Geo magazines, compared to my friends, they had Doll Magazine.

How to feel loved and seen is learned. And we learn things that are not necessarily the best thing to learn. Then we have to unlearn it! Unlearning is my next step. I'm not in that place. I am addressing it, but I'm saying, like full commitment to talking about unlearning. It’ll probably be my next shift in things, because that's super important. Because your teachers have mental health issues. Your counselors have mental health issues. The way that they were taught may not be the only correct way. As historically the creation of psychology has been systematically racist. So, then, you're getting people who you should trust in power and not understanding the fact that they don't get it. Because maybe they have this abuse at home that's going on. Maybe they were abused as a child or as an adult, and have had unworked trauma. Being in this overworked system of education, working with young people. You come to a point where you're just like, oh, my god! And not understanding your cultural practices that have been gained through colonization is actually harmful to—in perpetrating—So they don't even, they just think it’s a funny little joke to like bug kids or like, be that figure when realistically, it does not translate over.

I lived in Surrey up until I moved to Victoria. But I feel like in Victoria, attempting to receive mental health services was the exact same way of being treated but just in a different font. They seemed a lot more respectful here, like I'm sorry you're going through this type of beat instead of being like, okay, month long wait. And people on the phone genuinely do seem like they want to…help you. But it's the process of I want to get a referral for something. Nine months later some random Tuesday at 3pm, I get a phone call.

Hey? Hello! What? Hi? It's like, oh, it's. Dr. so and so, and we're calling for referral. The one I sent in in June? It's September. Ah yes. No, yeah, it's like, oh, great. And you call back, and then they lose your referral time. Can you send me a new referral, can you talk to your doc. It's brutal. It's brutal!

Neurodivergence

I like making people laugh. I want to paint them a story when I talk.

In grade school, I really liked sorting the recycling. We had a juice box program at our school. Loved it. Why the fuck did I love it so much? Because I was in control and organizing things! Those systems! I was called the Recycling Wueen, by my Vice Principal. They came into my classroom. Grade 5 or 6. 'Can I borrow the Recycling Queen?' I have no friends! You gonna do that to me?! You're really gonna do that to me? Oh, it was brutal. Anyway. So in Grade 5 that's when people started clicking and getting into niches and certain topics. So my parents step out of my relationships. Because before my mom would meet another mom at my school and they chat and were like, oh, my kids, blah blah blah, wanna hang out? And the kids will play. When that stopped, and parents stopped putting effort into it. It happened quite young, actually, I think by 10 and 11 years old. It kind of died down. The fact that I needed to have organized play dates. That's when shit hit the fan. I was like, oh, my god! And mental health wise, it was steady. It was nothing irregular that I hadn't experienced before but it's still negative.

I had a big issue with connecting to people. And now I've learned social cues and stuff, and I'm learning more social cues. I understand that walking away during conversations is not normal. Or, like zoning out and staring at the sun, like you have to make eye contact. I hate eye contact, so things like that. So that kind of pushed my interest in different things. Girls started to like guys, and romantically— It's not even like anything of a sexual nature. Crushes, right, like a little high school crush, middle school crush. So I did not experience any of that, and that was nerve-wracking for me because I was like, oh, my God! Like what is happening! And then trying to ask. I found one good thing that I thought was a bad thing, but I think about my friends—All of us nowadays are neurodivergent, and it's kind of a full circle moment? But middle to late elementary school, they sent me during lunch to the special needs room. And it's just kids who are special needs and needing a place to chill, and they give me snacks, and I love snacks. They're like the Ritz—The breadstick ones. Fake cheese? So good. They are nasty now, I cannot stomach them anymore, but you know? So I was happy to be there. But I didn't understand why I was in that space. Why in the third grade my teacher gave me popsicle sticks to ask questions. She's like you have 5 popsicle sticks for the whole day to ask any unrelated question. And that was perfectly fine!

No one was like, why is this bitch asking so many questions? No one. They're just like here, popsicle sticks. We created an inside team where my teacher would give me options and allow me to invite a friend to stay inside during lunch time, so I could play inside, just me and a friend. Why was I not documented? Like that's definitely an emotional-behavioral support form! Or just tell it to the parent. Be like, hey, Mom, Dad, I picked it up, your child is kind of being withdrawn!

My parents and teacher all chatted, but it was never acknowledged to us in a way where it was said that your child has emotion and social issues, you should probably get them into some sort of—implement…implement things. But in another sense, not having that diagnosis or that label in that time period was beneficial, because I thought myself as more of a normal person. I was not the same as the kids I was sharing the space with.

Last year, I realized that I was back in the same situation. First year, I had very limited friends, and like my dorm leader was like, oh, come to the community game nights! And I went, and it was all the weirdos. Like in a neurodiverse way. And I don't mean anyone harm because I've realized that I'm fucking weird. Like, yeah, we all have a child's 1990 Meteorology and Earths Studies book on my wall. Why? Because I really like Meteorology and Earth studies since I was a child. Okay. So that's also a whole thing! I was really into non-fiction materials! I still am. All these books around me are non-fiction except one. And my parents are like, you like general fiction. I'm like, no I like knowledge, anyway. So, being nerdy, you're geeky and sciencey stuff. It didn't really help my case a lot. But again, back to last year, I realized I had a whole melt down that night. I was like oh, my God! I'm back to square one. I thought I was doing so well and now I'm back in the same situation with the weird kids. And I was really upset about it.

And then came second year, and I spent time with people who were just generally a bunch of weirdos who I love dearly nowadays. Who would just dance how they want to move and stim the fuck out if they wanted to stim…And talk about it? These friends are mostly white. I think all of them are white.

Because—another thing—by being in this space, it's like, okay. I get one part of my identity acknowledged, but not the other. Walking up to other people of color to talk about mental health issues but they haven't talked about mental health issues. And this is the space right now. So I'm getting some of my needs met, but not all my needs met, and we're kind of stuck in the loop.

But I realized that I really like hanging out with neurodivergent people. Why? Because I'm kind of neurodivergent myself and we like each other. And we give confirmation, like, hey, you good? Yeah, I'm good! Like literally like this! In the back of the club, or in a performance. We look at each other and make eye contact, and ask hey you good? Do you want to take a break? And all of us will go out and take break. Come back in. And not like oh we'll take a break and get high and get lost, and I get anxious about finding my friends at noisy overwhelming things. Other people get upset about it, or they'll get weirded out. I'm like, oh, yeah, I had great time in the club. I wore ear plugs. It was amazing. The orange like foam earplugs. And they're like you're such a fucking weirdo like, why are you wearing earplugs in the club. And I'm like, dude. They're amazing. No one can talk to you because they visually see that the earplugs are in. It reduces sound but doesn't cut the sound out. I *feel* the base and the lights, and I can have balance right?

Yesterday, we went to the UVIC Fine Arts thing, and it was a queer night space and neurodivergency. I feel like the queer and neurodivergence situation is like interlocking. But it's really cool, but that's a whole other topic. But I can always talk about the queer and the neurodivergency intersection, and finding that intersection was really interesting? That people who are neurodivergent have issues with their identity when trying to meet society's thing of social location. So being queer—not straight, not cis, and not typical of what society expects of you—You end up in a space where you're happy. And finding gay joy and stuff like that. So but yes, now, a year later, almost a year later, I'm back in the same spot. But I'm back in the way where I can accept it. And the way it was approached was not the way that I wanted it to be approached. When I started to choose myself, and who wanted to hang out with, and what I wanted to do, and just honestly say, like fuck it, like if you're gonna make fun of me—I'm already Brown with a mullet that is shaved. But it's also bed head from like 2 nights of clubbing. So we're not going to worry about that.

I feel overwhelmed because gay people dress really well, I must give them that. There's expectation. My body. If you look so cool—like I want to look like a sculpture—admire me. Admire me. You know, me and my art.

But honestly that goes for anything. What can I do to feel the best, and try and achieve the feminine shape of the body or the masculine shape of the facial hair and the muscular figure your body has to adopt? And kind of confined to, does and doesn't exist in queer spaces. The whole principle and the theory of queerness, can translate so many different ways. And when you bring cis, when you bring your conformations—conforming, you're also bringing in internalized things when you're trying to still achieve things. When you come into the space, you're not identifying it as internalized, and they're still trying to figure out why bisexual people are often labeled 'confused,' or 'pick a side.' And that's the most miniscule thing, let alone the spectrum of what gender sexuality really is, and the fact that there's things past LGBT. That doesn't even transfer over.

Rewind to high school

Going back to the timeline. High school. Grade 8, right? Grade 8 was fun. I liked Grade 8 because I was in the band program. I stuck with them for a while. Also. Very weird thing! Art kids—like the arts like Fine Arts, band, music, dance, whatever—queerness, is very much there! And so is neurodivergency! Playing music is practically stimming, just saying. There's a correlation—I have no like academic scientific proof. This is very emotional based. I know concert band were geeks. I think the drama kids had it over us on the hierarchy of social status in my high school. But, our space is safe. It was cool. We can geek the fuck out about what we want to geek out about, wear what we want to wear, and we were nerds, we were geeks. We were losers, we were weirdos, we were freaks. We were, you know, all the labels you can give us of a negative social implication. We were just like, okay cool. And we would look stupid marching around the hallways, during Halloween time with your instruments trying to look cool. But we were never cool because we're marching in the hallways with our instruments on Halloween.

Grade 8, Grade 9 was a wee bit rough. Again. I found solitude a lot. So my elementary school was K to 7. And then on to high school for 8 to 12, which I love so much. I can find myself being emotionally mature, finding friends or people I want to enjoy time with, older than me. So that was really nice to be in a space where I can have my 10th and 11th grade friends, being my friends and being myself. And then they graduate and I was like, oh, fuck, I have no friends anymore, but. A lot of it worked. I was in a lot of leadership teams. I was in a couple of school programs. I was engaged in activities. But also like sobbed almost every night, from the end of 10th grade—whenever my sixteenth birthday was. I was just crying every single night for like a year or two.

Just so much had built up that, I never got a chance to process anything. Having a negative emotion would build up throughout the day. And I just snowballed. And it was really bad. But the thing is, I was excelling. So no one was concerned! Because I was engaged and everything, and would cry silently at night. It was very much my own solitude, processing of my day and emotion and stuff. Cause I can't tell my parents—they'd be like. Mom, Dad, I had a bad day, can I get a hug? Like I could have. But like I just don't. It wouldn't have worked. My mom has issues that she's dealing with. I'm gonna stop there.

So it was a mix between that, and everybody had a different friend group. A lot of it was perceived as a friendship-making issue. But then I soon realized that it was an emotional issue. It was just a realization. It was a systemic issue of my mom's treatment of how she was treated as a child, and her emotional responses to things that were inadequate or the wrong thing, and her language barrier. She speaks like 5 languages! Cantonese, English, Punjabi. Two other ones I can't remember, but like a really random lady. So the way she communicated was very harsh.
I wasn't met with like, oh, my poor baby! It was like, oh, what? You know. So no one talks about that.

Then when I got to university. I was like, uh oh. First semester went really well, second semester I tanked in the ground. And it tanked for a while. And thing is though, I no longer had that social structure. I didn't have school 8 to 3 every day, lunch at noon. Cadets and swim practice at 6, you know, I didn't have it anymore. So when I started to realize I didn't have the structure. I was like, oh, my God! And then I found different therapies, tried to reach out more, and my mental health was probably the worst between Grade 11 and first year university. It did not play out. But that's kind of a timeline up to now. That's kind of a brief overview.

Family dynamics

Example. My mom would say to me when I explain something to her: this is why no one will like you.

You know, it's really fucked up to hear as a child. My issues are that I have a lot of quirks. And I'm not trying to be—'I'm so quirky'. You know. I genuinely have quirks. I think out loud, I ramble, I process things intensely fast, like I need to keep going. I'm genuinely, you know, either overstimulated and under-stimulated at the same time. It's super weird. I like bounce up and down when everyone's like chilling. I'm like the music stopped. I need to keep moving, you know.

Taken through a negative way through society, colonialism. That's really important. The responses to me were a combination of a general malpractice of emotion and not responding with the correct thing to say, because, like who the fuck says that to your child? And then creating this division between my dad and my mom and myself.

So me and my dad are really close, and he'd often defend me. But then, example, my dad would be like I’m going to be with your mom today. I'm gonna spend time with you later on. We [my mom and I] were rarely ever in the same situation, because it's always tense.

And my mom says to my brother. Oh, I don't talk to her. She's just being annoying, or she’s just acting up, or she's just angry. My mom would say this to my brother. He wouldn't talk to me for the longest time!

Conflict is very important to have. I love having conflict. Especially when you're young. It's siblings. We'll never leave you. My brother’s four years younger. So it was an age gap. But it was fine. My mom would be like don’t talk to your sister, you know, like she’s just upset, or she'd be like, oh, she's in mood, or whatever, like you’ll get yelled at. Okay. And when I left for school, me and my brother’s relationship like we revived, and we talk a lot now. And I think I have a really good relationship with him. I don't think he has mental health issues. Like obvious ones, like very evidently impacting daily life. I don't know what he faces on the inside, because again he's not gonna talk about it. But I feel like mine were very evident in my way that I socialized.

THERAPY – My first therapist

Uh my first therapist. I hated her. But I went because it made my mom so immensely angry. It was in Grade 9, 10? Probably 10, actually 15. She had to e-transfer the lady. She didn't think it was working. But it was working. It wasn't working to the point where it was needed. The thing is, when you approach therapy, the first therapist you're going to get may or may not be the one to fit your needs. I went first for like a talk therapy situation, where I'll just talk about my issues and kind of vent a bit and get a response. 'Yeah, it's really bad. Yeah, the 'try this' method,' you know, not necessarily approaching with any sort of therapy. A treatment plan was never made. Cause again, I was high functioning. I was chilling.

And Grade 11 second semester. COVID ran around, and that made a *huge* issue, because it was so much uncertainty, so much emotion, dysregulation. I was very angry, and I realized a lot of my anger was kinetic. I mean, I'm proud of this. I never hit someone. Could have! But I choose not to. Instead made lovely dents my wall. Or slammed doors. I shoved my mom that one time like whatever, but like generally, when I have these moments of being upset. I would be kinetically angry. Like I would touch the door handle, and you know the door handle would go flying into the door. I have a lot of energy like that. But I never. I kept it in. So I think that's why it came out as a kinetic.

The way I was processing it, like my brain was so overwhelmed, so overrun, that it didn't stop. That voice was kept going, and it kept going, for hours and hours, and asking why my friends leave me, why people leave in my life. A lot of abandonment things, like no one actually abandoned me, like my family, never abandoned me. Like my parents, never divorced or anything. No, but like socially, people like left quite a bit. I know that things change over time. But I always blamed it on myself, and not the person. I realized to the point where I used to be like, I’ll blame the person not myself. But now I’m like there's no blame. It was just –I’ll deal with. Like that.

That was probably the peak of my emotional dysregulation without assistance, without any medication or any therapy. Now I do DBT therapy, and I love it. I do feel like I’m gaslighting myself to think okay, it was working. you know? You're like, no one hates you. They're just tired. And then a week later they say to me, oh, hey, sorry, I had a rough week. It's fine.

I really like that. I think it worked out really well, because it was where you talk about how to process it. And filling the blanks with the negative implications, does not do any help. That's the gaslighting part, trying to like, trick your brain into like rewiring yourself to think of it in a positive way. But I feel like it does work, cause now I'm like, what if no one is available to fucking talk right now? Are you mad at me? Girl, I was in the shower. Oh, I'm sorry. So want to hang out?

So now I try to think that it's just a situation, that they didn't hate me, or they don’t think I’m annoying, and if they do, then you don’t have to like everybody. I'm a really funny person. Like you don't like my jokes? It’s kind of on you, a sad little life, like whatever. You're not cool enough to understand? You’re not advanced, mature enough.

So I saw them [therapist] for a bit, and I liked it for a little bit. It was nice to have a space to vent, since I was so emotionally stunted at home. And never took up emotional space at home. Cause I didn't have emotional space to take up at home. But, my mom. Telling my mom to pay the lady made her upset and made me want to go more because I was like a rebellious little teenager. I was literally picking a fight, right?

I started therapy because I had a major freakout and I asked my parents to take me there. I don't remember, because generally with severe like emotional, really emotional moments, your brain has gaps, so I have no time or place, and I maybe remember what happened? I don't know what the tip off was, but I know I freaked the fuck out, and they got scared.

We knew this person because they live in our neighborhood. It was funny. I'm walking in there and really anxious because they knew the person, but it was like my mom and dad knowing them, it was not like they knew *knew* each other. It was kind of like in the neighborhood? And they're like, how's the kids? I was like, how's the kids? I'm about to trauma dump right now, and I was like sobbing and had a full breakdown and was so emotional. I think it's important to note that going to therapy as a minor held me back a lot, because I didn't want to talk about things such as self-harm and suicidal ideation. Because I was aware enough that when they talk to me about it they're like, hey, if you're gonna say this, we're gonna tell people. Which is their legal obligation to tell people! Including people who need to be notified—your parents. So because there's that legal obligation. I never disclosed that until I was18 or 19. When I realized that they…don't have to rat me out anymore.

I was functioning, and I never cut myself or anything. But I would take really hot showers, and I never thought the idea of really hot showers are like a form of self-harm. But it was not like relaxing hot showers. It was like, I'm sobbing with this hot water like hugging myself. So it was very bad, and it was negative and dangerous. What's it called…negative and dangerous…sensory finding thing. Trying to find that feeling. Which we'll do, and they are like in spaces of self-harm and suicidal ideation and stuff. So that was really interesting, because, you know, even if I had these things to talk about, and a lot of people do. I just never brought it up. It was like you do not need to know this. That stunted a lot of my progress with her.

Because I can never communicate with the doctor that, hey? I'm gonna like top myself! Obviously I'll never kill myself, because I'm here. But I never really attempted either. But I've had really intense emotions where I’m like. Oh, my God. I could do it right now if I wanted to. I have people in my life who I noticed— I didn't tell them about this, but I just respected that they were existing in my life. It was like I'm not going to kill myself. It's kind of a waste of space. That's too messy. I'd rather go out to the beach, sunset, or like an ocean, and just like you know what—I’m not going to talk about the ways I would kill myself! I’d rather die, in a natural way at a good age, with a nice sunset. There we go. Anyway, yeah, I didn't tell anyone about it for the longest time, and that really stunted the therapy for the longest time, and then I took a bit of a break, and again I returned back to my negative health. It didn’t really help. I think it was just that it made my mom mad and I liked it. She was like it’s not working! But we still have to pay the lady because you don't pay the lady, she’s going to be like what the fuck, where’s my money. So it's kind of nice.

Susan

Yeah, then I had…Let’s call her Susan. That’s not her name but we're going to put Susan down. She's Brown, so she's definitely not a Susan. My first therapist was a Punjabi counsellor—a Punjabi woman. That's very important to me, to find someone who is a BIPOC counselling service, because colonization has treated—our way of family, has been very different from white, cis, and heteronormative families. So someone knowing that I can't block my mom. I can't leave it. Yes, it's abusive. Sure you can call it that. We can call it that. The fact is, Punjabi culture and our family are very tight, and I do not have the ability to be like, ‘Mom, you know what, you are invading my space. Can you get out?’ Like that does not go—…I'm talking back. And because it ends up in a state of anger and state of emotion, it came out as like, what the fuck, that's really mean.

So I often aim for finding a BIPOC counsellor. Sometimes therapy by white people can disregard the fact that culture can't be separated from mental health. And the fact that it's communal, in the space. And it's very similar to some aspects of religion, for example, where leaving maybe the most ideal thing, leaving a religious organization, or moving away, or stop talking to these family members. But understanding that's not an option.

So I often only search for BIPOC therapists solely for that reason. When I tried to access mental health services in Victoria as a mature minor, so when I was 17, I was thinking about receiving some support from people, but… their title and what they have written down, and the degrees they have gotten did not apply to my insurance company. Because he was like an occupational therapist, or something like that, and not a—whatever they do, all the letters fucking letters. I don't understand them. But like, it was not the right one. Anyway, so I couldn't access that. It was super bad. So this Susan girl, she had a Masters degree. We were chatting for a bit. It was ok. But when I moved to UVIC she kinda ghosted me.

It was private practice and Zoom. My first counsellor was in-person up until March 2020 [which happened halfway through Gr 11]. And this was all online therapy. I don't like online therapy. But now I just take what I can get.

Susan didn't really follow up. And I was not in a space to follow up with her. There wasn't very much of a connection. But I didn't think therapy was finished.

‘Recovery is not linear’

Like I currently now have a progress report. It was once weekly, and now it’s once every 2 weeks. I've had a rough time last month, so I'm going back to once a week for a little bit. And my end goal is to meet once a month, plus once every 2 months to do a little check in and regroup. But understanding that, like recovery is not linear so important, and it's so hard to put in practice. Like *incredibly* hard.

Example. So let's say, we congratulate people or praise people for moving therapy to once every 2 weeks, or stopping going to therapy even. But in a sense when we relapse, in our self-destructive behavior, self-destructive relationships, that’s considered to be a relapse to my brain. I feel it's a lot more stigmatized because it's not openly accepted. It's hard to be like, ‘Oh, I'm doing super well. I'm being super great.’ To, ‘Oh shit I’m not doing good anymore. And I'm going to be doing better soon.’

And that transition period is very hard, because I feel like mental health is approached as if it should only result in a positive. But really it’s gonna be back and forth for your whole life. And speaking this out loud now, I need to take it in too, because I could talk all want, and it sounds super smart. But I need to listen to myself. Because, damn, it's cost me a lot of money.

So I had a freak out. Oh, my God, I'm going to go back to my days of thinking I'm going to like top myself or hurt myself. Right? And I was like girl, you know you're not. Don't be stupid. Like my other brain, my other half of like—Yeah, I understand I now have resources, I have practices, I have counselors, I have friends. People I can talk to about this, people that care about me. I'm independent—I want to be. If I want to go get checked in, I can go get checked in. I'm 19. No one's going to be like. Where's your mom and dad?

Resources in high school

There was like 1,700 students at my high school. 1,700 students. 6 counselors for everyone. My counselors went by last name, which I think is the stupidest thing ever, because my school's like 98 percent South Asians. So a lot of S last names Singhs, Sandhus, Sengeras. A lot of P last names. The counsellors were also supposed to provide academic support. So it wasn't just emotional support. It was also getting kids' schedules fixed up. My school was inner city, so a lot of kids had issues with like home life.

My school was the weirdest thing ever. And I genuinely want to do a social experiment on it. Like not actually, but like analyze the sociological lens of my school, because I had kids pulling up school in Range Rovers in the 11th and 12th grade. And kids showing up at 8 am for breakfast in the morning. Same property, one is in Starbucks, and the other one is hoping they get a meal, not knowing where the next meal is gonna come from. And that was very strange to me, because you always talk about like social demographic areas.

With mental health too, that like, if you're in an area, you generally share commonalities of income, of race, in the city, of social status, and certain like suburban areas like in my community. And we just had a really weird situation where my school wasn't poor. I mean, technically it was a poor school, but like the kids in my school are driving Range Rovers right? And like having cars themselves. And you know there's a lot of gang implications and affiliations within my school too. So there's a whole other aspect other than me being a mentally ill queer person. So it didn't work out. That's when I started talking to my first therapist. That, and a really bad freak out.

My parents have issues too. So when I talk about mental health issues with them, I don't want to. Because they get scared. They get overwhelmed. And even nowadays, they say come home now, come home come home come home. Not in the loving way. It's so sad cause they just want to make sure that I'm still alive. The thing is though, I'm dying inside and I'm thinking about my hot showers and knocking down the medicine cabinet. So it doesn't even matter where I am. But I can't tell them that, because obviously they're gonna freak out, and probably lock the medicine cabinet.

UVIC mental health services

Susan was supposed to follow me across the transition to UVIC, but then once I got UVIC, she ghosted me. Then I had my first semester which went well academically. Second semester it all just fell apart. It was really bad. It was very severe. I think I was trying to top myself. And then I said to myself, you should probably reach out to people. So I called the doctor. What I told them was anxiety and depression, right? I didn't tell them I was going to off myself but um…December 24th I started Lexapro. Shit was messed up.

In that first year, I tried to go through UVIC the Wellness Centre. And what a joke that was. If somebody's at that point where—…it's hard because when I'm trying to be there for my friends, I tell them there's services there for you, regurgitating what they have said to me. But I just know in practice, it don't work like that. But I have money to see someone privately to get therapy.

I have a family doctor I have known for like 19 years back in Surrey. Honestly, she can fix like any broken bone in my body. But for mental health, her and I have had a really tough relationship.

So I called someone else [the UVIC Wellness Centre]. I'm like, hey I need to see a therapist, and I don't know maybe a doctor. I just need a good hug. Can you give good hugs? I was talking to them and I remember, asking for a hug is fucking weird. But that’s what I needed. I needed a human connection and contact. And the person on the phone seems really nice. That's the thing. They are really nice, which gave me a lot of false hope. And they were setting me up and booked an appointment and like, okay, cool, we have no more same day appointments, our next current one, guess when…a month and a half later. It was February, and they said, come back mid-March. Sooo how does that work? Let me just pause the mental illness real quick, and resume a normal, thriving life. And, not shave my hair off. I definitely did not shave my hair off. And maybe we did a buzz cut. A mock Britney moment, but like not really—it was a horribleation. But you know it was an interesting time in my life. And I didn’t have access to therapy because-because our medical system is so isolated from each other.

Because my doctor doesn't do the therapy. The doctor’s office doesn’t do the therapy. The doctor gives just a prescription. The doctor can send a referral to a general area of psychologists who can then pick it up from there and then give me a call later on. Which is super freaking weird.

My dream is bodily autonomy

My dream way of seeing this healthcare system play out during that time period was, I have access to heart doctor. Without a referral. Have access to a psychiatrist as a therapist. A doctor, like a regular family physician. And yeah, just holistic, maybe even a naturopathic approach. That would be the most ideal way. Obviously that's not how it played out. But in my head. I needed someone telling me my heart was okay. I didn’t have any heart issues. But, like the anxiety was triggering the heart issues. And I needed probably even a brain doctor at that point to just look at my brain. And just like the comfort, the comfort and confirmation and security of that.

And I'm a real strong advocate for knowledge. I'm not great at processing myself, I don't know anything about the human body, but if someone knows something about the human body, they could tell me about it. Like I want to know about my brain and how medication is working in my brain, and how it feels in my body. I know my kneecap. But I don't know where this thing in my back is, because I have issues with that and I have medical anxiety in general. If I just knew how my body worked and why I was so handicapped…We're not taught body autonomy in an academic and scientific way. This is my nose. I know I got that. I know my throat hurts when it's inflamed.

My brain hurts. And I can't communicate that. That there's a chemical imbalance in my brain that I now realize needs like 40mg of Prozac every morning, probably for my whole life. Disregarding the changes I will go through my life, including with relationships, children, my emotional state will change. Like right now this the perfect dose for me, but what about when things change?

Rewind to UVIC services

So I tried Lexapro in December and stopped in February. And I called the Student Wellness Centre February 1st and asked to see a therapist, but they gave me a date of March 24th. There was no point in me doing that.

Oh, I had several mental break downs and ran down to the beach in the middle of the night. I have a habit of running. Not necessarily running away in a sense of like up and go. But rather, I didn't know where to go. So I went to the one place I knew on the Island, where you can go without a car. Cadboro Bay! You know what happened? I got scared. It was too dark, I get scared of the dark, so then I ran up the hill, *the* hill. While sobbing, crying, wheezing, and like it, was awful.

My friends are not trained as therapists, and I feel like I always can help them. But for me, I will never reveal things to people that are not paid professionals, who have trust, because I'm so scared they are not going to take it in well. They're gonna get overwhelmed. They’re gonna get scared. They're gonna be like what the fuck, who the fuck thinks like that. I don't think like that. Like that's not a normal thing, and they get freaked out. So I don't tell anyone anything. No one knew what was happening until I came back, and I was like, hey guys, had a little break L-O-L. A silly little moment. It was night. I know it's 10pm. So we're all sitting here watching me cry.

But yeah, so after that um…I don't quite remember. I think I just called it. I just decided I'm going to just get my academic stuff done. So I got a lot of it done, and I was on concession. I have actually been in concession probably 2 going on 3 times now. So I filed last February for my spring term. Then I filed this year for the last Fall term in 2022. I filed then. And I'm probably going to file again for this term. I don't know for what classes yet, but I just know that it's gonna hit, and then I’m gonna freak out.

But even through that—it’s so stupid because they look at that. And just with the professor, like, okay, cool. Cool, you can have your break. You can have your concession. I'll sign it. And it all kinda stops there. Like there's no follow up. I feel like there should be mandated therapy. Like our mandate is to check in on the person, to call you once you file for concession, saying, hey noticed you’re not doing so well. What's up? No, there's nothing. Just sign the form. You go back to living. You're like struggling with mental health. I think I'm just supposed to continue on? I just toughed it out. I just had to do it. It was a survival mode type beat, and it got us through the door because it was much easier to… act normal. You know? To keep people going. I was very honest with them on my mental health status. I was feeling certain things—I never talked about the issues cause I can't. I don't want to scare them. I don't want to trauma dump on them, because I know they're mentally ill as well. It was just really really odd. Did it until May when I go back to home.

And then I don't like my routine getting disturbed. It's probably one of the worst things ever. Do I follow a routine? No, but I have a routine to procrastinate. That's the important part. So I don't follow the routine. But I procrastinate the routine. When that changes, I get really anxious, and I try to notice that. Like now verbalizing it, during these major points of my life: transition to high school, transition to university, going to UVIC, starting a new semester, going for reading break. Why were these moments such a…trigger for my mental illness? And it was definitely because it was a change in my normalcy that I didn't really like.

When I say that to other people, they're kind of like, what the fuck…and? You don't understand, I went home on Sunday night. I went home for Reading Break last week. I have no concept of time to be honest, and I know where I need to be when I need to be, but not what day it is. By Monday I was like, oh, my God, I'm gonna have a panic attack. It's like my heart is going to explode. Like I feel like I need to like take it out and just let it—fucking put it on the table, you know? But I tell my dad and he's like, 'Why do you feel like that like? You're literally in the safest place?'

I'm not going to look at my mom and dad and be like, hi yes, the house you have of like 19 years. I'm a child at home. It's full of *all* the triggers. So I don't tell him that or anything of why. So it's a really unfortunate situation, which kind of led to more issues, more conflict, more…just more disorganization. And sleep. I slept a lot. But yeah, so that's kind of a good synopsis, I guess, of like the little things that kind of added to it.

Example. My friends—actually not my friend friends, but they were always my dorm friends that I had last year. They like to party, but I cannot handle partying. It was obviously the worst thing ever. I'll go there, smoke a little bit of weed. It was like, okay, cool, I'm chilling chilling chilling, and then not chill anymore. And so I'm gonna go home. Go home and hold onto my bed, lying down on my twin bed, then grab it and sob and scream and feel like I'm going to literally die. And then be like ok I'm chillin. So definitely sensory overload issues that are just never talked about, and it shows from day one that like…I don't like certain things.

So May 2022. So after first year, it's spring, the summer time. I was like oh, my gosh! L-o-l like I got flagged for bipolar disorder by a random walk-in medical doctor, because I lost trust in my current, family doctor. That we had to work and rebuild and talk about. It was quite hard to like go back to her for mental issues. Because I trusted her the one time, and it didn't go well. And that's the thing too—because she didn't even believe in mental health issues! Maybe she did but wasn't like communicating properly. Some doctors generally are like, 'You're fine.' And that goes for teachers. That goes with parenting. That goes--because everyone's individual in their way of processing information.Like everyone has a response to different things, that the system of having a sole-based provider does not work. And I was going through a really rough period.

Bipolar disorder. They flagged me for it. But the thing is though, I wasn't manic on Lexapro the first time. Then my other doctor, like a month and a half later, confirmed that I'm not bipolar. Because, you would have been manic, you would have been like legitimately manic. I've probably been hypermanic before, but I don't think I have ever been full on manic. So that was dumb.

And then they finally put in a referral to get a psychiatrist to book it. And they lost the referral! Someone in that timeline lost the referral. How do you even do that. And they don't tell you they lost the referral. I call back, in like in July or June, and I was like, hey. Hey, how's it going like? Where is the psychiatrist? And then they're like, oh, L-O-L, we'll get your doctor to sign it.

Levels to privilege

And this is *with* a family doctor, *with* insurance, *with* money. Like not tons. I'm not swimming in it. This is budgeted. But, like you know, with money, with a car, with flexibility in my schedule, let alone! If people were facing other issues like I don't know, raising a family? And working multiple jobs, and not having the access, the sanitation, care, or the time, or anything, this is like literally the most average—average privilege that I can provide. Just not cis white male like settler colonial—I am a settler and colonial on this land. But you know, you are raised here. Like you're English speaking. So like I feel like it's the next step of privilege that I can experience. And yet I'm still facing such an issue!

So once they figured their lives out, I got a call from the doctor in September. And this is where I guess he has to call, and I don't even know him. I don't know his name or anything, he never called back. The psychiatrist. Never called back. Or anything.

There's such a disconnect because you can call Dominoes and be like, 'Hey? Can I order a regular large pizza please? Thank you.' Go inside. What do I get? A pizza. It's not crazy! Okay, call a doctor. I need mental health services or let me see if this person—Wait! Let me lose something real quick. Ok let me call this person, you call that person back? I'm actually not allowed to talk to you about that on the phone, you need to come in person…Girl I just want mental health services like I want my pizza. 15 minutes, hot and ready. Like, can I? Can I not like? Can I not do all of this, this way?

So I talked to the psychiatrist one time in September on Zoom (he was based in Surrey), and I like trauma dumped on him. He was like, okay, and he did this little form thingie. He diagnosed me with Borderline.

A diagnosis of borderline

I think it's completely inaccurate. It was a really interesting call. It was September this year, 2022.

And medical people are transitioning their language. So this is now a whole other thing because Borderline Personality Disorder has such a bad reputation. That medically, they're switching out the language to ‘emotion dysregulation’ as a way to talk about BPD because of the stigma BPD has already had. The movies and the TV shows, and the characters who are violent, who are emotionally unstable, untrustworthy, you know, the whole stereotypes of mental illness and media.

So that was interesting. They're describing them, instead of being like oh you’re Borderline, instead, it's more of an emotion dysregulation. Definitely a whole other layer, but this is my personal experience of people talking about it as emotion dysregulation. The thing is though emotion dysregulation encompasses so much more.

And I never got the plan. I never got a copy of the plan. I never asked for one. Because I never had any experience with it, so I didn't know what to talk about. No one told me like, go to a psychiatrist and ask. Some guys won't even listen to you. They really just looked at me for 45 min. We were like, okay, cool.

They recommended DBT. But I told him that I think I have an ADHD thing, because this stigmatism with Autism is sooo so bad that I didn't want to bring it up at that time. I didn't want to talk about that with anyone.

Researching on my own

I was online and used social media is like a starting base. Like those infographics of like ‘signs that you I have emotional dysregulation,’ or like stories or comics and things that people have posted, designs or whatever. Zines, magazines like those story things where they don't have a restriction of a system to censor their work or take control over what they produced. And I started to realize, oh wow! I thought the lights at Walmart were just bad lights, but no, people can actually function inside a Walmart? Or like people can actually multitask? They can sit down and say, I’m gonna complete this paper. It's like an assignment in 30 minutes, sit down and complete it in 30 minutes? That's a thing? I can have a better outcome of life? A better quality of life? So it was a lot of grieving.

Or like similarly that they have support of being Autistic in school, and now they are in a space where they can realize that they need their team to follow them. They need to wear their headphones, stim out, fucking cook whatever, be obsessed about whatever you want to talk about, you know. It wasn’t until recently, I started talking about how I think it's an Autistic ADHD moment. So I didn’t know what exactly, could be both. But like it just wasn't…
and Borderline doesn't really fit.

BPD is very much emotional-based. And what scared me the most is the term Borderline *Personality* Disorder—I was told it was not medically treatable. There is no medication. They couldn't prescribe me a medication for BPD. They gave me one for anxiety, I’ve got Prozac. So the psychiatrist sent their recommendations to the doctor, and the doctor chose which one was best.

It's even crazier, because the way medication works. And I'm telling you this right now. But like you start off on 10, and then you wait 3 weeks, right? You talk to your doctor and they say like, hey, how you feeling. Oh, okay, wait 3 more weeks. How are you feeling? I'm feeling shit. Okay, Go up 10. Wait 3 more weeks. It's a year later, and you're still figuring out dosage. And sometimes it'll just stop working for you. Or I have really bad side effects. I have no sex drive. I don't feel emotion. I don't feel sadness, I can’t cry. I feel like I’m acting. Nothing’s real, a lot of dissociation. So if I am taking medication, like going to 20. They want it to battle my depression. And then I was off school for that. And I was on Reading Breaking down here so. I'll say that it's never linear. So hard to talk about it, but like...the way we push it is so individualistic.

Masking symptoms

Okay. So let me treat the anxiety for you cause if I give you ADHD meds your anxiety is gonna get worse. I understand that, that makes sense. You're giving someone with anxiety, a stimulant. But then, do we think about the fact that the ADHD can be causing the anxiety, depression? Because that's a very common trifecta? And the fact that it’s underdiagnosed in girls because they're better at masking, great. And then the fact that I’m Brown so people don’t talk about it. Okay, great. And then you factor in everything else. Next thing you know, it is the same result.

I'm really a 7-year-old white boy at heart! In my brain! And mixed with the little gremlin underneath the bed that you're scared of at night, so. It's a bit lacking right, and if I talk to my mom or dad, hey I think I have ADHD, they're like no you don't. I was like, okay….while there's me like stimming all day long, going around the house like ballistic, getting upset and angry.

It's a profile, like BPD has a profile that exists with medical people. That comes with all these medical issues. There's a profile that fits and I am older. I'm no longer a young kid, right? I am functioning? You know. So how can I have? How can I be autistic if I'm functioning like a regular human being? But the thing is though, I'm just masking through everything. And suddenly I—oh fuck, maybe I don't want to do this. Right? Which is so much too—and I didn't learn it all at once. This is like built up over time.

Self-efficacy

So making realizations like, oh, yeah, when I was 5 years old I had these issues. Well, I didn't know when I was 5 or 6, or 15 or 17 even, 18 and a half, you know. It wasn't until like now, when I realized, so like. Oh, okay, the more talk about it, the more I learn. The more I take time to do individual research for myself instead of banking on people to tell me. That's when I realize, okay, let's rewind, take a break, and come back to it.

Me and society. Society and me.

It was just really odd…in that way. I don't know, it just gets progressively worse. And then you go back to the whole sociological aspect—my favourite topic to talk about. Society and government.

Do I want children? Then I can treat children the way I treat myself. And then my genetic mental illnesses, the social systems that came with it, the fact that the price of living is going up. But then the fact that I need kids to support me when I'm older! And we need pension? If you don't have kids, if we don’t have kids now to work for us to work and contribute to pensions. We won’t have pension.

Colonization in India before I even was a thought. Like my great great great yeah, all the way back, right? So the other way, to a point where I'm thinking way, way, way, way into the future, and the fact that I won’t be secure in my pension because I don't have a child. Ok. Then I have mental illnesses, and how that relates to colonization, and like my physical health and the fact that PCOS is so common amongst South Asian women. We have a lot of facial hair, irregular periods, yeah yeah yeah, and infertility. It all stems back to colonization, and how you were treated physically through that. And the fact that we have low iron. That’s what I'm personally connecting. It’s not scientific based.

But the fact that there have been studies done where South Asian people have trouble losing fat around their love handles and midline stomach. Because the British starved us. So we now have a genetic thing in our body to store fat. Because we were starved! Hormone levels! And your bodies, and the fact that people who are South Asian –I’m just speaking about South Asians only, can’t speak for anyone else. But across the board of South America, Africa, East Asia, Southeast Asia, you know like it’s the same energy. But speaking on that as my experience.

Biologically, the factor of colonialism, it’s implications are so intense. We were living through a colonial system and we never talked about that. And then you try to workout but then you’re like why can’t I lose the little stomach pouch? And then, why do I store fat so much, so easily, like where my weight fluctuates, and I’m trying to go towards colonial standards of beauty. And then, you know, that's a circle, that’s been the pinwheel of death when you get on your back. You start to like—And this where I get really stressed.

My interests are in social studies, right? So then, I obviously want to engage with it. But then, like taking that home with me. And still thinking about it, and info dumping on people, because I think that's one of my specific interests. It's like a society issue. I think that’s why I like my degree so much.

But now I have the worst—Say, I don't have a session with alternative lighting, because it's pretty. Girl you just hate the overhead lights. My gender is not silly. You have undiagnosed Autism. I often play it off as my gender is silly because I don't believe in gender. But really it comes down to the whole aspect of my identity and neurodivergency through mental illness, community, culture, and society. Where do I take that? Law, scientific study, or very artsy? I just talk mine through experiences which, is fitting for situations like this.

Example. I go to my neighbor's house. I live in an illegal basement suite. There's another side to the house. So I go over sometimes because they're from Surrey, they’re Brown, and they know my parents through family friends. Like their uncle knows my uncle, who knows my dad. And not uncle, not as in brothers. Uncle as in like some random old man that I don’t know.

So I go there. And within the last 2 weeks, I have this weird interaction with this one girl. She's the girlfriend that lives with them, and she was like, ‘Oh, my gosh! Reading week was fine until my sister started acting gay.’ I was like. Are you seriously going to say that right now, like I am right here. Right? Thing is though, they didn’t know I was gay! I was like. Hmm. Sorry are my piercings not noticable enough? I'm sorry, I should show you my tattoos, butterfly on my thigh. There's a lot of naked people on my wall right now. No one noticed. Thanks! I'm gonna try harder now! Like wear a full latex outfit next time I see them.

So they're saying homophobic stuff, so that wasn’t even the worst homophobic thing that she said. My roommate is also gender queer, and through that I learned a lot about my own gender and sexuality. So I appreciate that they were open with it. But then they called my roommate a T-slur, like ‘tranny’ and I was like, what the fuck! Like! Are you kidding?? And so that's when my queerness got removed!

My Brown-ness is not fully accepted, because I’m never Brown enough for them, and within the culture of that, because they never accepted me for who I wanted to be. And the fact that I don't speak Punjabi. The fact that through colonization I’ve lost a lot of things. And the fact that I have more beliefs and values now that align, with pre-colonial India. And the fact that I'm still Punjabi-Indian. Well, I don’t say I’m Indian anymore, because the political relationship with India and the region of Punjab and the—okay, there's a lot more historical context.

Pre-colonial India embraced gender sexuality, diverseness. Probably neurodivergence, too. I don't know much about that history, because it was not documented in a sense. A lot of it needed to be passed down through oral history. I want to show my parents, my grandparents, and grandpa and be like, hey, look! This existed.

What we now call ‘the global south’ of third world countries…Indigenous Peoples and ways of learning have been so prominent through BC's reconciliation process. Whether they can achieve that, because it’s not really going further than email headers and allowing acknowledgments in meetings…It was interesting to see that through First Nations in Canada (not really ‘Canada’), and how they processed gender sexuality, made me think about, okay, well, precolonial-India is Indigenous. There’s countries outside of Canada.

Reclaiming ‘hijra’

That got me thinking about like how there is a term ‘hijra’ which is now, slur-ish. But it's kind of reclaiming the power. ‘Hijras’ are just trans women. I'm not sure if it’s encompassing gender bending, or just trans women. But they were once valued, worshipped and respected as a god, a deity. It was once respected. But then, through colonization they have become the lower class citizens of the city, and…it exists.

You just have to flip the narrative, to unlearn what you've learned and understand that, like queerness, gender-bending, this idea technically of even having this option to gender bend, it shouldn’t even be a thing. You should have been born with nothing and formulate your own…emotions. Cause like I can say that I feel feminine and but like in my brain, I can feel like a he/him. Sometimes I feel like a trans man, but I'm not going to open up the portal of ‘correct.’ I'm not ready for that conversation. Yeah, that's too much thinking. But you know, like I often think about that. The fact that, like, am I just a trans man, but then I want to present feminine. I want to have feminine energy. I want to be a caretaker for people. I want to be respected and feel inside to myself as a trans man. Example, like a masculine energy inside. But outside I want to be feminine, that energy. This is not new. It’s not something I created. It's part of social theorizing, we do talk about it. So we do have the academic language to transfer gender into what I'm saying now, so the fact that this idea of masculine and feminine energy has always existed. Yeah, we just call it something else. That relates to why do queer people have mental health issues? Far more than non-queer people? That's something I ask.

Maybe we talk about it a lot, but a lot of my straight friends don't talk about or don’t acknowledge mental illness like that. Me and my friends are like, let's turn off the lights and put on fairy lights and put on the ambient music and switch up our clothes because it's the wrong texture.

My current therapist

My current therapist, I see online on Zoom. It's out of Alberta too, but my counsellor is in Calgary. I found them in the app. I really needed mental health services, and I was like, okay. Got to figure that out. I took this little assessment thing.

The app was through UVIC. No one told me about it. I found it myself. I never attempted to use these immediate crisis services for mental health. I feel that's gets pushed a lot, in especially universities. A lot of services are crisis oriented? Because not everyone's in crisis! I don't feel comfortable using those, and that's a sort of respect that I believe these systems deserve, because the phone lines are for people who have severe critical crises.

Humanicare is what they did. That's what the insurance provider through this app covers, is 6 free sessions. It's for short-term counseling. So it was free counseling for a while, and then I gotta pay. I opted out of UVIC insurance because my parents have full coverage.

The app is actually really cool. My counselling calls happen through it, but they have other things, too, about general mental health stuff, student life, my quality of life, safety, scams. They also give reports. So I took a little quiz. And they have a personal care plan.

So the report is said: my depression high, panic disorder high, ADHD high, intermittent disorder high, OCD is also on the table. But it was for the thoughts. It was not for more traditional compulsive behaviors, but those are on there. Sleep disorder moderate, bipolar disorder mild, alcohol use disorder mild. Because I don't drink, actually I drink once or twice. But also they have like the questions like, do you have enjoyment for things? Do you sleep a lot? That was really cool.

So they have a triaging system through the app. It's literally text message form through the app. And it says here, ‘Hi! I'm your personal therapist, and this is your safe and confidential space. Feel free to tell me about yourself. We can get back to you as soon as I can.' And then the little robot guy was sent it to someone else. And he said, thanks for reaching out, my name is… And then then he referred me to his colleague, who's my current therapist.

I wouldn't consider it DBT. When I started therapy, I knew I was going to commit to it, so like when we're chatting about it, like in the beginning like the housekeeping stuff I was like, 'Hey? what's it gonna look like,' so cause we started off with that, we didn't start off with like the most pressing thing of DBT. It was kind of like a lot of time --chew through things. Because I was committed to it. I was like, I'm ready. Go through it slowly and surely.

I remember my first appointment with this current therapist happened so quickly. It all happened within a week in October. I reached out, and was connected with the counsellor a few days later.

In sum

And at the end of the day, I would've appreciated a psychiatrist just for the medical part, where I can get medication sorted and different things for that. But since it's so hard to get access to, a psychiatrist and the fact that Canada's very racist. What I mean is that people who have medical degrees in different countries can't just get a switch over, or an exam done here. So since the psychiatrist I saw was like that, I started researching myself, and that's how I got into the therapy thing.

I had to advocate for myself. I have to be patient. I need to tell people. It's really hard to talk to my doctor, because she's been my doctor since I was born. It's pretty crazy if you think about it because not a lot of people can say that. That their family doctor has been there for 20 years.

The ER doctors. Every single one of them they were treating me with respect, because again I am…I am…I'm not low income. Technically I am low income because I'm a student. But like family-wise, I'm not low income. Like I come in, and I'm dressed proper, I'm clean. I have a certain image I'm giving to them that I am requesting of services. But I knew that I could be an Indigenous man, and be treated completely different. But they didn't help medically, they gave me Gravol. Generic Gravol. And then they gave me a can of ginger ale. Cause that makes it better. That was in December 2022. My heart gets weird and I was throwing up. It was really bad.

I went so many times in one week. And my friend—Love her to death—my personal emergency driver, ambulance driver. So my friend is very petite. I got a significant amount of weight on her. Like I could probably like carry her with my backpack like, you know. When I was sick, and I couldn't really walk by myself, and I had to call the ambulance, the ambulance didn't show up and it had been an hour. So I was in the washroom, I'm puking, yelling at my friend to tell them what to say, because I'm also trained in first aid. So I know that they're gonna ask all these questions. Uh so, my name is Fen. I'm on this medication.

I'm screaming from the washroom that I'm nauseous—I know it could be a stomach bug. But it could easily be anxiety. It could be both, it could be stress. But okay, I'm not feeling good. I'm throwing up, my heart rate feels like it's too fast, and I have a fear of low blood sugar, low blood pressure, too, like generally. Also kidney disease in Brown people is so common. I don't know why. Actually I do know why. Because it's just genetically—our diet that we historically had and was in support of our health. But then, because of colonization of our food and the sugars that we consume, our kidneys are fucked. Yeah. And since I'm not a doctor to say that, I may not be correct in that way. But the observation is made. I'm just like saying like, I'm thinking about it, because our diet is not traditionally Western, but using Western sugars in our tea, or in our sweets. I know there’s a lot more to diabetes than sugar, but I'm just saying that sugar is such a staple in my community.

Anyway, I’m also a preemie child, too. I was like 4 lbs, 6 ounces. 7 weeks early. So I also just have a general lot of like anxiety from that. Because again, no one ever gave me autonomy of my body. No one ever said, this is what it’s doing—This is what your heart is like. This is your baseline. I didn't even know my blood type! It's weird!

So I thought I might of gotten like a nasty stomach bug, or like a parasite or something. But yeah, it was just really bad, and I just threw up a lot. And the only bowl I had that was big enough, was the *glass* bowl which I left on the couch. I filled it with puke when I went to the hospital. Then my roommates saw, when they walked in. We're no longer friends. Yeah, we just don’t talk anymore, they just left.

And again, in the summertime in August, went to the hospital—heart problems. That was in Surrey.

I have issues with my jaw. I grind my teeth at night. I'm a very aggressive—like I shredded through 4 or 5 of night guards. You know what the most common reason is for grinding your teeth? Anxiety! It's very common for your anxiety to come out at night through grinding your teeth and the tension you hold in your jaw. Yeah, no one is going to tell me that. Why? Because they don't believe that I have anxiety. I just saw a doctor—and they said, oh just try this, this, this, and this. My next step is my next flare up. So I had a flare up in winter break. Went to the hospital for it in Surrey. The next step is to get botox for it, to just semi-paralyze the muscle and relax it a bit. That's the next treatment option. Thing is though, it's expensive. It’s billed as cosmetic because the office that provides Botox is cosmetic. I don't know if insurance covers it.

They're expensive. People go back for treatments. It's not permanent. It may not work. So before I commit to that, I just wanted to see how things work before that too.

I needed to just throw it all out there and make all the connections and just see how it all interacts with them. We started off with one thing and ended up in the same spot. It’s interesting to see that. And obviously it's really like the societal impacts. And historical implications. That's especially important to me. It’s nice to have the space to tell anything, share my story, and how I want it to be said. And that’s exactly what I’m gonna say.

COMMENTARY

I was worried that I wasn't mentally ill enough or had enough history within the medical system, or formal interaction with the system to share my story. I soon realized that, like the point of this, is because of the fact that our formal medical system does not appreciate this. The fact that I was never in crisis in the sense of like ‘being on the bridge,’ makes me think my mental health is a lot less legitimate, impactful, valid, compared to people who are on the bridge. So that's kind of nice to be validated and be like, okay, cool—like it's a real thing. And understanding that science and academia—honestly thinking the only output was through correlations and studies and hypotheses, and theories of mental illness, science and health.

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REFLECTIONS IN MAY 2024

I had a pivotal moment. I realized I need to figure this out and kick it for good because I didn’t want to live this spiral anymore. The psychiatrist connected me to a support group, not a
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therapy group. So I’ve been in a DBT peer support group since March, and it has been very validating. It’s been people from all walks of life, and we’ve been having meaningful and genuine connection. Hearing their stories, it makes my sociology brain say this is delicious. I’m seeing men who show up and who don’t want to be a deadbeat man. We’re trying to nip this in the bud together, encouraging each other, validating each other, recognizing the change in each other. We can show up as we are. I can show up when I’m not doing well.

And I wish I could have been part of a group like this earlier. Life could have been so different earlier. I’ve been learning more about BPD traits, especially quiet BPD. I’d never been given the ‘fast facts’ about BPD before. Like how it can be lots of little cuts as a child, it doesn’t have to be some huge PTSD trauma. We were all children, and our energy is pushed and pulled like silly putty, and we might end up stretched and dirty or stay pristine and clean. Why is there so much stigma and fucked up information about people with BPD on social media? Where are the strengths like empathy and creativity? We’re all unwell! Where is the information saying to people that this doesn’t have to be for life?

I am neurodivergent, queer, and I have social anxiety. And I am choosing to not be in my Amy Winehouse era. No benders. I am choosing a better life for myself. For me, my family, for whoever comes next, whoever I interact with. The concept of ‘myself’ is an orbit around something greater, and it’s for me to figure out how to navigate this. When I hear from group members that they tried that shit and it didn’t get them that far—I could give into the stresses in my life but I’m not gonna do that. I’m gonna pick up the guerilla glue and put the pieces of my heart back together.

And we're gonna do it together. You have a problem that you need to fix? You and me are going to fix you together. I learned that group therapy for mental health issues isn't just for substance use.

Mental health is so individualized. I work at a pharmacy and everyone is on low doses of SSRIs. It may not be a them issue, but they are told they are the issue. It's horrible. It's racism, it's social issues, it's messy. It's like melting all the Crayola crayons and it turns into a brown mucky and yucky mess.

Can we piece together why our society is so mentally unwell right now? The medication is to keep the beat going for capitalism. But what we need is rest. I have such privilege coming from a middle to upper class family – and it's freedom to have rest.

This is my work. I'm carrying some hefty work and figuring these things out. And along the way, my humour is to cope with life. I don't need your tears. Instead of long-term sustainability, we need regeneration.

Tonia’s Story

Tonia (she/they) was 23 years old when she shared her story. Their description of their racial identity was Black. The date of the first interview was on March 11, 2023, and the date of the follow-up discussion meeting was on May 8, 2024. Below is their story.

An overview

I entered the public mental health system when I was 13, but I really had displayed symptoms of mental health, I think, from the age of 2. So it was a long journey of kind of trying to figure out what's going on. It wasn't significant enough that my parents were like --Oh, my God! -- we need to get her into somewhere. But then, once I hit puberty, things worsened quite a bit, as it often goes. And so from age 8 to 12 was kind of when things really peaked. And then at 12, I dropped out of school completely, and at 13 had a series of suicide attempts, and landed in the hospital. And then landed in an inpatient program. which is where I kind of finally got—I think—moderately good treatment. There was still a lot of issues with it, for sure. But I was able to get a lot of resources, like I started medication, started seeing therapists, and started CBT. All these things. So yeah, 13-years-old was really--I would say-- the start of getting into the system, the start of everything.

When I was 2 years old, I had really severe stomach-aches and stuff, and we couldn’t figure it out. And then the doctors were like, ‘I think she's just really anxious.’ And my parents were like that seems a little excessive, like she's waking up like in pain. But that's something I've had--I've carried with me my whole life -- is the more anxious I am, I get these horrible stomach-aches. When I was 13, I was diagnosed with anxiety, major depression, kind of the things we already knew were obviously going on. I wasn't in school. I was losing 80 pounds. I was, you know, in bed every day. A bit later on, the mental health professionals were like, it could be these other things, but she's too young and we don't want to diagnose her with that. So I kind of got stuck in a loop of where like -- I wasn't getting a ton better, and they were just sending me to different therapists, and they were like, well, we don't want to diagnose her with anything so extreme so young. This could go away by the time she hits 18.

I was definitely lucky because I had, because I had been in an in-patient program. I had a psychiatrist. I had a psychologist. I had a pediatrician. And I had a therapist through a substance abuse program. So I was very set. It was just. I think they weren't--because I was so young. I don't know that they always knew what to do. I started feeling a lot better. I was on meds that worked. But when I was 12, I suffered an assault. So that came up, and luckily through that—of course it was not a fun experience, but I was connected with an amazing trauma therapist who was Indigenous. So she was my first ever counselor that was also a person of color. I was 18. So it had been a long time.

She was amazing. I would say one of the most formative counselors. She was like, I think to be honest, A) you definitely have PTSD. And B) I'm concerned about OCD, I think you need to see a psychologist. So when I was 21, I went to see a psychologist and they were like, yeah, you have really severe OCD. And we're surprised it's gone undiagnosed because you are textbook. And I was like, yeah, that's a bit weird. So that was great, though, because I then, you know, got into a program and a long-term therapy specifically for it.

And then when I was 22, my psychiatrist, who I'd been seeing since I was 12, was like, okay, you're too old to see me anymore, like I'm a childhood psychiatrist. I was like, yeah, fair enough. We're like 4 years past when I should have stopped seeing you. But she was like. I'm still concerned. Now that you're older, you definitely probably have something like Borderline

Personality Disorder (BPD). So I wanna recommend you to this specific BPD unit like therapy thing. Went there, and they were like, yeah, you also have BPD, for sure. So and then, thank God, I was, you know, admitted into the program. So now I'm in that twice a week. So that's kind of been what it was up until now. Lots of therapy, but also lots of like. You're so young, we're not willing to give you these diagnoses. And now I'm like, my God, I could have been getting this *really* helpful therapy like 10 years ago?

The first hospital visit…

It was not amazing. I was 13 years old the first time I attempted. The nurses were pretty aggressive. They kind of blew it off, and were just like, fine, we'll admit her. But I bet she's fine to go home. It was very weird, like they just kind of wanted to get me out of there as quick as possible. Gave me a few pamphlets, and then they basically were like, you know. There is elevated like, certainly there's some toxins we're seeing that she, you know, took in. But you know she's not going to die, so you can come back in the morning basically and see our psychiatrist. And he'll give you a full assessment. And then you guys go from there basically. It was very…It was very weird. And then they gave us the number to the inpatient program which was at Queen Alexandra. It was very odd. And then the psychiatrist the next morning, he basically was just like, oh, you just have insomnia and like a weird concept of self. But there's nothing else going on. I was like…huh! I don't know that I've ever heard of insomnia causing this stuff. But fair enough, I guess.

I think my mom was pretty upset. She at the time was a midwife, so she was very familiar with hospital systems. So I think she was just like, oh, my God, what on earth are they talking about like. This is ridiculous. She was very frustrated. I think my dad didn't totally know what to do with it. He was just like, if they recommend inpatient, let's do inpatient. The psychiatrist was just so unhelpful. So my parents were like whatever…

I was 13 years old, so I think I took the teenager route of being like this is stupid – ridiculous! I kind of just blew it off. And I think things really didn't set in until it was like, okay we're packing up for inpatient. We have to buy you bed sheets and, like…you can't have your phone and like many teenagers I, even at that time, I loved my phone. I was on the burgeoning of social media like, you know! So that was kind of when it was like – Oh, that was kind of a big deal. I think because there wasn't a bed open, I had to wait about a month. It was quite a while where they kind of were just like, 'Okay, you can figure it out for a bit right?!' I get it though. It sounded like there were no beds open. They just had no space. So it was really, unfortunately, just like a waiting game.

Ledger House

Looking back, I think…it was okay. I think I needed it because I needed a psychologist and a psychiatrist to look at me and go, 'This kid is not okay.' But I definitely had a few issues with it. Like I told them kind of right off the bat, I was like, 'I'm not comfortable being alone with men. I don't want any male nurses.' And they were like, 'Absolutely. That's totally fair. Like we'll make sure that doesn't happen,' and then they like—that never was put into place. The psychologist who did my assessment, which was done in a little 4 by 4 room, was a male. Like. They just never…Never put it into effect. It was unfortunate and I definitely think it was the first thing that really soured my experience there. No one followed up on this request. Which we still look back on and like me and my mom are like that is *so odd*. Because, yeah, no one was like. oh, why? Like what is it? They were just like, okay. The person I had told was the head of the unit. If they had asked, I'm not sure I immediately would have been able to articulate why. But I feel like it could have started the process for me a lot sooner I think at least. Why is this? And potentially it could have kind of helped me explore it. As opposed to me kind of just for quite a while going. Huh! This is weird. And then one day, being like oh my God! This was this thing! You know so. Yeah, definitely could have been a safer way for me to explore. I don't think they screened for trauma. It was very much like depression, anxiety, mood disorders. Things like that.

I was very—I *am* very close to my parents. And I had quite significant separation anxiety from them and on my first day, I was like I need to call my parents. I would like to talk to them. And they basically were just like, 'No. Like you can't just call whenever you want. You get one call a day.' And so I snuck my phone in! And I called my parents on my phone, and basically was like, 'Come pick me up. *Now.'* My first day there I had such a bad experience. I was like, I'm willing to stay the whole course, but this first week, basically I was just like, I want to go home at night, and then I'll come here at 8 am. Which they agreed to after like 2 days of argument. Cause I was just like. It's not gonna work for me to sleep here. Yeah, there is quite a bit of…I think just… Not a lot of willingness to make it work for *me*. It was kind of. I had to be willing to do exactly what *they* viewed was best for *my* treatment. Which was not great for me. I think it was like, this is how our program works. This is how we've set it like, you know, everyone else here is willing to do what we're asking them to do. It was just, this is the way things are. So it was interesting.

I don't think they thought about cultural factors at all. They diagnosed me with separation anxiety. They were just like, 'No, you can't call. Like you're here.' And the other thing was, they told me that I didn't qualify for visitation until I'd been there for 2 weeks. So I wasn't allowed to *leave* the premises for 2 weeks. I couldn't call them. I couldn't see my parents. They couldn't come see me either. I believe I was there for the full 6 weeks for the assessment.

For diagnoses, they diagnosed me with major depression, general anxiety, social anxiety, and then separation anxiety. Interestingly, they did say PTSD. But they attributed it to an experience I'd had where a teacher was just like really mean to me. So I was diagnosed with PTSD. But not like *correctly*.

I…think, to my benefit I have always been a very like hyper self-aware person. And so I at the time had done a ton of research, and was like, I think it's OCD, and I think I have some kind of mood instability disorder. Um and they were like--they totally dismissed it. And I was like, yeah, I was like, I *swear* it's this like, I know it. And they just were like no, it's-it's not. Like you show some symptoms of you know this thing called Borderline Personality Disorder, and you show some symptoms of OCD, but they were like we're not willing to give you that diagnosis. And I think my parents kind of just were like-they were like we totally hear you. But like you know, you didn't get that diagnosis so it's likely that's not what it is. And I just for years was like. No, I'm pretty sure I'm right. You know,

Relationships with Staff at Ledger

There was one day nurse who I loved. I thought she was fantastic. She was definitely one of the best. Like you could tell she wanted to be there because she wanted to be there. So she was fantastic. She also reminded me of my aunt, which helps, I think.

Unfortunately, I wish--I don't remember her name, because I was just like so not present at the time, and…however many, almost 10 years now. But yeah, she was--She was fantastic, and it was always the bane of my day when she would go home at shift change. And then the psychologist was really great.

There were two psychologists who essentially tag teamed the assessment. The man wasn't too bad. He was okay. I think he was doing his practicum. But there was also a female psychologist who I really liked. I think she was kind of just one of the only people that was willing to not be incredibly serious with me. I was kind of able to joke about the situation. She treated me a lot more like a person as opposed to you know, a sick child that needed to be patronized. Cause I was very much a teenager that, you know, likes to feel like an adult. So I really appreciated that it was just yeah. We were always on level ground. I think that was a big piece.

Everything was my decision. They said the psychological assessments, like normally, they do it over a series like the whole 6 weeks, and I, for whatever reason was just like I don't want to do that. I'm going to do it in 2 days. So they were like, are you sure? Like that's gonna take—We're literally gonna be here from 8 am to like 6pm. And I was like, yeah, we're doing it. And she was like, yeah, cool. Let's do it. Which I so appreciated and was not common.

Unfortunately, the person who was the head of the unit at the time he was just—I think he was trying his best, but he was very just like, ‘There is a specific way this works, like we're not willing to be flexible,’ until me and my parents were making a big deal about it. And then there was a male nurse who was very like—I did not—I had to like specifically be like I'm going to like freak out if you guys let him in my room. Because he would like—I'd take a nap during the day, and he kept like—he'd come in and he'd wake me up and he'd be like, oh I'm just checking that you're okay. And it's like I—How would I not be?? Like I'm sleeping. So I was not a huge fan of that nurse. It's hard to say if it was me just being triggered by an older man, or if he was like—I think there was just kind of… He was very aloof. He was not a very warm character at all, so it's just kind of like I don't really want you to come in my room and wake me up from a nap.

Reflections on Ledger

I think looking back, I'm glad that I got set up with such a robust team that I don't think a tonne of people get. Because I'd been there. I think they've changed quite a bit. Because I've talked to a few other people who are were for kind of like similar times and then a few years after me— it sounds like it was not nearly as restrictive as it had been.

Discharged and connected to CYMH and Discovery

It was not a great fit with two different therapists at CYMH. I was lucky enough to get into specifically a substance use program, Discovery, and I had a really great therapist that I met there.

The first counsellor - It was quick. The month that I was waiting to go to Ledger I was connected with one. And I didn't like them. It might have just honestly been just—I'm going to inpatient. I don't want to have to deal with coordinating with an outside therapist or something. I don't totally—I don't remember it being anything huge. It could have just been me being a teenager.

And then after Ledger. I was co-seeing the therapist at the substance use program as well as the Child and Youth Mental Health therapist. And I think I saw the Child and Youth Mental Health therapist for I feel like 4 to 5 months before I was just like this is not working—this is ridiculous—I think she –she kind of like hit the last nail in the coffin when she called my parents when I was in crisis and basically told them it was their fault. And I was like. Yeah, we're not. Like that's such an overstep. And so inappropriate. And was just like, yeah, I'm not seeing you again. And then that was kind of was when I cut ties with CYMH.

I think they just were one of those therapists who had…a very specific concept of what I guess therapy needs to look like. So they would often like…It's hard to describe. They would often assume what I was feeling when I'd be saying like. No, I'm—I'm just like upset that I didn't get something or like something really simple, and it'd be like, oh, that's actually a bigger thing. And you're actually mad, because, like your parents disrespect you. Or something like it'd be something totally…And I'd be like that's no – I'm upset because I didn't get a hoodie. Like something really, you know. Not a big deal at all! And it all of a sudden it's like, oh, it's because, like yeah, your grandparents didn't show you the same attention. Like something really crazy. It was always just these weird—I don't know where you're getting that.

Basically, what happened was I'd stolen some liquor from my dad, and he called her and said, hey like I'm really worried about her, because I hadn't been drinking for a few months-- And then I'd stolen some liquor. So he's like, hey, I'm worried about her, she stole some liquor and this is kind of a warning sign for her. I think the counsellor was basically like, 'It's your fault. You didn't lock it up. You guys obviously haven't been watching her. Like you're not paying attention.' Like all this like stuff. Meanwhile, the liquor was in a locked cabinet in a locked suitcase, and it was sealed. Like all this stuff. I was a teenager looking for liquor, you know. So yeah, that she just like went off and made my parents feel horrible when that's not the case. It was not collaborative and it was judgemental.

Luckily I had a few pretty good counselors at Discovery. So the counsellor through Discovery I saw till I was I think, 17 almost. From about 13 to 17. I got to stay with the same person throughout. It was good. It was definitely like…I mean, of course, like I think, considering there was a lot of other stuff going on that hadn't been recognized? Like talk therapy certainly had its limits. But I think finally having someone who actually listened to me and was very collaborative and um… let me direct it, was great. So yeah, she was fantastic. She was super great. Yeah.

Psychiatry at Ledger

The psychiatrist I had at Ledger, I didn't love. It's funny because she's actually my psychiatrist now because she's in the program for BPD now. But I think she's—to her benefit she's I think, done a lot of work and really updated her knowledge. So she's great now. But at the time, like she was just like, yeah, you're too young for any of these diagnoses. I'm not willing to give you any of them. And was very like…I don't know what it was for her with medication. But I was very like I really advocated for myself to be on meds. And she, like kind of just, was very like I don't think you should be on like SSRIs, but you can try Prozac. And then I was like this doesn't work for me, and she was like, try a higher dose. And I was like, this doesn't work for me, and like was really not willing to kind of change. And just like you know. It was just like when one thing didn't work, it was just like, okay, there's no other option. She wouldn't try different SSRIs for me. And I had a lot of sleep issues, and so she kind of just was like, here, take like an insane amount of melatonin. And then I was like this made me groggy for 48 hours. And it was like, okay? Well, then, I don't know. So.

And then the psychiatrist I had after that, who I had been connected to through the hospital and basically was like on a waiting list, for. She was great, and I mean she was the psychiatrist I saw until…last year. She had her things, I think, like psychiatrists do. I've just yeah, I-I don't know. Same thing with meds kind of just like you know we tried kind of the things she viewed as the things to try, and then, once we were out of that it was like, okay, I don't know. It was like, there's nothing else? Really? Like. I don't feel like I've tried that much? But she—and same thing until probably last year, was like, 'I'm not willing to give you an OCD diagnosis or a BPD diagnosis.' And then last year was like, 'I'm pretty sure you have a BPD.' And it was like, oh, okay. That's a bit of a weird switch.

I think it was just because I mean…I think, to her benefit like of course she'd known me for the longest out of everyone. And she was also a child psychiatrist. She did not work with adults. So she might have just really been falling back on her training of like, you don't give young people, you know, such strong diagnoses like BPD. And then I think she realized like cause we—when we started coming to the end, it was like, oh, my God! I'm in my twenties like you've been like this for 12 years. And I think that's when she started to be like, okay, your things are still going on for you that we're seeing repeatedly. Like these patterns are not stopping because you're an adult. And that was when I was like, okay, we seriously need to consider like there is something else going on. SSIRs are not fixing this. Anti-psychs are not fixing this. This is obviously not depression or anxiety like this is…something else. So she was thankfully, she was very willing to be like, okay, you're an adult like. Let's actually look at this. I had the same psychiatrist from age 13 or 14 until last year, so it was really great to have that continuity of care.

A period of stabilization

Kind of around 16, I started seeing a lot of improvements. I was on the right meds finally, and was seeing people consistently, and so I was able at 17 to go back to school full time. For the first time since 13. And then was able to graduate when I was 18.

Early adulthood: Transitions and changes

I don't have my high school diploma. But I advocated essentially like, I should qualify to be a high school graduate, and they said yeah sure, because your grades are really good. And then was able to go to college and started my degree in English. It was a really stressful time and it was partly because just I didn't know if I could even get into college. Partly because I didn't have a high school diploma. So it was a question of, you know, can I even do this? Do I have to upgrade every class I didn't take? So that was very stressful. And then I was also working full time in a bunch of contracts because I was a grant writer. I was a trained grant writer at 18.

And then, unfortunately, just like that stuff that had been super stable like the meds kinda started not being enough anymore. And then I think the pieces like the OCD and the BPD, that had been just so pushed aside were rearing their head, and I had nothing to cope with it, because I had never been given coping methods. So that was kind of when it was like, okay, I need to like this needs to be addressed now.

Luckily Camosun was amazing and they were essentially like take a test so we can see where your English level is. And then were like, okay. Your English is really good, like you don't need to upgrade basically. So I was able to go to college. And then there was just, I think, I was doing really, really well. I was, you know I was working. I was going to college. I was like hosting events and all this stuff. And then. Of course, like most people, COVID hit, and I started having to work from home and do college from home, and then college completely shut down. So I didn't have school. I didn’t have work. I was just like… Stuck. With my own brain for the first time in a really long time. Meds stopped working as well. Cause I'd been on them so long, and things just kind of…And then I took a job that meant I was working 80 hour weeks. It was like a school administrative position. So I was the school administrator for like a theater school.

And COVID was just like—I don't think anyone knew what to do. So they were like we’ll put on camps. We're gonna have children's camps. And it was like, okay. So I had to become the head of the children's camps. Because we only had 4 employees other than myself, I was also a camp counselor. I was a nurse, like it was ridiculous, so many issues. So I was working like, I think, like 40 hours of overtime every single week. So that doubled onto all of the previous stress. I just was not taking care of myself in any way. And moved out for the first time. And all of this. So it all just, I think piled on. My parents separated like—2020 was just an insane year of just things on things. And then I just yeah, I really struggled to cope with all of it.

When I was 18. That was when I was connected with the racialized counsellor through the Mary Manning. They're like the child version of the – What is it? The Victoria Sexual Assault Center? I think the actual name is like Child and Youth, Sexual Assault Prevention Center. It's very long. I think it is a private non-profit.

This counsellor was the first person of color that I had interacted with in mental health services. It was amazing. We still like go for coffee every once in a while, like we still are close. But she was like. Yeah, she was so fantastic and…just like it—It was amazing to have like…Of course—I'm Black, and she's not. So it's not exactly the same. But we're both mixed. So there was like, I think, just having that piece of you know, the whole thing was about, of course, my trauma, but having that kind of cultural piece that we could talk about. It wasn't just like, oh, I don't get that at all? Like, yeah, it was just, I mean, and she was amazing. Like she was just like…she was so willing to give me her opinion on things and like. Yeah, I don't, I can't even--yeah. She was just. She was amazing. She was so good.

Because my dad really had his own struggles as being like an immigrant, because he's originally from Barbados. So when he came to Canada it was not a particularly Black-friendly place in the 60s. So…he had very much his own struggles of. I think, he was very assimilated, so it wasn't like, particularly. There wasn't a ton of pride around that side of our identity. So it was really something I had to learn on my own. And I think, in the context of therapy, when I bring my family in, or even talked about them to white counselors, there was very little understanding of the context of like, my dad as an immigrant. The understanding of mental health --it's different in the Black community. Like it was very automatically assumptions like your dad is a bad dad. And it's like, well, no. He's a Caribbean immigrant. Like we don't talk about mental health. Like it's-it's very different.

This counsellor just so immediately understood the context of like it is very different in that community. And it was so helpful, not constantly having like, oh, your white mom gets it, but your dad doesn't, and it's like well. It's different! Like it's culturally very different. They have never like directly said it, but it was always very like obvious that it was like, your mom—Like, often they went to my mom. And when they were talking to my dad, it was a lot more like, you don't really understand what's going on with your daughter. It was very like, you could tell the underlying meaning looking back. It was totally because he, you know, was a Black immigrant. It was. And it's just so different like, whereas my mom was, worked in hospitals and was a white woman. So yeah.

I know my dad talks about when he came here, in the nineties, like there was literally him, and probably like one other Black guy, and they mistook them for each other. I can't imagine coming here after living somewhere else. My dad had first immigrated to Ontario. Both my parents are from Ontario. But they met here actually. And got married here.

I worked together with this counsellor for 4 years until I was 21, doing trauma-focused work. She said she was very inspired by Dialectical Behavior Therapy. And then we were doing obviously like talk therapy, lots of like mindfulness. And then, like skills-based kind of directions. And then yeah, like kind of just kind of unraveling the pieces of-of the trauma. And how to make that work in my life.

OCD treatment

And then I called like private psychologists' group. And was just like, hey, I'd like an assessment. And I think it was like, maybe 3 sessions? And then they were like, yep! You have OCD. And then I—luckily the psychologist I was seeing for the assessment was like, I actually am an OCD specialist, and I do the like, the ERP (Exposure and Response Prevention) treatment. So do you want to do a 12 week course with me? And I was like, yep! It all worked out.

It was good. It's definitely like—it's been hard to kind of integrate in my life. Like it's definitely one of the bigger pieces, I think obviously because it's been so long, that it hasn't been treated. But it was-it was amazing to like *finally* have that validated, and have someone be able to say, okay, these are actually going on. That's not just you, that's not just something wrong with you. And it was great. Yeah, she was great. I was lucky that I found like a psychologist just immediately. That was super nice and …yeah. This was last year. Luckily she was in her practicum. So it was significantly cheaper. Yeah, still expensive. But not full.

USTAT: Transitioning to adult mental health services

So after that I was essentially closing up with my psychiatrist that I'd been seeing. And she was just like, I want to make sure like you're not just left high and dry, so I want to find you adult services. She was like, best bet is going to be USAT with Island Health because hopefully you can get into the DBT program. So I was recommended there, and luckily got an intake pretty quickly. And then, by like, within probably 2 months, which with USTAT, is kind of insane. They were like, yeah, we have someone you can see. And then they were like. Okay, you definitely have BPD and we're gonna get you into the DBT program by October--And so by October I was within, you know, the weekly group and one on one. So I was, I was very lucky in how quickly that process went.

It's been really great. It's similar to the OCD stuff. It's just like. Oh, my God! I wish I had been able to access this so much sooner. Because of how immediately I'm seeing the shifts. It's like, oh, my God! Like this is so overdue. But I'm just thankful I got in anyways, because it's yeah, it's a really great. There needs to be so many more programs like this on the Island. I know I'm pretty sure USTAT is the only one that's doing this. So yeah, it's been great. It's been really good. I think it’s been seven months. I have a psychiatrist, and then I think if I needed one I would have access to a psychologist. And then the group is led by 2 therapists, and then I have my 1 on 1 therapist as well now. Amazingly my one on one therapist is also a person of color. I was very lucky in that sense as well, because everyone else on the team is white. But I got this therapist!

I think it makes it like, there is such a baseline level of kind of community with someone that you know is going to get the experience of being racialized, even if they're from a different community or not mixed, or whatever like. There's just a very like. Yeah, it like, because it's been very nice being able to talk about things like being a bigger, racialized woman, which I've never really had a counselor be able to actually like, understand, or get, other than my counselor, at Mary Manning and then this counsellor. So it yeah, it's just. There's these—these very little things that you don't think about. And then all of a sudden it's like, oh, my God! This has been a core like belief of mine. But I haven't been able to talk about or really explore, because this person was white and just did not get the nuances of the experience. So yeah, that's been really *really* nice.

My therapist at Discovery did kind of try and explore that with me, and she, you know, I think, did her absolute best as someone who was an older white woman who lived in Victoria her entire life. And it did…help like to an extent at the time when I didn't really have a ton of other resources. But I think, comparing it to my experiences and talking to other racialized people, there's just…I think, just that piece of having that understanding that makes it so different.

REFLECTIONS

My drive to gather resources and the support I need

Definitely it is a credit to—probably my parents. Because I think they really like, they just advocated for me so hard, that it was just always it was like if you think this is not the right thing, look for something else. Like it was always--there was never any like--You need to stay with this therapist, or you need to try this thing more. And I think that's definitely-- my mom has been very -- I mean she's working on becoming a Registered Clinical Counsellor right now. She's always been so pro therapy, and like it was never some kind of like taboo thing in our house. So I think definitely just my parents setting that example. Which was a huge piece in me being willing to kind of advocate for myself in a lot of ways.

My dad was definitely supportive, he was the one who brought me to Ledger every morning and picked me up. He came to lots of appointments. He really did do the best he could have, coming from the worldview he came from, and from a family that still doesn't talk much about mental health or wellness at all!

I think my mental health journey has shifted things a lot for my dad. He goes to counseling regularly, and he's very like pro all that stuff, and I think he always has been. I think he hasn't always known how to like, seek it out. Especially like seeking out service providers of color, which I think has always been something he's been lacking, and hasn't realized that was what he was looking for.

I think both my parents have felt very upset about how the system was. But they are grateful that I was able, that they were able to navigate me through it. And end up on the other side kind of thing.

Perspectives on mental health within the Black community

I think…especially like the Caribbean community. I think, especially from Barbados, like being such a small island, and having so little resources for mental health, it's not like…It's very…It’s hard to describe. My grandmother came to Canada, and she's like, “I came here so you guys could be fine”. You know, the very, typical immigrant. “You're lucky you're not in Barbados. If you were, things would be worse. So I don't hear, you know, upset about anything.” I think, in the Caribbean, just a very common to think the family members that have mental health problems, “Oh, that's the crazy one,” you know? There's not, it's just like--there's support in their own way of like…We still love them, and we do what we can. We always take care of each other. But it's never like. You don't get treatment for it. You don't talk about it. I'm sure, because it's such a small island. Everyone knows everything about everyone, and you know half of us are related. And unfortunately, I think that just came with us to Canada. My grandmother continued that with her kids, of just you don't talk about it, because people can find out and you're going to affect our status. So I definitely like, yeah, I see that so much, even in my dad.

When I hit like 10, I became very aware of my ‘otherness’ as a racialized person, and it was something that I became very intent on learning about, and was something that I became very proud of. And so kind of trying to almost teach my dad that in some ways of like, you're allowed to be like Black. Like you don't have to wear sweater vests, and, like you know, like totally assimilate and play golf, or whatever like. And so that was like a huge transformation for him over the years of, I think, going back to a place where he could be very proud of, like being an immigrant from Barbados like, I am originally. It's amazing to see. He is very—you know—half of his clothing is like specifically activist t-shirts. Yeah he's got like a [huge tattoo about it]. I think it's much better for him.

What I would have wanted instead

A huge piece needs to be, not only like cultural understanding or white practitioners being given cultural understanding, but there needs to be so much more room and resources for racialized practitioners, because there is just not enough. And I can't imagine it's because, you know, people from our communities are not wanting to. I just can't fathom that like statistically only white people want to be psychologists or something, that just doesn't make sense.

And I feel like I know so many other people like us that want to be, and it's like. So it's just interesting that I'm like. Why, where is that representation then? Where are those pieces getting lost that that's not continuing all the way? And so yeah, I think there needs to be a lot more and I would have loved—it would have been amazing to have more of my practitioners, or even just to see more faces that were, you know, similar. And I think also just like—Which I think, is also like important in a cultural context, I think there just needs to be so much more like *belief* that your patient knows what they need. Cause, I worked as a peer supporter at Royal

Jubilee at the psych unit for a bit, there is such an implicit belief that like we, as practitioners know best. Because we went to school for it. So we *must* know better than them. But it's like well, they're the ones in their own story. They're the ones in their own head. They are gonna know 100 times more about what *they* need. Which I think would have been...I would have liked my experiences a lot more, I think, if I was trusted. Yeah, I think that would have been, probably the 2 things I think would have been huge pieces for me.

I worked with the same white child psychiatrist for 12 years. At the beginning, she tried to highlight the family dynamics too. Over that long period of time, she was able to see that the family dynamics were not a problem. She would bring in each parent for solo meetings too – and that was the way she did things with all her patients – which is different because I haven't heard of that before. She was able to get my dad out of his shell.

What I did not want

Looking back at my experience, I felt dismissed and not super heard. There was also a de-prioritization of family ties and especially a villainizing of my dad. Connection to my family was not hugely emphasized throughout my care.

Even when they were talking to my mom, there was an assumption that my mom is a helicopter parent – and I had to frequently tell them that I want my parents involved and I have no problem with it. We'd have family sessions and because my dad is quiet and stoic, people would ask, "Did your dad not want to be here?" There was a lack of understanding for my family. A holistic perspective would have been so helpful. Maybe during the first meeting a counsellor checking in to ask, "Your mom is involved and your dad is withdrawn, are you ok with it?" And when I say yes that's fine, my family is healthy, a lot of practitioners did not drop it when they should have. My dad was definitely treated…being a mixed family, it was very difficult to engage with the system in the same way for each member of the family. Until the Indigenous counsellor, there was never a wrap-around care for all of us. They did not know that my parents were doing everything for me. There was never a point where they said, "We're bringing her into care and we're bringing her parents into it too." No perspective of, "This is what works for this family." It would have really shifted a lot of things for us and how we experienced a lot of the system.

The separation anxiety diagnosis was never repeated by another practitioner after Ledger. I would hope that I would want to be seeing my family! And my safe place and things were taken away from me. For a teen who is struggling with their mental health, 6 weeks and isolated, and who wants support from my family? It's kind of sinister to say that this is a disorder that you have. I went to an overnight camp for one week once, and I struggled with it, and everyone was white.

My first racialized counsellor interacted with my family quite a bit because she ran a family support group – my parents went there for about a year and they formed a close relationship with her and because she knew I was so close to my family and I was younger and so there were a lot of goals to be collaborative with parents and so they came to a few meetings. My more recent counsellor who is also a person of colour hasn't met with my parents that much, but I talk about my family a lot now because they're important to me.

Meaning-making of myself and my family

I'm lucky to be taught self-advocacy so hard. I was so young and I was already, "This is what I need, this is what's going on." When my healthcare practitioners weren't helping, I was the one figuring it out with the support of my family. I even have this document that I bring in to tell people what they need to know. It's kind of bittersweet that I had to learn that so hard, but it served me so well because I've needed to advocate in other areas of my life. As an outspoken Black woman in Victoria – I don't even care, I've advocated for myself in the worst situations, I can do it here.

Meaning-making of the healthcare system

The collectivist perspective as a racialized person and how important that is to me and my family as a racialized, mixed family is so important. When we have had people who understood the collectivist perspective, it's so different, and it's collaborative, whole care, and it's something that I try to bring into my work that I do. It's so different when you're not an individual being paid to come talk to another individual. It's a hope I have for the healthcare system that it's something we can move toward one day.

The idea of a baseline of community with BIPOC practitioners – that has been huge for me. Working with other BIPOC people and being part of BIPOC organizations, I wonder if we can build that in somehow, even if it's a BIPOC peer support person. Having a baseline understanding was so life-changing. Not having to work so hard to build that baseline understanding that I have with other people.

Unfortunately, I definitely have a specific distrust of the healthcare system that I'm still working through. And unfortunately, I'm not proved otherwise often, which has sucked. That distrust – there needs to be change. And I'm often really seeking places where I can add my thoughts to see how that change can happen. There is unfortunately a lot of system, legislature base issues throughout how the healthcare system operates. And that is so unfortunate, especially in the mental health system, and youth who are in vulnerable positions, and then on top of that, racialized youth. There is so much that needs to be changed at its core. Unfortunately, that's the meaning and take away from my experiences, but there are really good people in the system who are really good and motivated to do that change and to see our racialized opinions heard and to investigate why these are the shared experiences.

Raven's Story

Raven (they/them) was 25 years old when they shared their story. Their description of their racial identity was 'Metis' or 'Indigenous'. The date of the first interview was on December 1, 2023, and the date of the follow-up discussion meeting was on February 20, 2024. Below is their story.

'How it all began'

It's always hard to talk about how it all began. I have a lot of mental illness in my family, a lot of alcoholism, and death from alcohol from both sides of the family. Sometimes I think about the Indigeneity of my family, and I feel like we lost our culture when my relative died of tuberculosis, and what was left behind was kind of like just the trauma. No closure, it was just the substance use and the pain. And so I feel like that's really palpable in my family. My immediate family and grandparents, things are good, but you could still they are like…I don't know. My grandma is very much like the 'adult child of alcoholics' like whatever that is called. She was definitely like that. And so there's definitely stuff in my family that I think gave me a predisposition.

But really things started for me when I moved from Katzie territory in Maple Ridge BC, to Victoria – like Brentwood Bay. From the very first day – I would get bullied. Like I remember the very first day, someone saying things to me. Ever since then, it was quite targeted, it was really intense. I was 10 years old, going into Grade 5. It was shocking, because when I was in the Lower Mainland even though I lived in a rural area, like it was just a bigger city feel, so like, people's strangeness was more accepted? And then when I came here, it was quite a small town, in Brentwood, and—immediately, just like different.

I just remember it stated the first day, and that was really intense. So that set me off on a downward spiral, and like, by Grade 6, my first year of middle school, I was being bullied really badly. I remember that was the first time engaging in self-injury. And I don't even think that I was aware of what I was doing, it just felt, I don't know, maybe cathartic? So looking back, self-harm has continued to be a big theme in my life, but when it first started, it wasn't as ritualistic as you would think. It was just like a kid, trying to…manage.

And then, in Grade 8, there was a peer of mine in school, who started to abuse me and a friend of mine. There was sexual coercion, and like it was just like very, traumatic, and very abusive. And I think one thing that is interesting, is that part of it was over social media and texting. And it was very new at the time, I think 2010 or 2009, but like texting was still very new. Instant messenger was still very new, so a lot of it was very hidden from my family.

The abuse really changed my life. A lot of awfulness came from that. Being isolated. That's when I first started feeling suicidal ideation and started to engage in really ritualistic self-harm. And that's when—every day of school was already a nightmare –but that's when it was the most intense I guess, and the beginning to my mental health issues.

It was unaddressed. I just remember that finally the school found out about some of the sexual interference that was happening, and I remember being called in to speak to the school counsellor, and them explaining how they had uncovered some of this sexual interference, and then they basically just asked, "Are you okay," and I was like, "Yeah, like I'm fine," and they were like, "Okay great," and sent me back. I think the school counsellor just assumed I was okay because my grades were good, and I had a nice family. So it felt like that was my first opportunity to receive help, and I just didn't, get that.

At the time, I didn't want help or support. But you have to kinda force it on the kid! They didn't involve my parents, and I was actively keeping things from my parents. And the other friend of mine who was also interfered with—they had a meeting with their parents. And I didn't get that. I think it was because I looked like I was functioning. I have always been high functioning, and it's actually been a barrier to my care. The student got suspended for like 2 weeks, and was back in our grade, and was very persistent.

I think the biomedical system looks for illnesses. It looks for the presence of illness rather than presence of wellness. And for me, trying to pretend everything was okay, was really important to me. I had really low self-esteem, so getting good grades was really important to me. So I remember in like Grade 8, that horrible year, I had perfect attendance that year. Which is wild, right?

So that was age 13, and that was my first year of suicidal ideation. And that abuse continued into Grade 9, my first year of high school, before that was fully, I guess, "dealt with"… by them dropping out.

Sexuality and abusive bullying

I remember being in Grade 9, and I joined the Gay-Straight Alliance, it was either Grade 9 or 10, and this person had targeted me tried to force me into a sit down with them by telling the Gay-Straight Alliance teacher that they felt unsafe, and that we needed to have a sit down, and talk about what was going on, and kind of like, mend fences and stuff. I felt trapped by that. Because they talked to a teacher I trusted and made it seem like two friends who needed to mend fences. And it was just like…so they were like quite persistent about trying to be in my life and have that control. I was bullied really hard for being gay, even though I didn't know what my sexuality was, so like the Gay Straight Alliance was supposed to be a safe space for me, so that was really challenging.

The bullying changed over time, and the gay bullying didn't really start until Grade 8, which, was when I was involved with that student. At first it's, "Oh, you're an emo," then it was like, "You're slut," then it was like, "Oh you're a dyke," and then it kinda like progressed over time.

I remember at the end of Grade 8, in the drama room, a few people were watching a movie, and a few of us went to this closet area, and I was sexually assaulted by a boy, in front of a bunch of other boys. One of the other boys, tried to stop it—like intervened. I remember that was the last day of school in Grade 8, and that was also very impactful for me. It just like, set me up for the abuse with that friend, and it just set me up for a really negative relationship with sex. So that was really challenging. Then in high school I was being bullied a lot for being queer, and like, people didn't want to be my partner in gym, and things like that.

I remember once in an online chat room, someone was sharing graphic details about what they were doing to self-harm, which was very traumatizing. I gave them my email to reach out to me because I wanted to help them. Then I woke up the next morning and they said that they made the whole thing up because they wanted support. But I remember not sleeping that whole night being terrified. Part of that comes from not being educated about internet risks, dangers, and lies. I had also sent risqué photos due to extortion to another person in my high school and that person was eventually arrested, charged, and incarcerated for child extortion and creation of child pornography. They were one grade below me. I did not understand the very real permanence of it.

I got my first boyfriend in Grade 10 and my self-harm got way worse. I had another boyfriend in Grade 11, he was in Grade 10, I was in Grade 11, and when we broke up, I was like in a really dark place. I remember I went to the school counsellor, and was thinking to myself, "I'm going to out myself. I'm going to tell everybody I'm struggling, and just get help." And I remember sitting in his office, and as I was trying to verbalize what was going on for me, like others walked in, cause it was like a resource room. And he was like, "Hey come on in!" to others, people would come in and I was like trying to tell him what was going on for me. He was not attuned. And just like people coming in and out and he did not take it seriously. And like that was the only time I ever tried to tell somebody. It was the first time asking for help. I feel…really failed by my school system, and I think a big part was my grades were so good they just didn't…care. It put me back in that mental health closet. You know, not wanting to tell anybody, keeping it secret.

At the very least, I think people should avoid deficit-based care. When I had a boyfriend, they made me go to sexual health workshop, and it felt like it was because I was Indigenous. Every Indigenous student in high school had to do the program as soon as the school found out that the student might be sexually active. There were a few unexpected pregnancies among youth at the time which prompted the program. But maybe a better way would have been community teaching for everyone, not individually removing each Indigenous student from school. They didn't know that I was receiving very good sex-ed from my family which felt more culturally appropriate. Instead, they made me miss class or pulled me out of class to do this in high school.

Overlooked signs

I was also very physically unwell. I had a parasitic infection that we didn't know yet. And so they also tried me on imipramine which I think is an anti-depressant, or I think an anti-psychotic, that has smooth muscle relaxing, or smooth muscle pain management impacts. But I'm bipolar, which we didn't know then, and lots of times, anti-depressants don't work well with bipolar. And so I went, like, crazy at school. Like really mentally unwell. Like I dropped my lock from my locker, and burst into tears. And somebody—I don't like being called blonde, because I'm a redhead—someone called me blonde, and I *screamed* at them. They were like, "Oh I didn't say that, I said your hair was long," and I was so embarrassed. And so then I went to the office because my head was hurting, I was in my math class, my head was hurting, and I just didn't feel good. So I went to the nurse, and I ended up crying. And like, uncontrollably crying, and then they called my mom from school to come get me. And so looking back, that was like an indicator of having bipolar and not being diagnosed.

There were many times when things were public, and teachers witnessed and didn't step in. There was this one particular day, where, this girl, it was like in Grade 8, and this girl was like, screaming at me, and I was like, screaming full top lungs back. And I remember walking past a teacher who witnessed it, she was like, "Are you okay," and I was like, "Yeah I'm fine," and then I just walked past, and like that was it. And she *never* followed up. And so, the meaning of that, what I took away, was being alone. And also, part of that friend who abused me, I believed their messaging of classic grooming, of like isolating you. Making it so there wasn't anyone who understood you. So it was like, I didn't trust anybody to understand me. I felt like there was something wrong with me. But also, such an intense fear of if I were to tell anybody that—like what would happen? And so it felt like each time I tried to reach out, or there was some sort of entry level to an intervention, it was like a fear of, “If I tell you, bad things are going to happen.” It never felt safe.

Even though I felt very adult partially, because of that innocence lost, what I needed at the time was to have an adult put their weight into it, and intervene in a meaningful way. You know? Like that first meeting with that school counsellor who knew what had happened. Like call my parents in, and like make a big deal out of it, do an assessment, make sure everything is okay. It felt like a passivity of their resource people. Or like when I went to that school guidance counsellor, I had never been in his office. Like if a student comes in for the very first time, give them some care you know? Or when I was in the nurse’s office crying my eyes out, they *never* followed up with me. There was no, how are you doing, what’s going on, I care about you, that kind of thing. Even if everything was fine, to really make sure it was truly fine.

Teachers just liked me, because I was like good in class, and I had good grades, and I did good homework. Because I was high functioning, my parents were both teachers, they were really involved, good parents.

I remember being in Grade 10, and we had to do vision boards about our future, and on my vision board, I put that I would want to be a musician, and that I wouldn’t have any money, and I would become a stripper, I would probably do drugs, and I had pictures of drugs, and each year I would do roller derby, and at the end of my life, I would kill myself. And I actually had a picture of someone killing themselves that I found in a magazine. It was like Grade 10 Planning, my vision board. And I had a picture of a shitty apartment. Like I will live in a shitty apartment, and I had a picture of a stripper, and I was like this is what my future is going to be.

I got an A.

And there was another kid in that class, and we had an assignment of if you had won the lottery, what would you do. And his answer was that he would buy a bunch of drugs and then cut them up so he could make more money, and then buy real estate. And he got sent to the office for a check in because of that. It was the same class, and I was like what? I remember seeing that and being like okay, “Fuck me then!” I remember, at the time, maybe I didn’t identify it concretely as a cry for help, but like clearly, I was being pretty…open about…that. And I remember seeing *him* being sent to the office, and being like *oookay*…Clearly he’s not actually doing that. And also, like…he’s not going to win the lottery, you know? But like my vision board of my future, like had drug use and suicide in it. So that was just like really wild to me. Just feeling like—that was in Planning 10—that was supposed to be the life skills class, you know?!

That class always felt like a joke. I didn’t respect her [the teacher], not in the sense of putting her down, but like, you’re teaching Planning 10, this is a joke of a class, I don’t want to be here, this is so stupid. I think that is part of the reason why I took that risk of doing that vision board, because I felt like Planning 10 is a joke.

That was the Saanich School District 63. It was a joke. It was like really really really bad. I remember engaging in self-harm, in class, in lecture. But I was really diligent about hiding them. I remember being an emo kid, I had like a big wrist band bracelet, with chains on it and stuff. I was taking apart pencil sharpeners, and taking the razors, and using those. I remember, one of the people I was involved with, would like hold them in her mouth, and so I would do that too. And so I started engaging in like a different form of self-harm, and like, but I was really diligent about hiding it, because I was afraid somebody would notice, and then they would try to intervene.

There was a sense of wanting to be recognized by my abuser, because they introduced me to more formal self-harm. And then there was this whole—there's a few of us in this little circle—this idea of like, who is suffering the most. So at that point there was a little 'look at me,' and just wanting to be recognized by that circle of friends. And then when that circle of friends fell apart because of all the abuse and the teachers finding out and everything, then the self-harm became very personal. I didn't want anybody to know. The abuser dropped out in like Grade 10, I think.

School was still so unsafe. The bullying never stopped. It was super bad. The bullying got less everyday, but like, there were tons of people who didn't like me. So there were places I couldn't go, people I couldn't talk to, I was still very much like, an 'untouchable.' It was just…I wondered what was wrong with me.

The other thing is, I was so so so mentally ill, that I also feel…like I wasn't my best self, so I also to some degree, don't blame people for not wanting to be around me. But also, it was because of prejudice. Like it was because of culture, it became cool to not like me, you know? The abuse from my mental illness made me feel like I couldn't connect with other people, because, what do we have in common? And how can I really know who I am.

Teachers in the school system

Teachers were really important to me because the teachers who actually cared about me as a person were very meaningful to me. I think the words "high functioning" are problematic. Teachers who saw that I was doing well, and maybe because they were too busy or had big classes, just would say, "You're fine."

I had two important teachers: my sewing teacher, who remains a big part of my life today, and my English teacher, who inspired me to go into creative writing in university. Usually, because of my high level of achievement, teachers would leave me alone or not invest in me. But these two teachers knew I was already achieving well, and they still encouraged me to grow and made efforts to connect with me.

Intimate relationships and mental health

I remember, that first boyfriend of mine in Grade 11, I remember breaking up with him, and then dating my next partner, and then going for a coffee with the first boyfriend after that second relationship. And we had a sit down and like now that I have come out about my stuff, I was like to him, "I realized that like, you saw that I was hurting myself and you thought that I wasn't okay. Never--like the 6 months we were together--I never told you why. You never knew why I was hurting myself, you never knew why I was the way that I was, I just could not talk about it." And it was profound for me to look back and be like my very first love, the person I fell in love with, I never was able to open up. I couldn't let myself be my full self. Like that it was unsafe for me to be, my full self. And that the need to present as if everything was fine was so strong. That I couldn't even…I do remember there being a time where I think he straight up asked me why I was doing what I was doing, and I think, just knowing what I know about trauma and triggers, I just got so triggered that like the room was swimming, and I was so overcome, that I like shut down. Totally dissociated. And that was one of those times that he directly asked me, and I couldn't even go there.

I had a boyfriend in Grade 12, and by end of first year university, he ended up leaving because he was involved in gang activity. He actually knew the person that abused me, they were family friends, and like, they interfered with him too, so he knew. And he was the first person I told. And so as he was leaving, he was like—you need to get help, don't let yourself keep suffering, you know? It was really loving. And so because of that, that's when I told my parents, after, my first year of university.

My experience going into the health system

So I come out about everything to my parents. It was horrible, and--not like horrible, they took it well, but it was just horrible for me. I went to a psychiatrist, and my psychiatrist was a woman of colour. And what was really powerful at the time, was that I was really like afraid of…tenderness. And like the –honestly—the 'white lady vibes' of care. That kinda like, 'Aww,', that kind of pitying white lady version of care. And she was quite firm in a way that I found really helpful.

I remember telling her about what had happened with that classmate, and she was like, "Well that's fucked, don't hold on to that!" And it was like, "Wow." The firmness of, "That was wrong, that was wrong," was so helpful. And I just found her really…pragmatic almost. And I found that really accessible because I was so traumatized, that I was having a hard time accessing my own emotions, and she was just like, "Enough of that, we are going to fix this. Let's work on this," in a way that I found really *really* helpful. And like honest with me. Here was someone who believed me, didn't try to placate, or be all 'aww.' Instead, "That's fucked, let's talk about it, you're right!" And like problem-solving oriented. And that felt like care to me. It felt like somebody who was really going, 'Wow I can recognize that, I can name that as being fucked up, and that wasn't your fault. Let's work on it."

I found her really special, and she did look after me. And the other thing that was really funny, when I first started going there, I brought my mom out there with me, and she kind of like at first treated it like—and I think this is kind of related to honestly to my Indigeneity—she kind of treated it a little like, “Oh why are you bringing your mom? You are an adult.” My mom was really able to read when I was triggered, and she would just touch my leg, and kinda like ground me a little bit, and the psychiatrist started to notice that dynamic. She actually asked my mom to come to all my sessions.

I also explained that my mom helps me remember things. Because I would be so traumatized that it was hard for me to remember what we talked about. And my mom would sometimes fill in gaps. She would ask questions, and I’d say, “Oh I don’t know, but my mom could answer some questions.” And so I think looking back, my relationship with my mom was so close, and also family is so important too as an Indigenous person, and also as an Indigenous person, the health care system isn’t always safe, so having a person was really helpful. I was often protective of my mum, because I felt like people were treating us like we were enmeshed. But it was very important for me to have a support. She also was an advocate for me, when I had a hard time communicating because I was in trauma, or when I had a hard time remembering something because of my trauma. So I sometimes would call her my external hard drive. She helped me understand things. Also, I was young, I didn’t understand these things.

Profound connection through a vision of a raven

During that time, I tried to get counselling, but I was looking for free counselling because I couldn’t afford it. I was at UVIC, and I started to see a free counsellor at UVIC. She was the Indigenous counsellor. That I was talking with her, the very first time about my trauma. And, I remember sitting in her office, and I started to have a vision of a raven. It landed on my shoulder, and I was leaning back, and she was like, “What’s going on?” I genuinely felt like I was going to touch the feathers when I touched my shoulder. It was really really amazing. And then at the end of that—she was Indigenous—she helped me interpret that as a vision, from like the spirit. It’s actually been a moving memory that has filled me for years to come. It was *so* profound. And it made me feel like I was cared for by this spirit, and it’s continued to feel like it’s looked after me over time. And that was incredible.

But I feel like if it was a white psychologist, they would have told me I had a hallucination, I had a psychotic— they would have pathologized it. I feel like they would have been writing notes, and not listening to me. Either it would have not been addressed, or it wouldn’t have been as impactful for me. And at first it was kind of scary. And they might have communicated to me that I was having a psychotic break or like, a pathologized—there’s something wrong with me. Instead of realizing that this was a really powerful gift.

Engaging with my Indigeneity

I knew about my Indigeneity in school, but I didn’t really engage with it. I started engaging with it when I got to university. I was always interested in it from a young age, but I never had the opportunity because I went to a school really close to Tsartlip Reserve. So a lot of the youth that were in the Indigenous programming were in W̱SÁNEĆ, which makes sense. But I was the only Métis person, and so like, I just didn’t really feel like it was my space. I didn’t feel very connected to my culture because I didn’t have connection to my community as a non-First Nation, non-reserve, urban Indigenous person away from homelands.

When I came to UVic in 2014, there was a Métis Elder, and there were Métis teachers, and students, and so it was the first time I was around other Métis people. And so that gave me that grounding. Oh I do have community, we do have common values, we do have a culture. All that.

Counselling with that counsellor was transformative. Feeling like I could access the Indigenous counsellor, and feeling so safe in that space. And seen. It was so profound. So I did really big healing work in that counselling relationship. And I was seeing my psychiatrist.

And then, that counsellor left UVic, and I was looking for more free counselling, and so there's the Foundry. And I was having a hard time getting into the Foundry. At that point, people still did not know that I had bipolar. I still wasn't diagnosed. And so there was like a youth and family addictions program— Discovery.

Discovery

I was desperately looking for counselling, and I remember messaging them and saying I'm not addicted to drugs. But I'm addicted to self-harm, it really is an addiction. I can't stop doing it. I'm doing it all the time, and so I think I should fit your mandate, and I think you should take me. And so I had to convince them to take me. I had to come up with an argument. Honestly, it felt like maybe I should start taking drugs, cause then people would care! That would be the red flag! Well I was sober, so I kept thinking, I'll just start doing drugs!

So I started that program, and it actually ended up being really bad. It was really bad. Like soo traumatized. And drained. And she was also–maybe because I was so shut down—she was trying to get me to express my emotions. But I honestly, looking back, I don't think that was a good idea because if I had expressed those emotions, I wouldn't have been able to handle it. I remember her putting something on the wall and saying, “We can throw things on the wall, let’s throw pillows, let’s throw things on the wall.” I was like, I don’t want to do that, I don’t want that. So that was really awful, and I stopped going because it would just…it was making me more traumatized. And it was disappointing, because I worked so hard to get in. The one thing that I learned through that experience is that I like to colour. I discovered my joy of pencil crayoning.

It was very harmful. They didn’t give me an opportunity for feedback. And I just didn’t come back again. I went for maybe 4-5 sessions, and I didn’t go back. It was wild. It was just like for someone in such trauma, you should not be visiting that for 3 hours. I know now about containment.

Continuation of care

And so then, my psychiatrist, actually passed away. It was really sad, it was really hard on me, but I’m really grateful that her team lined up someone else to take her patients. And so I started to see an old white man. He was quite good. He wasn’t very compassionate, wasn’t very…emotionally involved. But good at his job. Competent. And saw me fairly frequently. I think I maybe saw him once a month. I saw him over a number of years.

During that time, I also went to a field school, through school, to the University of Northern BC, and I had a really big mental health issue while I was there. I just really struggled. I was doing an Indigenous field school, so it was set in the summer, so I took myself to the Indigenous Resource Centre. I said I need to see a counsellor, and they set me up with an Indigenous man, and this was my first time having a male counsellor, and again, I found it really transformative. Really transformative. He had this approach where I would say something like, just as an example, like 'I'm unlovable,' and he'd go, I want to challenge you on that. Like let's unpack that a little bit. He would kind of…if I was on a story line that getting negative, he would interrupt me and be like, let's interrogate that, let's not continue to cross that path. And again, Indigenous, and really compassionate, but like, not in again, a white lady way, but frank, you know. Like let's unpack that, that thought isn't serving you anymore, let's challenge those things, that thinking. And he was incredible. And again, two university-based Indigenous counsellors. So good.

By the 'white lady way', I mean patronizing, sympathy, pity, but almost like a patriarchal approach, of like, "I'm the counsellor, I'm the caretaker, and you're the patient, and I'm going to like, impart on you, the healing, or something." And a lack of interpersonal respect, you know? There's something about the two way, for me, that reciprocal part. You don't have to tell me about your life, but I need you as a human being, and I need to know that you see me as a human being and not just a patient. Because when I think about that racialized psychiatrist, that part of the boundary that other people wouldn't cross, cause you're not supposed to give your opinion, right? Like you're not supposed to give direct opinions, you're not supposed to give direct advice, but when she was like no that's fucked. Almost as a friend, or as a relative who has a relationship with you, "I need to let you know that that was wrong." Instead of like, just tell me how you feel about that moment.

And the reason that I also think that I would attribute it to white lady, it just reminds me of white feminism, of like…I don't know, providing care that doesn't feel authentic or feels patronizing, or like patriarchal, and when I think about sitting in that guidance counsellor's room, he was a man, but just the lack of deep listening, you know? And so having that Indigenous counsellor walk me through that vision and be like, that was a gift, that was a strength. That was a strength. That was a sacred gift. That was so culturally relevant to me.

So after I had that male counsellor, it really invigorated my desire to go to counselling again. When I came back home from that field school, I applied for a Métis women's group, and in that group, we had access to a free counsellor. And my counsellor is not Indigenous. I've been working with her ever since then. That was maybe 2016 or 2017 and I've worked with her since then. It was through Bridges for Women Society, and Bridges was not an Indigenous program, but they were running a women's Métis program. So she was picked as one of the counsellors for us to see, and she's white. But she has been…super culturally attuned. And has even said to me in the time we have been together, "Oh, like have you been doing ceremony? It sounds like you are really missing your connection to your culture, let's talk about that." She will actively engage with my Indigeneity. And she never pretends to know something she doesn't. She can engage in those conversations, and she can remember that culture is important to me and reminding me of my culture. And she can remember that my Métis experience, of being in the Métis group, was super transformative, and she can bring it back to that community. So she does that. And she's not Indigenous, but the way she talks to me, really incorporates my Indigenous healing worldviews.

Someone who is a white person, can make a Métis person feel super seen. That's really special. And the two Indigenous counsellors I had were transformative. But we don't have enough Indigenous counsellors for every Indigenous person to have an Indigenous counsellor. Mental health care for Indigenous people needs to be free.

A big thing for me is a psychiatrist. So that man I was working with, he was the one that gave me the diagnoses of bipolar II and obsessive compulsive personality disorder, and I already had the PTSD diagnosis. So what was really hard, was that he retired, the session after he diagnosed me. And he had no plan for who would take care of us after. And so I went to the Adult Short Term Assessment and Treatment program—USTAT. And that was really helpful. They had a psychiatrist, they let me see her for longer than you're supposed to.

Then after that, I've just been discharged, and I have no psychiatric care. And I'm like highly medicated, and I have a lifelong illness.I haven't had psychiatric care since at least 2018 or 2019. And so recently, I felt like one of my medications was giving me side effects that were too difficult, and so I decided to take myself off it, which is something you are not supposed to do. But like I didn't have a choice. I didn't have a doctor, and I felt like I was knowledgeable enough to do it myself. I did it really slowly, and the withdrawal was really challenging.

So looking back, I wonder if the removal process should have been like…well it should have been medically supervised and I wonder if I would have benefited from advice. It wasn't safe and it was silly to do it on my own, but I had no choice. If you're First Nations, you have the First Nations Health Authority (FNHA), they have psychiatrists. But I'm Métis and we don't have that. There's no psychiatrist, no ability for me to get one. Maybe there are people taking waitlists? But my doctor keeps saying there isn't anyone taking waitlists, and won't even try to put me on a wait list. I am 27 now (as of Feb 2024). I haven't had a psychiatrist providing me with care since I was 22.

'High-functioning' and suicidal

What was really challenging wasn't the diagnoses. I knew what he was considering, like he was also considering BPD and stuff. I was actually like, you know what, yeah, that totally makes sense But what I found challenging is that when I got the diagnosis, it was in that meeting that he told me he was retiring. He was like, “Okay, I’m diagnosing you, but I’m retiring at the end of the month. We only have one more session.” So I never felt like I got the advice of what it is. So I had to look into it myself. What is it? What does it look like when I’m hypomanic, what is the difference between OCPD and OCD? So it was really challenging that I was dumped with this diagnosis, and like one thing that was really hard is I know that bipolar is a lifelong illness. Like when I got the diagnosis, “Ok so I’m just fucked? Like I can’t do anything?”

I was also going through a breakup at that time, which was really bad. Honestly I had a lot of risky sex, cause of my sexual abuse history and just that awful time, I just looking for connection, and affection, I was feeling like there weren’t a lot of options. This was as good as I was going to get, there was nothing else I could get. I often had a sense that psychiatrists were giving up because I was still really academically excellent. I was still working, I still had a social life, I still had relationships, like romantic relationships, so like, sometimes I felt like things would stagnate, and I’d be like okay, does it get better? Is this as good as its going to get? And I remember telling my mom that I had been suicidal for 10 years, and she was like that’s not possible, and I was like, well, it is. My sustained suicidal-ness was just like really exhausting. I felt like I was always *just* making it through.

It’s like, are you functioning? Do you have your job? Do you have your school? Great. And this idea of ‘imminently going to kill yourself.’ Because it was like, it was hard for me to articulate, yes, I’ve been suicidal for this long, and to some degree I’m stable, but it feels like any old Tuesday now, I’m going to crack, you know? They’d be like, do you have a plan. I know in my head, I know what you’re asking. You’re asking, do I need to go the hospital. I know what you are asking. You’re not actually asking me how I’m doing. You’re risk assessing. So of course I’m going to lie. I will tell you just as much as I need to for you to take me seriously, but I’m not going to tell you the fact that I think about plans everyday. Because all you're going to do is put me in a hospital, and I don't trust that's going to change anything. And I don't have time, I'm a student. I don't have time. I don't have time for that.

Even though I've never gone to the ER, I kind of regret not having everybody knowing it was that serious. But at the end of the day, one of the metaphors I used is: I have this Jenga tower of my life together, and I felt like I couldn't really unpack things because if I did the whole thing would fall. It was a feeling like I can't get too far into it –I can't let myself go there. That's sort of high functioning. And so they wouldn't believe me.

You can't learn to swim when you're drowning. You can't develop the skills you need for thriving when you're just surviving. I was really afraid of institutionalization — I felt like I didn't have time to miss class—what about my sports—what about university. At the same time, I really craved an institutionalized, residential, or overnight experience because I wanted an acute care experience —wrap-around, urgent care.

The year-long Métis Women's Program

So one thing that was really, really positively impactful for my health, was I did that Métis women's program for the whole year, and it was life changing.

They gave me free counselling, I got connected with the counsellor who I still work with to this day. Every week when I met with the other women, we had a dinner together, so I had that food security, like we would always eat together. We would do cultural activities, like life skill building, like learning about what is an abusive relationship? How can you identify it? How do you communicate? How do you carry yourself, and like all these very, CBT skills almost? Life goals, and also culture. I learned how to bead, and I have my beadwork here. I still bead to this day.

Beading has been huge for my health. It's connection to culture. I remember very distinctly being in that circle and they were all much older than me. I remember looking around and have a similar feeling from high school of, 'no one is going to like me, I'm not going to make friends, and I'm different from everybody, I'm dark.' And I went to the counsellor, and they said why don't you just give people the opportunity to make their own decision. And so I was like okay. And so I just started to give people the opportunity to like me, and they all did. And it was so healing that at the end of the group, I had all these sisters and aunties who loved me dearly. Who saw me and knew who I was, and knew I was struggling and loved me anyway…I was acceptable. And so all that community I didn't have as a kid, all of that feeling like I was different and didn't belong, couldn't talk to anybody, isolated, all of that, was healed. Not overnight, but this is an example of my cultural community loving me.

It was life changing.

The group ran for a year. And I think what was special about that, is if you think about the biomedical Western health system, it's like can you function. But a lot of what was making me ill, was isolation. And in this group, I wasn't feeling isolated, I had people loving me, helped me love myself, I was learning coping skills, which I feel like the health system didn't give me, like beadwork, like sewing, all these cultural activities, I didn't have that. Here was an opportunity. I was just reading a book by Juliet McMullin, it's called The Healthy Ancestor. And they were talking about biomedical western health systems as health is the absence of illness, and that Hawaiian, Kanaka Maoli, old understandings of health, Indigenous health, is like, it's the presence of positivity, the presence of wellness. This is the perfect example of how the western medical system was looking for absence of ability, and they didn't see it. Whereas in this group, it was where is the presence of health? Where is the presence of wellness? And they were helping me fill that cup.

It was life changing.

And so that's one thing that I'd loved to see, these kinds of community programming, not just a talking circle, not just a support group, but like a social-based, activity-based, cultural-based, community building program. It was weekly. Food is such a cultural thing. And as a person who is really mentally ill, you can guarantee we are not eating well, you know?

To have bus tickets, parking passes, or like gas tickets so that we can pay for things, and everything was taken care of. And knowing that every week I would have a social activity where I felt belonging and safety. And then having the counselling alongside it, so when I had an issue in the group, or felt worried about the group, I had that counselling once a week, so I was working on my mental health healing and putting it into practice into the group.

A direct contrast

Another big difference, that is meaningful for me to say, is that I went to the Victoria Sexual Assault Center, and in order to access their services, you have to do group sessions before you get into the individual sessions. Maybe it's different now, but at the time, I went to their first group orientation, and first of all, one of the things that was so triggering was looking around the room and knowing the only reason we were all here was because we have all been abused. And then the idea of having to do group sessions—it was like—I cannot. Handle. Listening to other people. And I can't handle talking—like the whole concept of the group therapy thing, I was like, I can't do this. So I never accessed their services after that, because it just didn't feel safe. And the difference with the Métis women's program—this is the thing—like all of us were traumatized, but the thing that united us was that we were all Métis. It was like, yes, we all had trauma, many of us had been sexually abused, but the reason that we were together was our culture, and not because we all had the same abuse. So that was really impactful about the group, that we had something to bond over, other than the fact that we were all abused. We are bigger than our trauma. So I didn't go back to the other thing that was awful.

When I went to the Victoria Sexual Assault Centre, we had that introduction, and I was doodling because I was so stressed, and like the facilitator made a comment about if you need to leave at any time you can go ahead, if you need to doodle and not pay attention that's fine, go ahead. And I snapped back immediately, "I am paying attention, this is just helping me focus." And I think that made them feel real bad. But that moment, like fuck you, I don't want to do this. And actually when I originally started, when I tried to reach out to them, they said they wouldn't take me, because there wasn't any physical touching in my abuse, and I actually had get in through an advocate, from UVic, who called them and no you have to take this person, how could you do that? They were very embarrassed. They were actually embarrassed that like whoever answered the phone was like…but again, I had to advocate to get in.

And I had to keep advocating for myself! I had to keep convincing people to take me. I also applied for the Crime Victims Assistance Program which was really helpful. CVAP. I had to get a reference letter from my high school which was hard, and so that was a really brutal process. It had been maybe 7 years? And also, again, nobody knew that they didn't help me. I ended up going to one of the school's administrative staff, who mostly knew what happened because she knew my mum. But it wasn't because she really knew what was happening. But I did get a lot of counselling out of CVAP because they funded my work with the counsellor from Bridges, which was helpful. I actually followed her into her private practice. She left Bridges, and I continued seeing her after the program was over. I started seeing in her private practice, but she is really expensive, it's $175 every session, and so I had CVAP to pay for some of my sessions with her. And now it's just out of pocket. I have some insurance, but like, fuck UVic, the graduate plan— It doesn't even cover all of the cost of my psych meds. But I still had to pay 45 dollars for this most recent session. So that's messed up.

Actively harmful care

I was in class recently, and they had us draw a picture of an experience we had in health that we didn't feel good with. It's a really small picture. So after that psychiatrist retired, and I saw the next one, I actually got put on a list for another psychiatrist, and I met with him, and he was a white man, and like it was *so horrible*. One of my first interactions with him, I said, "I'm bipolar," and he said, "You're not bipolar. You have bipolar." And I was like, "Okay." And then, the next thing he was saying was like, "What do you want, why are you here, what do you want to do." And I was like, "I don't know, like fix my mental health? What do you mean what do I want to do?" And he was like, "What are your goals." I said, "I don't know, you're the one who's supposed to know what to do with me?" But then, finally the thing that was most upsetting, he was like, "Well do you have faith?" And I was like, "What do you mean." He was like, "Do you have a connection to a higher power?" And I was like…I don't remember what I said, it was like, "I'm Indigenous don't you fucking ask me if I have faith." Like it was really upsetting to me. This white man asking me basically if I believed in god, because like, first of all, fuck you! But I was so upset by that. My anger emerges out of being a queer, Two-Spirit Métis person, and knowing that a lot of my pain comes from christians and christianity. So like that was really upsetting, and I remember being so triggered in that meeting. I was crying, and really upset, and at the end of it, he must have known that it did not go well, because he was like, "If you want to see me again, you can book in with my secretary." And so he must have known, but it was really really horrific, it was just so…damaging. Really awful. So that was my last attempt to get like my own psychiatrist.

I guess the meaning I took away from it, was that he did not care. Also that I was like negligible or bad. The fact that he was like, you're not bipolar you have bipolar. It was like, don't you tell me what my experience is. Like I don't have bipolar, I'm fucking bipolar, don't try to police my language. I felt like…again not pity, cause he wasn't very nice, but just like he looked at as if I was incapable, or incompetent, or like he had something to teach me. It was very pejorative. It was just like very, hierarchical, and also like, he did not give a shit. In the end, him saying if you want to see me, you can call. Okay, *obviously*, not. And I also didn't feel like I had the ability to make a complaint. When he asked me if I had faith, and I found it really upsetting, it felt very much like he wanted me to be a Christian, 12 Step program. And condescending. Like you think believing in god is going to fix me? It was so violent to me. Like I'm Indigenous and this white blue-eyed man asking me if I have faith? Of course I don't. christianity has never done a thing for me… In fact it has been damaging. It was so insensitive.

There was no care, and he was an asshole, and there was something wrong with me. And I was alone. Really alone. ‘Cause you wait so long for an appointment and then get treated like garbage.

It felt like I wasn’t wanted or there wasn’t a place for me. I certainly felt unresourced, and at a loss for what to do with myself and for myself. So much of the trauma I experienced in middle and high school, I worked so hard to survive, that once I finally accessed services when I got out of high school (and out of the bullying) – even though I didn’t access services until I was 18 or 19, it felt like I was 13 or 14 years old when talking about the trauma. I really needed support then. I didn’t fully come into my Two-Spirit identity until after high school because I felt so unsafe.

USTAT

This meeting with the psychiatrist was right before USTAT. And the USTAT psychiatrist wasn’t very culturally attuned, but she was very good, just very competent. The program is supposed to be short term. I think they offered it for a year. And I think I might have been 24.

And part of their programming is that you get psychoeducational kind of like support and then you also get free counselling. I said to them, “I don’t want the other two, because I have my own counsellor, and I do not feel like—I’ve been in this for years, I do not need to hear about life skills.” They were kind enough to let me do that. So they let me just see the psychiatrist.

You could tell that the psychiatrist felt bad about it [the lack of referrals into the community afterward for continuation of care]. I was like, “I’m facing nothing, what should I do, I don’t want to be this medicated forever, what can I play with,” and that’s when she was like, “If you want to reduce, you can consider reducing the quetiapine but you’d have to be careful. You could consider reducing this one." I said to her, "If I start to struggle, is there anything I can increase? She was like, "Yeah you could do this one." So she almost gave me like a DIY road map of how to take care of myself which was good of her to do, but it shouldn't be that experience. So I thought she dealt with it really well.

Métis Nation BC

Métis Nation BC has a counsellor connection program where they pay for 10 counselling sessions a year. Métis Nation has that now which is great, and Métis Nation also has Health Navigators. So that would have been really helpful for me if I had had a case manager, cause that it was my mum, but not everyone has their mum to do that. It would have been really helpful to have somebody case manage.

Because the government separates Inuit, First Nations, and Métis peoples, resources and programming are separate and inequitable. It took longer for Métis Nation to get a navigator, and they continue to not have a health authority like FNHA. FNHA has a psychiatrist you can see to skip local wait lists. Métis Nation doesn't have one.

When I finally told someone, if I didn't have my mom to help me navigate I would have been out of luck. If I didn't have her, I would have needed to have navigators or a case worker to help. It would have been good to have someone know the community services instead of me researching secretly. People who know how to get psychiatry, get a counsellor, how to access CVAP.

Intergenerational resilience

I think that each generation of my family has healed a lot from the last generation. Each one has still left homework for the next generation. Each generation lifts itself beyond the last. Which is really powerful. This is my Métis family that I'm talking about.

Each generation in my Métis family, there a lot of trauma and death. My settler side of the family, so my mum's dad, there was trauma there, and they were indentured home children. And my dad's side of my family are Dutch immigrants. And my dad's parents survived the war. And were occupied by the Nazis in the World War, and then my dad's family was like—has a lot of alcoholism, and drug use in the family.

This is what I mean that each generation has healed themselves. Like my grandma grew up dirt floors poor and then like got pregnant at like age 18 or 19. And so they like worked really hard to give my mom and her sister a good life. And like, neither of them had education but instilled in my mum and aunt that education was important. So they went on and got degrees and lifted the family out of that poverty. Yeah so, my mom has her Masters, my aunt has her Bachelors, and so they worked really hard. And my dad's side of the family has a lot of trauma and stuff, but my dad had worked really hard to lift himself out. He got his degree, he's a very very loving man, he's an open feminist –they're all very social justice oriented, and above all, the love is so strong in my family. Like really loving.

My family is big on teasing, which is kind of okay, but at the time, I was being bullied so it felt like bullying at home too. My mom, dad, and brother were very solid, but like my broader family like my grandparents and aunt and uncle were like teasing, and I remember my grandma saying some things that were not okay to me, but I think it came from trauma. But also one of the things that kept me from telling my parents was just the conditioning from that abuse. My brother was going through a hard time, so I felt like I couldn't take up more space. After I told my parent it broke my heart. They were so upset. I think they were really upset they didn't know and they didn't do anything. But they couldn't have intervened.

They are both teachers. My mom was only brought into my school once in Grade 6 when there was really targeted bullying happening. She brought it to the teachers and then the teachers had a sit down with the girls and me. That was the only intervention. We just had like a 'come together,' and that was the only intervention. So the rest my parents weren't involved in, and I just know they were really impacted. Especially now that I'm out about things, I put my parents through a lot. I think my whole mental health journey has put them through a lot. I didn't want to hurt them, I didn't want to burden them.

She [the person in my family who was most connected with my Métis identity] had died of tuberculosis a few generations ago, and so my grandma's mom grew up without culture. And there was this big interruption of our cultural continuity. Because we are far away from our homelands, there isn't much community presence. I returned to my homelands for the first time this summer for Sundance. It was incredible.

I think a big thing that's missing from my journey early on was ceremony and spirituality. And so being able to be involved in sweat lodges and now Sundance, has been extremely healing. It was incredible. It was, it was. I just felt very connected, connected with something so beautiful, and feeling like really profound to see the landscape my family saw and things like that.

Reflections: Looking back and looking forward

My mental health journey started so young and I feel like I was failed in so many avenues when I was under 19. I wasn't able to access care when I was younger because I just, was failed. I felt unsafe, and I wasn't able to start receiving care for the things that happened when I was young until I was older, and consistently aging out, then things are 19 and under, then 20 and under, then 25 and under, and so it was like always aging out. And being desperate for care, still being a kid, brain still growing, don't have a job, still a kid, you know?

I think family care is so important but I have no idea what that would look like. It feels too idealistic to consider.

Thinking back on my experiences with education and healthcare workers, persistence is so important. In those instances when I tried to reach out, or they tried to reach out to me, and all my fear and trauma made me instantly clam up…I really wished there had been an adult who persisted and pushed further, and perhaps gave me more opportunity to come forward.

I wondered, why are people not responding to very clear signs of distress? Like when I was trying out medications in high school and was crying at the nurse's office. The project in Planning 10 – it wasn't art class, it was Planning 10. The point is to plan for your future and give life skills. It makes me laugh because of the absurdity. There were multiple times of clear distress throughout middle school and high school. And it was challenging because it was in the 2000s and 2010s, so I didn't have a good understanding of online-based violence yet.

Later in my life, I met people who are Indigenous with bipolar, and that meant so much to me because that meant I had a future. Because we look to our Elders to see what our future will look like. And so even if they didn't have bipolar, seeing Elders who had survived abuse and were still whole family members and community members gave me hope for my own future and healing.

I went to a Métis gathering and a young girl identified me as a safe person and divulged a lot of stuff, and I was able to go, I have been where you are, and I am honoured that you have identified me as a safe person, and years later, I can tell you that I've grown and healed. Being part of other people's healing, is so powerful to me. I hate the idea of 'everything happens for a reason,' but if I was going to have to experience this, I'm grateful that I am able to mobilize it and use it to help others.

It feels like it's so important and feels very empowering to give voice to this journey that I have had. It didn't happen for a reason, but I am making it meaningful.

Felix’s Story

Felix (any pronouns) was 17 years old when they shared their story. Their description of their racial identity was Indigenous. The date of the first interview was on December 20, 2023, and the date of the follow-up discussion meeting was on February 28, 2024. Below is their story.

Connection to land

I was born in Vancouver, and then immediately left. I was very young, still a baby. We moved to various other places. I lived in Halifax. I was in Ontario briefly. A very gross area of Ontario. I moved back to Vancouver again. Briefly. It was just a lot of hopping between areas.

I didn't get to experience much. And then I recently moved back here. It was mostly just parents’ jobs. And there's always a different reason every time. There's always a reason to move. It was me and my parents moving together until they split up. And then it was just me and my mom moving. My parents split about 6 or 7 years ago when I was about 11.

Halifax didn’t have a lot in terms of mental health resources. It's better here. It was very hard. I could never find any counselling, and then, when you do, you have to go through the IWK (IWK Grace Hospital for Women, Children, and Families), if you’re a child. If you’re an adult then I think there's different system. But they have a massive wait list. They'll almost never notify you of your appointments, and then, if you miss one, then it's pretty much over, and you have to do the intake all over again. It's ridiculous. Sometimes you have to wait up to a year just to get specific appointments. That's more of a problem here. But here the waits…I mean, it's a problem there. But it's also a problem here. The waits I've encountered here are more like a month though. But there it could be 3 months or more.

The first time I tried to access mental health services was years ago. I think it was when I lived here in Victoria, probably 4 years ago, for private mental health services. And that didn't work out because I moved to Halifax. There's a lot of encouragement from teachers to go the private route for most people that I asked. Other people who had been through the system. And it's probably like, wait times. That's the main complaint.

In Halifax

And then I tried to access services there when we moved. I was 15, 16, when I was trying to access services in Halifax. I fought with extended wait lists. I didn't have very much going on after that, because of how the system works. There, it was very inconvenient. I don't think they give reminders. I think you're just supposed to write it down and then if you miss the appointment—that’s it.

The first time I like successfully accessed public mental health was in Halifax. I was feeling anxious and depressed. I was having a lot of like school issues? Friend issues. A lot of people were mean to me. Some bullying. I needed help for a long time. But because of the way that the system was, it was really hard to get anything. The intake is done immediately, but then, for your first appointment, it'll be a wait time. I think it was like a month between appointments, even if I didn't get an appointment. I would have to wait a really long time for another one. It wasn't so much that I had to wait a long time to get support, it was that the appointments were not very…they were not very in depth or long enough. And then when I did get them, the next one would be like in a month – a month away. It's not enough. When you're really struggling. It's not. Now, I get like once a week.

Back to BC

Here they are better with rescheduling. The initial wait here [in BC] was also like 3 months for the intake. I was in like the main government's Child and Youth Mental Health. But I was--that was through a program called IMCRT, which is short term. So eventually I--they transferred me over to Indigenous Child and Youth Mental Health which has been hit or miss.

I moved back to BC when I was 17. And here they also have a giant waitlist. I think mine was probably around 3 months initially for an intake. And then later, it got smaller. Once I was actually in the mental health primary care, whatever. Once I was actually in that then the waits were smaller. Sometimes, if you got lucky you'd have like a week to the next appointment. Right now, my last appointment which I had to reschedule is, I think, 20 days, which is not that good. And then what they tell you is, if you are struggling outside of appointment to call the crisis line, and they're kind of useless, in my opinion. The way that they talk it sounds like it's written by robots. They just kind of rehash the same responses. And it's a problem that is also a problem that is in a lot of mental health systems? Not just here, but here I've noticed it a lot. But they don't actually care about how the patient or the person they're talking to is doing. They just care that they don't harm themselves

The Mental Health Act and hospitalization

I think when people tell you to do something that's not like in the common public health system, it’s because of the strain that's on it right now. It's only gotten worse. But I've never actually—except the time that I was under the Mental Health Act, and I kinda got forced to --I've never actually like gotten into the hospital because—the last time that I was there I ended up waiting for so many hours. This isn’t the mental health thing, but it kind of applies to it as well. I ended up waiting for so many hours that I was able to get help elsewhere.

I think they put me at the top of the priority list last time was there, and I still ended up waiting for hours, and I was supposed to have a meeting about that incident recently, but it didn't happen. But I think that incident was like very much unnecessary, and I realized how much the system in BC where they can force you involuntarily to go to the psych ward – I realized how much that's flawed. And how easily, they don't listen to you, I noticed. They don't really take your word. As long as someone has said that you're in danger. Because t's really easy to send someone there if you're convincing enough with the way you talk about them. It was an experience that damaged my trust in the mental health --any person has the power to do that. So even just normal doctors. This happened recently, like maybe a month ago.

The first time I went to the psych ward in Victoria was in the summer, but there was more of a reason. The second one was just no reason. No reason other than someone made a report about me that was not true. There are a lot of things that shouldn't have happened. I was very scared, one of the times it was an ambulance. One of the times it was a police car.

The first one

The first time was maybe in June. Cause I moved back in June (2023). I just moved back to Victoria. Everything was very confusing. I'd lost all my connections, all my stuff was gone. Some of it's still gone, because I had to move so far. So I didn't really have anything. I was not getting along with family, and I didn't know where anything was, cause I had just moved. There's a lot of stuff going on. I already wasn't feeling good when I was in Halifax--and obviously because the system--I couldn't get help. I tried to set up an emergency appointment. They still said, gave you a wait time for 3 months at IWK. Then they just say again, if you need help, call the help line.

The first time I was like breaking down and I was feeling suicidal. It was a bit of a necessary reaction. I guess the action was appropriate, but the way I was treated in the psych ward, it wasn't right. They treat you more as a liability than a person. They don't let you do anything. They just lock you in a room. it was scary.

I don't remember that much of the first one other than that they didn't listen to me nearly as much. The first time they really wanted to keep me, and I had to actually call people and get them to vouch for me that I wasn't a danger. Because they really wanted to keep me. They locked me in a hospital room for many hours, and they wouldn't give me anything to do. Not even a piece of paper. And I couldn't leave and obviously, they take all your things.

It was very upsetting.

But um they stuck an IV in my arms. They thought I took drugs, and it was really painful. And they kept swapping my veins and I kept telling them it hurt and they didn’t listen. The first time was…they were a lot less nice to me, cause I didn't have any witnesses and a lot of the times people, in like the psychic ward will get away with doing bad things because the people reporting them-- can just say that they're crazy. That didn't happen to me. But I've heard of that happening.

I didn’t have any witnesses or support, and therefore they were not treating me well. They noticed my beaded bracelets and they asked me if I was Indigenous. They asked if they could take them off before they stabbed up my arm with all the needles. I don’t know what they were thinking — if they treated me worse because of that. I do know that in some hospitals they will. They had thought I had taken drugs because it was reported — they didn’t take my word for it. They didn’t believe me. I do know the most common thing I hear about Indigenous people in hospitals, they think that their pain tolerance is higher so they’re a lot less forgiving with pain killers — obviously not all doctors and hospitals.

I do remember them being very ignorant to my distress and it was very creepy to have someone blankly staring at you while you’re upset and in pain when they were doing the needles and doing the psychiatric assessment. It wasn’t really an assessment but it was really me begging them and telling them that I wasn’t going to hurt myself and to let me go home. They didn’t believe me until they got testimony from other people they called. I was 17 then, and I think being a minor helped me in that situation because they could pass off the responsibility of keeping me safe to my parent or guardian. I could get them to call my parent and promise to keep me safe. Luckily I got out that night.

At the hospital, they do like the psychiatric assessment. But nothing came of that. I never got any follow up, I never got anything from the recommendations that were given. So it was just a waste of my time. It was either VGH or Royal Jubilee.

The second ER visit

The second time was the police car, which freaked me out because I'm kind of scared of police. The police are scary. I've had bad experiences with the police, and also like it was just scary. Like everything, even the lack of seat belts in the police car was scary. I guess it depends on the police officer. Some of them are weird. Some of them are like, overly extremely suspicious of you. For no reason. These ones I think were just going to transport me I guess. So it wasn't as bad.

Paramedics don’t have guns, or maybe they do, I don’t know. I don’t think they have guns. You never know. It's not the first time I've had the police called on me. I got really lucky one time, they were nice. I've been in like arguments with family that were really bad, and I like ran away. And they called the police

The second time I went, I did not trust them. I already knew one of the nurses that worked in the psych ward. I got them to come in with me and listen. So then it's less likely for them to try anything. They treated me better the second time. It was more annoying because it was unnecessary, and I still had to wait for hours. I remember trying a lot to convince them that it was all a mistake, but obviously they can't take your words. But again, they didn't really ask. They didn't care. They just cared that I didn't hurt myself. They didn't ask what was going on.

I don’t think that this second one was affected by my Indigeneity — they did not treat me differently because of my Indigeneity. It was more my mental illness that was causing discrimination. There was a nurse who was a witness so they didn’t try anything and they were much nicer to me. They believed the reporter more than me, someone with mental illness. They don’t take you seriously when you’re upset or in distress. The first time they were completely ignorant of my pain and distress. The witness was a nurse that I had known from the doctor’s office that I was at for an appointment. Someone had called and made a report about me. The Mental Health Act was used too liberally to “get you faster to the hospital”. But it felt like an excuse. The nurse at the doctor’s office planned to meet me at the hospital later that night as she had a shift there later. Having her there really helped.

The second time was nothing. I was not in danger, and then I said that. So that was very silly. Even the psychiatrists agree with me that the whole thing was unnecessary. The second time, it wasn't as bad. But it wasted my entire night. I couldn't do anything except sit there cause they don't let you do anything.

But obviously your word doesn't mean anything, and then they made the call without…While I was like repeatedly telling them I'm not a danger. Nothing's wrong. Please don't send me back there again. They think *you're* crazy. So they're not gonna take your word. I could say they did something bad to me. I was treated unfairly. They can just say, like, you're not mentally sound so. It’s used to discredit your word.

I believe it was someone that I knew who called my family doctor while I was at their office. I do know who it was…it wasn't like out of malice, I don’t think. it was a misunderstanding, and it wasn't right. They were concerned that I was in danger of hurting myself. And then I was at the doctor's office when it happened. Obviously, it's a bad place to be cause then you're--you can be, like, under the power of someone who can invoke the Mental Health Act if they feel like it. Then, after that call was made, and then that interaction happened. My word just didn't mean anything. I was explaining, this is all misunderstanding. I'm not in danger right now. I just want to go home. And also, there was a very important appointment that had to be cancelled. So that I could go to the psych ward for no reason.

I’m gonna say whatever I can say to get me out of here because I want to go home. I didn’t lie, but I said whatever you want, write down whatever you want, I’m fine, I’m safe. The psychiatric assessment in hospital is not going to be accurate because it’s a make it or break it, basically being held under duress and against your will. And it feels more like you’re getting approved for parole than a true psychiatric assessment. You just have to say whatever will get you out. And that has caused problems for me later in my care now. The records have followed me now, and I have to explain that I was just saying what I had to, to get out.

They can just invoke the Mental Health Act, and then they can just send you off and keep you as long as they want. Your word is completely taken away and it's very scary and upsetting. There's nothing you can say.

An experiment that I like to cite in these cases—which is obviously not always accurate, obviously not all psychiatrists and people working mental health are like this, but it shows what could happen is—I believe it's called the Rosenhan experiment. Where mentally sane people got admitted to psychiatric hospitals as part of the experiment, and even though they were all determined to be healthy before the experiment, they were all kept for extended periods of time and diagnosed with mental health problems. Obviously, it's not always like that. It's an example of how little power people have over themselves in those situations.

The Mental Health Act, it's supposed to be used as the last resort. But the way that they were talking about it when they use it on me, they talked about it more like we just wanna get you to someone fast. And we're going to force you. We're gonna do the worst possible situation. We're gonna handle this in the worst possible way.

It's a terrible place to be. That's what I've noticed since then.

Wait times for psychiatric assessment

Now I'm waiting again for an assessment — the strain on the system shows through the wait time. Months apart between appointments. Different people helping you all the time, and you can't get attached to them. Zoom appointments are not a good fit. They'll sometimes call you in the middle of you doing something.

It was an assessment that I had been waiting for, for a long time, and those assessment types of appointments are extremely hard to get. I had to wait months and months, probably a year, just to get a psychiatric assessment, and I never even got a proper follow appointment. They never properly diagnosed me with anything. I never got the full appointments. I never got all the follow up. They never gave me a proper diagnosis or any answers. They just said things that I showed signs of… but they never gave me any conclusion. It would have been helpful to know what's going on. It is so hard to get these types of assessment appointments. Like those types of long appointments where a lot of specific stuff has to be done. So it was a really important appointment that I had to go to, and the person who made the report knew I was going there. And then, while I was there. They made the call, and then the call was taken a lot more seriously than anything I said. It made me not want to trust any doctors for a long time. No matter what I said, it meant nothing.

And I just realized, like, how lenient they are about sending people to the hospital against their will. Obviously. But some of them act like it's just a way to get help faster. And it's not. It's not something you should do to someone unless they're actively going to hurt themselves or someone else. It needs to be considered more seriously.

Services in Victoria

I do hear that there's a better help line here. The one that's specifically for Indigenous people. I've been told to call it a few times, and that it's better. But I haven't called it yet, mostly because they don't have texting. And I don't like talking to people with my voice.

I don't really like the therapist that I have been assigned at Indigenous CYMH. I've been trying to talk about it, but so far nothing has come of it, because some of them just…aren't willing to listen to you, and only care about like the primary goal of you not hurting yourself. They see me as a liability.

So it’s been a problem. My first therapist was good, but because of how the system works, and I guess the strain and also the way the IMCRT program works, you can't really get too attached to a therapist or someone that's supporting you because they might go on and you might get a new one. Which has only happened to me once, luckily. But in IWK it happened more. The whole strain problem is Canada wide.

I was at the hospital in June, and then in November (2024). I got connected with IMCRT some time in the summer, maybe July. I think you have to call the Island Help Line. I think my mom called the helpline, and then they tried to connect me with IMCRT. I saw this first person over the phone. And then eventually I got to go in-person. I had a good experience with that first therapist. I was gonna get a different one. And then they said that one wasn't gonna work out. So I eventually…I got swapped around a little bit. I didn't meet the second therapist, but I was supposed to have only like the first one. But then they said that they swapped it again and IMCRT connected me to Indigenous CYMH. And then I got the third therapist. That's the one I currently have. you could never trust anything is going to be permanent. But it's relatively consistent with the once a week now. I started seeing them once a week probably after the summer. Probably since September. I think during the summer it was more sparse.

It's not all bad. Its relatively good now. It's not perfect. Sometimes there's scheduling issues, and sometimes they can't make it. And obviously the current problem, they are not really listening to me. And then, if I try to access like some external services, then they'll just say, oh, we can’t do that. But then you're also not really listening to me, that I don't think this therapist is a good fit.

With the first therapist, I liked that they actually…It's really rare to find a therapist—at least in the public system—that treats you like a person and listens to you, instead of just saying like, all I care about is that you don't hurt yourself. It’s good when someone is listening to your problems and talking to you like another person. It was really refreshing and good.

One nice thing in Victoria, if you miss appointments you don’t have to re-do the intake like in Halifax, but the appointments are months apart. Here with the Foundry, they text you the day before about appointments which is really nice. In Halifax they didn’t, you had to write it down.

System navigation

So when you're in the Indigenous mental health system, they give you like a support worker that can make calls for you. And that's been really useful. I really hate talking on the phone and making appointments. I procrastinate and it gives me a lot of anxiety. So it helps have someone who does that for you. They have mostly just been connecting me with other resources outside of Indigenous CYMH, like the Friendship Center. There's other like referral counseling services where they do, or specific stuff, usually they have a long wait list, but they can get you on the waitlist, which is better than nothing. Cause I also didn't realize how much was here. I tried to do my own research, but a lot of things slip under the radar. Some things don’t come up when you look. Why can't I find things when I look for them?

Intergenerational trauma

A lot of it's…generational trauma as well. Some people don't even notice that they have it—cause it just kind of gets naturally passed on to them. I've been really interested in that for a while, but I believe there has been some studies that even if you don't know the people that suffered directly, no matter how many generations…There was a study on descendants of

Holocaust survivors, but specific reactions to trauma. Even if you didn't know the person who went through the severe trauma, like they weren't alive and so you didn't know them, you still have reactions from that, which is interesting.

I notice a lot of patterns that makes sense. This being *from* generational trauma that affects…a lot of people have bad families, and it's very hard to break because you feel like that's your responsibility to make sure the next generation doesn't suffer. And then a lot of anxiety about failing that responsibility, because with that type of generational trauma, you don't really notice that you're emulating those patterns. And sometimes I just realize, oh, I just did something bad because I knew someone else that did that. And so I kind of became desensitized. And then I feel really bad about myself.

There’s less generational trauma on my dad’s side, but I didn't spend a lot of time with my dad or his family. But members of my family on my mom’s side were in foster care. Experienced abuse and stuff like that. There's a lot of traumas as well, but that’s just some from the last generation, some even from the generation before that, just kind of more persistent. The foster system was not good to my family. I was almost in it as well. I was very scared, based on the stories that I'd heard. I managed to avoid it.

The way they [MCFD] are now, they're a lot more willing to make compromises. Back then they would just take your kid away. I've been told that I'll be taken away too. Because people in my family had been taken away so—that was their reality. Like my family constantly being a threat. I could be taken away because that was the reality. That's what they had been through. They had been told those threats, too. But back then they were actually true.

I’m not connected with my family because they have a lot of issues that mostly stems from alcohol, a lot of fighting between them. Not very happy people on that side. I did know a couple of them. Cousins.

With the Friendship Circle, it’s good to know people in the area since I moved. We get food sometimes, which is nice. Talk to people. Tomorrow I get to go to a ceremony which is, gonna be nice. I didn't think that there would be stuff like that here. It’s getting better though, in cities.

Dancing and ceremony

Realizing in September I danced in it, and that there were so many people there, was crazy. It was kind of scary cause I'd never been to a Powwow that was so huge. I wouldn't say public, because all Powwows technically are. But with so many people I was getting run over by people at every corner! And there's orange everywhere. I think most people were Indigenous. The end of the night was a lot more fun, cause there was a normal amount of people, and the weather was very nice. It was very cool.

I think it’s good that I danced in the Powwow, but it was also the extremely overwhelming. I couldn't see anything. I couldn’t figure out where I was supposed to go, but it was a fun Powwow. And also, the amount of people everywhere and…I was a lot less relaxed. I think.

More competitive Powwows are a lot more like stressful. They run on a tight schedule. The smaller, more local Powwows, they don't care. It's especially ones that are on reserves, because, just like this whole concept of ‘Indian time’ as people call it, where – kind of, ‘you get there when you get there,’ which is really nice. But in the competitive ones, are ones where there's a lot of people. It's a strict schedule. And a lot of people don't like competitive Powwows for that reason. They think it takes away from the healing experience.

Land disconnection = disconnection to community

I have been connecting with my Indigenous identity in Victoria to an extent. I don't think Victoria is as good with that type of stuff as Ontario. I’ve been there briefly. I've also been there for a research trip as well. Only briefly, but that's the thing with a lot of services in Canada. They'll be better in places like Ontario and Quebec, because they have the majority of the population. Things like health care are very hard to access. It's probably even worse in the other places like the Maritimes. Mental health, anything, doctors, anything, will be easier to get in the more dense population centres in Canada.

I've only been there briefly on trips but it's a lot easier to get access to ceremonial stuff. Here was bit of a struggle to get that stuff. There's a lot more Powwows. There's a 2 Spirit Powwow which is pretty fun, I've heard. I wish there were more cultural events. There are a lot more than I realized with the Friendship Center.

But actually. We were talking about this while I was there once. It does affect your mental health living away from your territory and your family. I get why. In my mom's case, it made a lot of sense. When you stay with people who just kind of echo trauma onto each other. it's just not very healthy for you or your future, especially if you're on a reserve. It's been getting a little bit better with people emphasizing that you don't have to leave the reserve to get opportunities. But still. Again. It can be a lot of people echoing bad habits onto each other. My mom didn’t grow up on reserve because she grew up in the seventies where it just wasn't safe to have any sort of connection to culture. Because of the threat of residential schools and foster care if you wanted to stay with your family. Because, even like any sort of cultural expression, was illegal. It was very crazy. A lot of people had to lie. I've heard of these types of stories a few times, but, like pretending you were Italian or Spanish, was a very common lie. About your ancestry. Because if any sort of truth came up, then very bad things would happen to you. Kind of scary how recent it was too.

Intergenerational Resilience

I guess the fact that they [my family] are still around and a lot of them are successful. Instead of just falling into addiction, depression. Most of the culture in my family had almost completely died in only a generation or a couple of generations, which is very scary. This is especially prominent here on the West Coast. In more Eastern Canada, it's in decline, but the language and culture still manage to be preserved. But here, I think mostly because of how much of the Indigenous population disappeared during the disease epidemics that happened, a lot of the culture and languages just completely died. And there's revitalization. It's not out of hope, but it's still really sad to see just how quickly, and only like a couple of generations how quickly, something can disappear.

So a lot of Indigenous people, especially those that were like descendants of people who got out and like got to the city, unfortunately, would have had to reject the culture, because, like horrible things would have been done. There's a lot of people that are reconnecting now, because it's only recently been safe to do that.

I've noticed that even some of my friends are falling back into that trauma. That's really sad to see. I get why people use them [substances]. It just feels better. It feels right. Even though that sounds really bad. It feels right. I don't get mad at people for using substances because I have done it before. And I see the relief that it brings. But I do think that if you have a family, that has those types of issues and you're around them a lot. It's easy to fall into that. And I see it a lot in people I know. It really really bothers me. And then you always feel really lame telling them that smoking is bad. “Don't do that.” They've been doing a lot better with smoking within the Indigenous community, because it is disrespect to the Sacred Medicine. And there are programs that target this.

Anecdotally. I noticed when I was on a trip with an organization I was doing where it was all Indigenous youth, and even like another trip that I went on, which was all research based, there was a lot of smoking. I was constantly being offered cigarettes, so it's definitely still present. But they've been doing better at targeting it. Which is also like amongst the general population, too—smoking being bad has not been known for well, it's been known, but not been known by the public that long. And even though it's been what can be perceived as a long time, it's still going to be really hard to turn people away from a substance that was marketed as being good for you.

For these trips, one was a research trip at the University of Ottawa, and the other one was an annual thing called the Gathering, which was really fun. Which was…part of like this program I was doing on like reconciliation and building better futures for Indigenous youth. I sought these experiences out and they were really impactful experiences for me. I was also placed in a large program, I think, was Canada wide and they had different. They had conferences in different cities, and they had one in Victoria and I went and it was about like the effects of intergenerational trauma. How things can be improved in the future. It was really, really interesting. I thought that was worth sharing. And I think there's going to be a report

Indigeneity and mental health care in my ideal world

I guess, like a lot of--a lot more like encouraging people to reconnect, you'd be doing better. But most people, myself included—a lot of that is because the Indian Act as well. Basically, once the law basically says you can breed someone out of being Indigenous. Like after a couple of generations, don't qualify anymore. Because of that, there's been a lot of issues with Indigenous people saying, oh, I shouldn't connect with my culture because I don't count anymore. And that's just not how it works in the culture at all. Of course, *of course,* there's no concept of not having enough blood. So I think that I would encourage that more. That it's okay to be yourself. That's kind of what they wanted, anyway. Like the goal of colonization is for you to think, oh, I'm not enough. So I'm not gonna bother. I'm gonna not care about my culture. Not *not* care. But I'm not going to connect with my culture cause I feel like I'll be rejected. And that's with a lot of people, not just Indigenous people. That's with almost everyone who is part of either a population that has been colonized or like even a diaspora population.

And like, just treating people like people. Being able to connect. Specifically for Indigenous mental health, encouraging people to reconnect more, because I've noticed that and it helps a lot of people's mental health to just feel like they belong, and no one is going to say they're not enough.

Then a second different thing. The broader public mental health system would probably need to treat people more like people. Some things can't be helped like the wait times cause those are caused by just a lack of doctors, constraint. I can understand the perspective that that might not be possible right now.

'Poverty culture'

I've also noticed that, like connecting with culture and family and everything like that can also push you away from—It's not even Indigenous culture—but like the negative things that happen like substances and mental health issues. It's not Indigenous culture, its poverty culture, or not even 'culture' at all. It's poverty issues. I think there's also like generational poverty. And that's not because your family's poor, so you're gonna be poor, too. It's because your family didn't go to college or didn't seek a different career, or weren't able to—it'll be harder for you.

And that I've noticed. I've also noticed—except for the one program I was in. People are not encouraged to seek higher education as much. I'm not in post-secondary yet, because of mental health. I didn't finish high school when I was supposed to. I still have a few more courses. I'm gonna go to post secondary, probably. But I've noticed that there's not a lot of encouragement. My mental health stuff has gotten in the way of that as well. And I just feel like I'm stupid. I'm not gonna finish school. But then I—I do break past those barriers.

Reflections

Talking about issues in public health mental health, talking about issues with Indigenous mental health, and the mental health of people that are in poverty. It's all anecdotal. It's just based on things that I've seen. Especially my experience with like the Mental Health Act. I just wanted to tell someone, make that known, obviously in a helpful way. That it could be misused.

The meaning I've made of my experience…The psych ward is bad. The CYMH and Indigenous CYMH is not perfect but not bad. The Foundry is pretty good. It's been getting better recently — you have to be on the waitlist for a while, but once you're in, it's good. But I do wonder what happens once you're past 25 and you're no longer covered by them. The Foundry provides primary medical care which is good, like anything you'd go to a doctor for, medications and prescriptions, and you can usually get an appointment pretty quickly, and if there's something you're concerned about you can talk to a nurse, and you have your own doctor which is nice. Counselling is through Zoom so that's not fun. Indigenous mental health is better for connecting with resources — recently they got me a psychiatrist, but they usually have a delay and things are slower.

The hospital is not good. They definitely abuse the Mental Health Act. And depending on if you have a witness or advocate, then you get it a bit better, but if you don't, they can be very cold and dismissive of your feelings and they treat you like a liability. They don't view you as a person. If you say something and you voice pain or concern, they just think you're crazy. "You're here for a reason, I'm not listening." They're not crazy! They're sad! They're lonely, and they've been mistreated. It makes me angry. All of the people there were really young — young people who are going through rough lives and they are being treated like they are liabilities without feelings. If they did these things to a "normal" person, someone who isn't mentally ill, it would be considered inhumane. That kind of stuff has been persistent for a long time.

Where is the humanity? It's just: don't kill yourself. Don't hurt yourself. We don't care why you did it. Just don't do it. Don't be a problem.

Chapter 4: Discussion

The purpose of this study was to explore the experiences and co-create narratives of racialized youths' experiences navigating the public mental health system in Victoria, BC. Their narratives shed light on the complexities they faced when accessing care. What started out as discussions about what it was like to experience the mental health care system as a racialized young person, blossomed into dialogues about the nuances and profound complexities of intergenerational trauma, intergenerational resilience, colonialism, navigating systems, power dynamics, and more, all while developing their sense of self and identity.

In addition to addressing the research question of what their experience was like accessing and receiving mental health services, they also spoke directly to what they would have wanted from their experience, and what they would want and wish the system could provide for other youth who may find themselves in a similar situation in the future.

The common themes across the narratives that were discussed during the joint Co-Investigator meeting will be presented in this chapter. These new findings were not presented in the Results chapter, and instead are presented here with the intention of weaving together observations about the current state of the literature, recommendations, and future directions, with the Co-Investigators' and researcher's discussion of the themes used to frame the discussion.

The themes have been organized into "Acts" in line with the conceptualization of this project being a co-constructed work of expression, a thoughtfully and strategically presented performance of great personal meaning to each Co-Investigator and I. An overview of the Acts and relevant themes are provided in Table 1. The Acts will explore and discuss answers to the research questions, such as the meaning the Co-Investigators made of their mental healthcare experiences, who they saw as important to their care and as sources of support, and what they wanted and needed from their mental healthcare.

Table 1. An Overview of the Shared Themes

Act # and Name	Themes
[Act I] Where it begins: “My context and my story shape my experiences”	• Colonization and intergenerational dynamics • Intergenerational trauma • ‘Victoria feels colonial’ • Intergenerational resilience • Proximity to whiteness
[Act II] *“Who I am” versus “How I am perceived”*	• Racialization • Feeling “othered” • “My voice is silenced” • Mandated reporting • “High functioning” • “Enmeshed”
[Act III] “The meaning I make of my experience”	• Agency • Lone • Collaborative care is possible
[Act IV] Recommendations for the mental health care system/service providers	1. *Do not be racist or discriminatory, even if you think you are being kind* 2. *Do not pathologize cultural differences* 3. *Recruit more IBPOC mental health staff* 4. *Assessment that* meaningfully *includes the perspective of the youth being assessed* 5. *Pay attention to requests that are made and be open to finding creative solutions to meeting them* 6. *Please be straightforward and kind* 7. *Limit service provider turnover to prioritize continuity of care* 8. *Give youth choices whenever possible* *9. Create intentional community supports for youth without calling them “interventions” – especially not “group therapy”* *10. Create confidential and private ways to access care that can be kept private from school and family* *11. Make mental health content that is more culturally accessible* *12. Mental healthcare needs to be free of charge*
[Act V] Across all 5 stories: The researcher’s observations	• Commonalities • Interacting systems • Education as a means for liberation • The ability to see nuance • The importance of accurate assessment • Self-determination, fortitude, and resistance

A Joint Co-Investigator Meeting to Review Themes

The themes discussed in this chapter were member-checked to enhance trustworthiness. During the process of meeting with the Co-Investigators individually, a few asked whether it would be possible to meet the others. I asked each Co-Investigator whether they would want to meet and discuss common themes across the stories. All five remained enthusiastic (even across several years!) about wanting to meet the others.

At this meeting, all five Co-Investigators met with the researcher together, and we reviewed the common themes across the narratives. I made it clear that the common themes were not pulled from any one story, but would have appeared across at least 2 or more stories (usually more than 2). I provided the Co-Investigators with a brief outline of the themes I had noticed (Appendix D). The Co-Investigators shared whether the themes resonated with their own stories, and also further expanded or elaborated upon the meanings of some of the themes.

While initially intended to serve as an additional layer of member-checking, this meeting evolved into a participatory method and is in line with the spirit of the study: of understanding and intentionally centering that knowledge is co-created, and finding meaningful ways to return power to Co-Investigators.

[Act I] Where it begins: “My context and my story shape my experiences”

Colonization and Intergenerational Dynamics

While the study's aim was to include IBPOC youth, there was no express intent or effort to recruit Co-Investigators who were from certain ethnic groups or backgrounds. Fascinatingly, all 5 Co-Investigators came from an ethnic, racial, or cultural background where there was a history of colonization in their story. This reflects findings from Canadian researchers that racialized groups in the country will be disproportionally affected by sociopolitical and historical factors such as colonization, acculturation, and racism (Hadjipavlou et al., 2018; King, Smith, & Gracey, 2009; Kirmayer, Simpson, & Cargo, 2003; Marsh et al., 2015; Menzies, 2008; Olawo et al., 2019; Reeves & Stewart, 2017; Rowan et al., 2014; Williams et al., 2022).

Furthermore, the theme of intergenerational dynamics was explicitly discussed in the narratives and at the joint meeting. The Co-Investigators considered whether they observed its transmission through epigenetics and biology, modeled behavior, or beliefs that shape and affect how they see themselves and the world. However, in the same breath, the idea of intergenerational resilience also arose. The Co-Investigators discussed how they resisted and continue to resist harmful or destructive power relations in their interactions with the healthcare system, and how they have and continue to find ways to empower themselves, their families, and their people. In direct answer to the research questions, it is clear that the Co-Investigators saw their families and their communities as a large influences on their mental health and well-being. They also saw previous generations' wellbeing as a significant influence on their own wellbeing, in both negative and positive ways. The Co-Investigators brought the literature on intergenerational dynamics to life by providing countless rich examples about intergenerational dynamics and how it affects their wellbeing.

Intergenerational Trauma

Both in their stories and at the joint meeting, the Co-Investigators shared how it is impossible to understand their story without first understanding what their background is and how their peoples' and families' histories trickle down to affect each of them as individuals. As Fen so aptly described, when asked when their mental health journey started, they responded that one must go "all the way back" many generations to when their family experienced the colonization of India. Collectively, they poignantly pointed out how their mental health story did not begin when they were a certain age, or even at their own birth, but started many generations before them. This theme speaks to a different perspective and mindset than a Western, colonial way of viewing and understanding "the self." Specifically, the Co-Investigators highlighted both explicitly and implicitly throughout their stories that woven into their concept of the self were their nuclear family members, extended family members, the generations before them, and their cultural communities.

Some of the Co-Investigators discussed the role of modeling from previous generations. They shared that even though they were in completely different countries, eras, and medical systems in the present, the generations that came before them were raised differently and had learned to mistrust and be suspicious of authority figures or institutions, such as healthcare professionals and medical institutions. They shared how this continued to be modeled for them even in a new country or even decades later.

For example, Felix, who is Indigenous, discussed how the generations before them continued to feel fear and warned them that they would be taken away from their family by child protection, because that was the real lived experience that those generations had gone through. Tonia discussed how in Barbados, due to the policing and colonization of bodies, their grandmother developed an inherent distrust of doctors, the healthcare system, and the government. Even though their family now lives in Canada and the Co-Investigator was born in Canada, these beliefs and behaviors have been modeled for this Co-Investigator, leading them to be inherently suspicious of the medical system.

Some research has already captured this phenomenon and documented how first-generation immigrants or those with a history of colonization – particularly Indigenous individuals – are distrustful of the medical system due to a history (that sometimes continues to the present moment) of being mistreated or abused by medical professionals (Turpel-Lafond, 2020). However, this narrative highlights how even for those individuals who are no longer considered newcomers (i.e., whose families have been in Canada for many years) and for the Co-Investigators who did not directly experience living in their heritage countries which were impacted by the colonization of their people, they still carry and live out the behaviours and beliefs they have been modeled for them. Tonia discussed how their grandma – now in Canada – will do everything in her power to either not seek medical help, or will purposefully withhold information from healthcare professionals due to distrust, believing that the information will be used against her. The Co-Investigator framed this as follows: “The default is to go in suspicious. Medical professionals have not given me a reason to trust them.”

This particular area of themes is so important to add to the current body of literature, as much of the research focuses on first-generation newcomers or Indigenous peoples and their experience of mistrust of medical systems, but does not specifically focus on the lingering effects and beliefs in subsequent generations of newcomers. It is fascinating to hear first-hand accounts across five IBPOC youth who were born in Canada and to hear their nuanced discussion of how they feel they carry the suffering of the generations before them in their bodies, in their minds, and in their worldviews. One Co-Investigator described this phenomenon as “intergenerational guilt” and explained this further through these questions: “Why do I feel like I'm suffering when those who came before me experienced those things firsthand and I didn’t? Whatever I suffered wasn't the real pain, so why am I still manifesting it?” This quote illustrates how confusing and unfair it can feel to people who are living with the consequences of colonialism many generations later.

The Co-Investigators discussed “genetic memory” and how research has examined the phenomenon of historical trauma being passed to subsequent generations through biology (i.e. epigenetics) in populations such as Jewish peoples who have survived the Holocaust (Kellerman et al., 2013; Yehuda et al., 2014; Yehuda et al., 2016). The Co-Investigators discussed the impact of colonization on their people via biological changes that show up in body size and health complications in subsequent generations. For example, the Co-Investigators discussed the role of how colonization killed off traditional Indigenous food sources (such as buffalo in North America) or cut off many Indigenous peoples from their traditional food sources. Another Co-Investigator discussed the impact of starvation in India under British rule.

The Co-Investigators discussed how starvation in those generations have impacted the development of bodies in subsequent generations. For example, Fen cited research on how South Asian bodies hold onto fat around their midsections and anecdotally had heard from their community members how difficult it is to lose fat around their midsections. Wells et al. (2016) explored an evolutionary perspective to this development of negative health outcomes, and proposed that one reason that may have contributed to this evolutionary development in South Asian peoples was the undermining of agricultural security during British colonization.

‘Victoria Feels Colonial’

Perhaps this is punctuated by the sentiment that all the Co-Investigators shared: that Victoria feels “very colonial.” Hassan described in their narrative how to them and their family, there are constant reminders of the British monarchy in the city, and that the British monarchy was responsible for setting destructive and harmful pieces in motion for their heritage country. Indeed, Victoria often celebrates its history of being the first British colony of Canada, which is reflected in the architecture, the street names, the annual tea festival, and more.

Dr. John Lutz, a professor of History at the University of Victoria with expertise in the history of Victoria, BC, estimated that while most of the settlers in Victoria migrated from previous settlements in Ontario, approximately 20% of the first settlers arrived directly from Britain, and many were "sons of elite British families who were not first in line to inherit the family's wealth, and instead came to Victoria to forge their own fortunes, preserving their accents, English influences and ideals" (Rudisuela, 2021). Dr. Alexandra D'Arcy, a Linguistics professor at the University of Victoria, discussed how the first English migrants to Victoria made strong and concerted efforts to preserve their cultural norms and etiquette, and has studied how generations of Victorians who were born and raised here still retained an accent that sounded English (Rudisuela, 2021). These accounts add evidence to the idea that Victoria is a place where colonial values have held strong throughout the centuries, and corroborates the lived experience of the Co-Investigators who have always felt as though Victoria was very colonial.

Intergenerational Resilience

All of the Co-Investigators discussed the importance of family, community – including cultural community – and relationships in well-being. The Co-Investigators discussed how they realize the importance of these relations to their healing and wellness, and that their healing and wellness would not be possible without these relations.

The Co-Investigators discussed the important role of family members in their lives and how those family members influenced their mental health journeys. They shared that they often had complex and nuanced relationships with their family members that the western colonial medical system had difficulty understanding and acknowledging. Nevertheless, the rich and nuanced relationships with their family members did affect their mental health and well-being. In the narratives, the Co-Investigators often spoke of how they felt it would be impossible to be well without their family members in their lives and being in meaningful relationships with them.

While speaking about intergenerational resilience during the joint meeting, one Co-Investigator shared:

> How do I respect, honor, and show my gratitude to my family for the intergenerational traumas they've endured through their time, blood, sweat, and tears? By them enduring this, they gave me the chance to have a more privileged life than them, and now I wish that they had a chance to have a different life too.

American researchers have discussed this concept of the children of immigrants wanting to repay their parents for the sacrifices they made by immigrating to create a better life for their children (Kang & Larson, 2014; Wu & Chao, 2017; Yu & Kim, 2010). The dialogue from the Co-Investigators is related, but differs in that the indebtedness and gratitude they feel extends to their ancestors and lineage, and not just the immediate generation before them. This is more in line with Indigenous ways of knowing and relating (Clarkson et al., 1992), although fascinatingly, the other Co-Investigators who are not Indigenous also viewed their people in this way.

Fen reflected how a dialectic exists when they can acknowledge the following: “I can be grateful for my privileges, and I can also wish that they had the chance to come to that place and own it.” They also lamented how previous generations would not have had ways to communicate their distress – especially distress regarding how they were harmed by colonization – in the way that their generation does now.

Many of the Co-Investigators also discussed how they wanted to prevent or protect their parents or family members from experiencing more pain or distress due to the Co-Investigator’s own mental health problems or because of the way family members were treated by professionals. This sometimes led to the Co-Investigators withholding information from their parents or family members about their stories, despite finding their family members to be profound sources of support. This reflects the deep care and positive intention that the Co-Investigators hold for previous generations.

Proximity to whiteness

The Co-Investigators also discussed an openness to working with people who are not people of colour. They described how skin colour is not the only way to approximate ‘proximity to whiteness.’ They explained that even if a mental health professional was a person of colour themselves, the extent to which the health professional has internalised colonial beliefs would in turn influence their delivery of services. This analysis is aligned with critical theory, which highlights the importance of each individual understanding their own social location and power to better approximate how relations may be perpetuating harmful beliefs, even internalized ones (Anthias, 2008; Anthias, 2013; Hopkins, 2019; Yuval-Davis, 2015). The Co-Investigators highlighted that it is not a professionals’ skin colour that mattered to them. Instead, what matters is meaningful self-engagement with each person’s own social location. They also highlighted that this meaningful self-reflection cannot be forced upon someone who does not want to reflect.

A culturally-attuned suggestion to psychologists may be to engage in pre-emptive conversations with clients about the psychologist’s own social location (including race and culture) at the start of any psychological services to invite clients to share their understanding of their world. While culturally responsive approaches have not traditionally been significantly incorporated into trauma-informed approaches (Esaki et al., 2022; Han et al., 2021), researchers and clinicians are emphasizing that truly trauma-informed care for racialized people will require some form of cultural responsiveness to address systemic racism for if it does not, it is at risk of perpetuating racial harm to racialized clients (Esaki et al., 2022; Han et al., 2021; Piper et al., 2021; Ranjibar et la., 2020; Shaia et al., 2024). It is essential when working with racialized clients for the clinician to try to see culture and race the way each client sees them, and to continually reflect on the clinician's own power and privilege so as to promote healing when treating clients who have experienced racial trauma (Esaki et al., 2021; Piper et al., 2021; Ranjibar et al., 2020). During this conversation, they can also let clients know that while they will do their best to monitor themselves to prevent mistakes or ruptures in the therapeutic relationship, if there are any missteps then the clinician would want to know and to have the chance to make it right if the client is open to rebuilding trust together, while also emphasizing that making amends is not the client's responsibility. This approach aligns with newer trauma-informed care literature that highlights the importance of practitioners acknowledging the historical and persistent effects of racialized trauma and taking accountability for hurts they may cause as a result of their position of power or ignorance, rather than blaming or pathologizing the racialized individual for a negative interaction (McCuistian et al., 2022; Shaia et al., 2024).

[Act II] "Who I am" versus "How I am perceived"

In discussing their experiences of the mental health system, there was a pervasive and resounding note that the Co-Investigators felt misunderstood by mental health care professionals. They discussed how their concept of themselves and their families, (i.e., who they believed themselves and their families to be) were different than the perceived versions by healthcare providers.

Racialization

In some instances, the Co-Investigators felt that there were overt racist assumptions made about them or their family members. This speaks to the concept that *racialization* is an active process that is done to another person – meaning that interpretations are made about who the person is based on characteristics that are physically observable (Carter & Pieterse, 2020). There is an emerging literature in Canada capturing peoples' stories of racism (Edwards, 2025; Salami et al., 2022), and an even newer body of literature emerging that is focused on the experience of racism in health care services (Gajaria et al., 2021; Hilario et al., 2023; Salami et al., 2021). The Co-Investigator's experiences add to this growing literature that is providing more proof that racism can and does occur in mental health care contexts (Hilario et al., 2023; Cenat et al., 2025) and that concerted efforts need to be made to rectify these injustices to clients. While health care services nationwide are struggling to meet the needs of their communities, racialized youth are particularly vulnerable to experiencing both a lack of care due to limited resources and an additional stress of possible racism from their service providers.

For example, Hassan recalled in their story about how a service provider had implied that his mental health symptoms were caused by his parents being sympathetic to religious terrorists because of their ethnicity and religious background. The Co-Investigators discussed how they would often be extremely careful and selective about what information they disclosed to mental health care professionals, for fear of that information being used against them in a racist or discriminatory way. Hassan shared that he is often afraid that his name would be used against him, as assumptions have been made about him in the past because his name is Arabic:

> But it's always a thought in the back of my mind…If my name was John Smith, they might not think much about it. But I have a different name, it's not a name

> that everybody has. They might subconsciously think something different that maybe is not so healthy, just by looking at my name in my file. Would that affect my care?

Their past interactions with mental health care professionals reinforced and strengthened the belief that they should not disclose certain parts of their identity or mental health problems, as one Co-Investigator said in the joint meeting: “Because I don't trust you, and I know you will be racist about it.” One Co-Investigator discussed how they can visibly “pass” as white, and will intentionally assess the healthcare professional for the emotional and psychological safety they provide before disclosing their cultural and ethnic identity. This speaks to the active component (whether conscious or subconscious) within the process of racialization: it is clearly a process that unfolds as a result of meaning made from perceptions. When the same person can be treated one way when they are perceived as white, and then treated differently when the professional is given information that would change the perception from white to coloured, it illuminates how the process of racialization is an active social construction.

Three of the Co-Investigators are mixed-race and have navigated multiple worlds while also trying to make meaning of their own individual identities as a mixed-race person. They discussed how their white parents were often treated differently by professionals than their racialized parent. They noticed how professionals would try to establish relations with the white parent more often, and in a friendlier way, than with the racialized parent. Indeed, a few of the Co-Investigators pointed out how their racialized parent was often painted in a negative light by professionals. For instance, Tonia described how professionals had “villainized” their father based on his behaviours of being quieter and stoic, and painted him as a racist stereotype of being “the angry black man.” Hassan described how professionals shared racist and

Islamophobic views about their father due to his race and religious background, and how professionals would make harmful and incorrect assumptions about his father because his white mother had converted to Islam.

Their experiences bring to life what has been discussed in the literature about the experience of racism in healthcare services, and the negative effects that can have on the individual and their community.

Feeling 'Othered'

There was a pervasive sense of feeling "othered" despite having lived in Canada all their lives and having English as a first language – a "hard-to-put-your-finger on sense that this system was not meant or designed for someone like me" – often because of how colonial it feels. Hassan discussed how colonial the city of Victoria feels, with street names that remind him and his family of British monarchs, how the culture of the city holds onto British culture and celebrates it, which continues the centering of Britishness and whiteness.

The Co-Investigators discussed how they felt they had to work so hard to feel understood within this colonial system of healthcare and still felt that after all of that effort, "It just doesn't understand you." One Co-Investigator wondered if statistics and research are weaponized against IBPOC, intentionally or not, to prove that IBPOC do not need mental health services because of low access rates. They stated that they have observed medical professionals embody this sense of "why bother" in response to efforts to include people of colour in mental health care, when racialized people do not access the mental health care system regularly or are the minority of the population that is accessing mental health care. They stated they sometimes reflect on how they feel professionals' attitudes seem to reveal their belief that it is not worth it to focus on making a small part of the population feel included when they are not the majority who's receiving the services. This treatment continued to reinforce the idea that the system was not built with them in mind.

‘My Voice is Silenced’

Newer research has captured how IBPOC youth experience racism when receiving mental health services which negatively impacted the therapeutic relationship and youths’ trust in their service providers (Cenat et al., 2025; Hilario et al., 2023). The Co-Investigators highlighted how their hypotheses and understanding of what caused their own mental health problems was not considered or was actively dismissed by mental health professionals when they were formulating their case and providing them with treatment. Unsurprisingly, when these experiences occurred, it negatively affected the therapeutic relationship and made it harder for the youth to share their perspectives in a trusting manner.

Many of these experiences are encapsulated by their experiences of psychiatric and psychological assessment. All of the Co-Investigators discussed how the experience of assessment affected them in their narratives. In particular, they often felt that their perspectives were not taken into account, that stheir questions were not answered, and that there was this pervasive sense that they did not know themselves or their own life experiences as competently as the professionals did.

Both Hassan and Tonia were admitted to Ledger’s Comprehensive Assessment Program when they were teenagers. Throughout those experiences, both Co-Investigators brought up or asked about various mental health symptoms they were experiencing. Even though the very purpose of this program was to assess for complex mental health issues, both clients felt that their perspectives and respective symptoms that they brought to the attention of staff were not adequately assessed or taken seriously. They both felt vindicated when they put the pieces together for themselves later in their lives and found mental healthcare that addressed these mental health problems themselves.

While their experiences at Ledger were not painted as "all bad," with Tonia feeling as though their agency was respected and honoured by one female psychologist at Ledger, their experiences still offer a valid critique of the program. The purpose of this tertiary care mental health program is to have accurate and comprehensive assessment of complex mental health concerns for children and adolescents, and they service all of Vancouver Island and the Gulf Islands. It comes at a significant financial cost to the medical system as it is an inpatient unit where the typical stay is 4-6 weeks. As the Co-Investigators highlighted in their stories, hospital visits and stays came at great personal and emotional cost for all four of the Co-Investigators who accessed hospital care for mental health reasons.

All of the Co-Investigators reported experiences during mental health assessments where they felt their perspectives were not valued. They felt their own understanding of their concerns was not incorporated into professionals' case formulation and conceptualization to the degree that it needed to be – which in turn, led to inaccurate assessment results. This is a clear example of how power differentials played out in these youths' lives in an unhelpful way. All of the Co-Investigators felt that they had not been accurately or meaningfully assessed in their youth. Although they all believed that had they been listened to and taken seriously when they voiced their concerns when they were younger, they felt they would have been accurately diagnosed much sooner, which would have shaped the trajectory and timeline of their treatment and well-being.

It seems especially important to highlight how this concept continues to apply with assessing youth, and not only with adults. Clinical psychology students are often encouraged to consider the perspective of the individual when conducting assessments, and are even sometimes directly warned not to interpret assessment findings at face value without first understanding the context of a person's life (e.g., personality measure results). When it comes to children and youth, assessors are usually encouraged to include the perspective of family members when formulating and conceptualizing. For youth, it is even more important to engage them in the conceptualization of their mental health journeys as their autonomy, capacity for self-understanding, and their personal lived experience is still developing.

However, it is possible that the classic psychological theories of adolescent development that many psychology students are taught (such as Elkind's theory of adolescent egocentrism, i.e., personal fable, imaginary audience), undermine the wisdom and self-understanding that many young people already have about themselves. Particularly when a social constructionism epistemology is considered, the stories we as clinicians tell ourselves about the capacity of our adolescent clients will likely shape how we interact with them. This is but one small hypothetical example of how traditional psychological systems can construct what is focused on in clinical training and therefore significantly impact how trainees may interpret symptoms in assessments.

The Co-Investigators also shared how they felt that they were not privy to critical information such as which diagnoses they received, what that would mean for them in their lives, or how treatment would be directed to address those concerns. They acutely felt the absence of their own involvement in their care when they were in their adolescent years, and some of the Co-Investigators felt that they were permitted more engagement and agency once they happened to be old enough to be served through the adult mental health system.

For example, Raven shared a story during the joint meeting about recently seeing a psychiatrist. For the first time, they had gone through a medication review together where the psychiatrist had explained why certain medications were advised to be discontinued while suggesting others to try. The psychiatrist also elucidated which mechanisms were driving their symptoms and how the medications would address this. Raven shared how liberating this experience was, and how for the first time (now that they are in their mid-20s), they look forward to meeting with a psychiatrist again.

Mandated Reporting

During the joint meeting, one of the Co-Investigators shared a dry joke about suicidality and the perils of telling a mental health professional, which caused the whole room to break out in laughter. This precipitated a passionate discussion about the usage of mandated reporting around suicidal ideation, as well as using the Mental Health Act to admit or institutionalize a youth. They often felt that they were not believed: whether it was how they were in serious distress and it needed to be taken seriously, or whether they were disbelieved and another individual's report was taken more seriously, or that their past experiences and what they had admitted to in the past negated what they were currently saying about their present situation. Felix felt that their “madness” was used against them to undermine the legitimacy of what they were reporting. They described how they felt vindicated after being discharged from hospital because the medical professionals agreed that there was no need for them to be admitted in the first place.

This defenselessness and vulnerability highlights the differences in power that are inherent in mental healthcare. Felix summarized this by saying, “The biggest lesson was, ‘I can't trust anyone in the system. Everyone will remember what I said and use what I said against me.’” The Co-Investigators described how instead of being honest, they felt that they had to misrepresent the truth so that professionals would not assert their power over them, particularly when it came to disclosing about suicidal ideation. This fear was sometimes due to what they had heard about mental health practitioners or also came from their own research and interpretation of public policy. For others, it was due to their own personal experiences of being doubted and mistreated. Researchers have discussed how someone's "madness" can be used against them in serious mental illness, and how there is a movement derived out of a need to reclaim the idea of "madness" by resisting psychiatric ways of knowing (Landry, 2017; Leblanc & Kinsella, 2016).

Fen shared how in their adulthood, they have participated in a Borderline Personality Disorder process group, where group members are allowed to speak openly about how and why they are feeling suicidal, and are allowed the space to discuss and explore the drivers of suicide. Fen shared how powerful this experience has been for them, as it has allowed them to address the root cause of their suicidality, rather than simply preventing the behaviour.

All of the Co-Investigators agreed from their own personal experiences that just stopping the behaviour momentarily would not help, as the suicidal behaviour would continue to show up. Tonia also shared that even though they had a good relationship with and trusted their IBPOC therapist, they kept their suicidality hidden because they knew that disclosing this would trigger mandated reporting.

"High Functioning"

The Co-Investigators reported that since they were seen as "high functioning" (i.e., going to school, not appearing dysregulated, able to have relationships, etc.), their suffering was not seen or attended to. The Co-Investigators often shared in their narratives about how they needed to continue to perform academically, maintain responsibilities, and appear "okay" at school. They discussed an inner tension between feeling as though they were very unwell and that the professionals were not seeing it, versus feeling that they were not "unwell enough" to access crisis services. This theme is in line with what Sheikhan and colleagues (2023) found in their study of barriers to help-seeking in youth, that youth are in “constant negotiation” between feeling “sick enough” and “not sick enough” to receive services.

The Co-Investigators also described how they decided to try to make their distress known to school personnel but were often overlooked or outright dismissed because they appeared to be functioning well. This theme was especially highlighted through Raven’s experience of their Grade 10 Life Planning class where they made a “vision board” about their future that depicted them using hard drugs and ending their life, which received an “A” grade and no follow-up.

The Co-Investigators described throughout their stories and in the joint meeting about how they felt that school staff were not able to support them in the ways that they needed. We now know from decades of research on youth that schools are one of the most important places of intervention for mental health issues (Das et al., 2016; Dray et al., 2016; Fazel et al., 2014). However, the Co-Investigators’ narratives shine a light on how some of the most vulnerable youth in Victoria were overlooked or dismissed in their schools when they showed signs of needing mental health support. While some of these signs may have seemed subtle to professionals, the Co-Investigators shared how their actions felt anything but subtle to them (e.g., visiting the school counsellor’s office unprompted for Raven; Hassan being willing to talk at all to their school counsellor; Tonia dropping out of school entirely; Fen feeling like they could not go to their school counsellor because they had too many students on their caseload; Felix moving to different cities and schools many times throughout their life and not finishing high school “on time”).

“Enmeshed”

They felt similarly about how their family dynamics and family members were perceived by mental health care professionals. Often family members were seen as “enmeshed,” regardless of the specific racial background. Of note, this is a misattribution that has been discussed and researched in previous literature, and researchers have made clear how damaging it can be to misunderstand familial relationships when providing mental health care (Measham et al., 2014; Rousseau et al., 2013). There is a lack of literature highlighting the impact this might have on young people and youth of colour. However, it is clear from the Co-Investigators’ stories that these misperceptions negatively affected their relationships and trust with healthcare providers. The Co-Investigators discussed how their close, complex, and nuanced relationships with their family members were simplified by professionals as conflictual, family enmeshment, or another type of problematic relationship dynamic.

For example, Tonia was diagnosed with separation anxiety disorder when at Ledger House (the tertiary care inpatient facility for children and youth) because they wanted to speak to their parents and were not allowed to call them. Raven shared in their narrative how their relationship with their mother was perceived as “enmeshed” when they actually found great strength and comfort in having their family member there because they felt so unsafe in the medical system. Further, their Indigenous cultural understanding of closeness between family members is understood to be integral to positive development and wellness, and is not the same concept as enmeshment as understood in the clinical psychology literature. As defined by Minuchin (1974), *enmeshment* entails negative processes and consequences within the family system due to a lack of internal boundaries within members. An important critique about enmeshment that has been identified in the literature for decades is that this concept is not applicable across cultures, particularly collectivist cultures (Joseph, 1993; Kerig, 2005; Manzi et al., 2006).

[Act III] “The meaning I make of my experience”

Agency

Throughout the stories, there was a theme that the Co-Investigators had internalized the implicit message of: “I am not deserving of input, care, attention, a voice; I am not entitled to agency.” They shared how they experienced mental health assessments as “a one-way street.” They felt that professionals thought this was a process that was going to be “done” to them rather than being a collaborative process. There seemed to be an expectation that the Co- Investigators would be passive participants in the act of assessment, which reinforced this idea that they were not entitled to agency.

However, throughout the stories there was also a sense of the Co-Investigators resisting these assumptions that had been made of them, and pushing back against this belief that they would be passive participants in their mental health care, whether it was in overt or covert ways. The Co-Investigators’ stories highlighted how they needed to be on the lookout for signs that they would be treated differently or misunderstood due to racism or cultural differences.

One Co-Investigator referenced Audra Simpson’s (2007) *ethnographic refusal*, which they summarized as the idea that “I get to choose to keep this information from you, in order to resist your power over me.” They framed this as a common way of resisting the powers of colonialism. Another Co-Investigator extended this idea and described how their grandmother (who refuses to seek medical care in Canada), is perceived as being combatant or “disobedient.” However, what they really believe is happening is: “I'm not being combative or disobedient, I’m doing this because it’s just the way I've been conditioned in so many ways. Because I have no reason to trust you." The Co-Investigators discussed how they intentionally did not disclose information to medical professionals if they felt that the information would be used against them, highlighting how they resisted the "power over" them. For example, these experiences included becoming angry with a psychiatrist who used insensitive language when referring to religious beliefs with an Indigenous Co-Investigator, or the Co-Investigators choosing not to disclose their suicidal thoughts, or a Co-Investigator choosing not to tell a mental health professional about their Two-Spirit identity or their spiritual vison, or another Co-Investigator choosing not to engage in discussions about an incorrect assumption about them or their family.

Lone

Co-Investigators discussed how they felt pushed to find their care elsewhere because they had to. They felt that the medical system would not be able to help them find the care they needed. There was a theme of feeling lonely as an IBPOC youth, where the people surrounding them did not look like them. This extended to healthcare professionals, diverse people of colour, or not seeing other IBPOC youth being open about having mental health problems too. This brings to life the findings of Chiu et al. (2018) and Wu et al. (2011), who discussed the vulnerability of racialized youth to feeling less belonging and acceptance if they live in areas that are not racially diverse. When the population is not racially or culturally diverse, there may be less impetus on service providers or fewer resources allocated to research and implement cultural adaptations that would facilitate better care for racialized youth and their families.

Collaborative Care is Possible

The Co-Investigators also discussed how much it meant to them when they found a professional who was able to provide care for them in a way that made them feel seen – human to human. While this happened more frequently with professionals who were IBPOC themselves, the Co-Investigators shared how it is possible to receive this kind of "good care" from practitioners who are white. Again, they highlighted that it is not the skin colour that matters, but rather, "It's how they use their proximity to whiteness and power."

They described that the virtues of having practitioners who are knowledgeable about intergenerational trauma, who are open to other ways of understanding family dynamics, and who know how to help people process these complexities is more important than the skin colour of the clinician. The Co-Investigators discussed how as long as a clinician has a decolonial understanding of what intergenerational dynamics look like and how to address them, the client themselves can add their own identity and own cultural elements to the interaction. This speaks to the importance of having *culturally-attuned care,* which goes beyond adapting the content of interventions to be more culturally appropriate, but rather involves clinicians aligning with the client in a way that shows that they are actively attuned to the cultural needs of the person in front of them, thereby proving to the youth that the therapy relationship is *culturally safe enough* for them to express and explore what their needs might be.

The perspective of culturally attuned care can be used to respond to needs arising from both cultural differences as well as from the process of racialization. For example, a second generation immigrant Korean youth may need a different approach to services than a first generation Korean immigrant youth due to possible acculturation differences, differences in cultural practices in modern day Korea compared to Korean cultural practices from decades prior when their parents immigrated. Even though they are from the same cultural and racial background, they may have vastly different viewpoints. A service provider who is approaching each youth with a culturally attuned approach would tailor, adapt, and be flexible to the needs of each individual person in front of them, and would be interested in understanding that specific individual's understanding of the world so that they may align with them. Two Indigenous youth may have vastly different cultural backgrounds depending on the nation or band they belong to despite being part of the same race. For mixed-race youth, the issue of how they self-identify racially and culturally should be explored with them rather than assumed. Taking action to show clients that we are aware of these nuances and willing to engage in this important work with them is tantamount. Therefore, it is not enough to say that individual cultural adaptations such as cultural competence, cultural humility, or cultural safety alone are adequate in providing culturally responsive care.

The Co-Investigators discussed how much they value straightforwardness that is kind and compassionate, even if it is not considered "professional" by Western colonial standards. Raven used the term "white lady care" in their narrative as a way of describing patronizing care that is attempted to be delivered in a compassionate way but only further alienates them. The Co-Investigators described how it is much easier to feel understood by IBPOC clinicians, and how sometimes they felt understood without needing to use words to explain it. Some described how it is healing to be around others who "just get it" and emphasized that this kind of healing community connection does not need to be in a professional setting or relationship. The Co-Investigators were not prescriptive about how those healing interactions needed to happen, as they acknowledged that what each individual needs would vary from person to person.

The Co-Investigators highlighted how powerful and transformative it was for them when they connected with a service provider who was able to be culturally attuned to them. Interestingly, most of these positive experiences were a result of service providers taking it upon themselves to change their approach to the client depending on what that individual needed (e.g., Tonia's psychiatrist eventually working with her parents, Raven's counsellor intentionally working on intergenerational trauma and resilience related to Raven's Indigeneity even though the counsellor is white, the nurse who offered to be a witness and support to Felix during their second hospital visit). These examples highlight how individual service providers can embody culturally attuned care with the choices they make in their own practice. Service providers can still make a profound difference in their patients lives, even without a systemic overhaul.

On a systemic level, Raven's experience of being part of a Metis Women's group, and Felix's involvement with the Friendship Centre and dancing in Powwows are shining examples of how current recommendations for cultural adaptations to mental health services are worth implementing and can make substantial positive changes in a youths' life.

[Act IV] Recommendations for the Mental Healthcare System and Service Providers in Victoria, BC Who Work with IBPOC Youth

Below is a list of recommendations put forth by the Co-Investigators for the medical and mental healthcare community and service providers in direct answer to the research question about what they would have wanted and needed from their own mental health care experiences. These recommendations are given because the Co-Investigators remain hopeful that culturally-attuned care is possible:

1. ***Do not be racist or discriminatory, even if you think you are being kind***

   The Co-Investigators were annoyed but not surprised at this recommendation. It is illustrated by the concept of "white woman care" and the benevolent racism that many of the Co-Investigators experienced by well-meaning clinicians. They endorsed without question that they had all encountered racist experiences through their mental health care. They recounted experiences of being treated differently because of their race or culture and being perceived as "other."

2. ***Do not pathologize cultural differences***

In particular, the Co-Investigators wanted to highlight and emphasize how their family dynamics were frequently pathologized and deigned to be problematic when they were not. The Co-Investigators recommend that service providers remain open to the possibility that family dynamics are much more complex and nuanced than they might think, and that family members can be important sources of support *even if* there is a conflict that is occurring. The Co-Investigators wanted their family members to be included in their mental wellness journeys, and would have appreciated if professionals had made an effort from the start to offer to include their family members as a part of their treatment. An approach such as *Two-Eyed Seeing* is much more appropriate when trying to conceptualize mental health across cultures (Carter et al., 2017; Martin, 2012). Two-Eyed Seeing places equal value and emphasis on two or more perspectives, holding the dialectical and honouring the tensions, understanding that both can be true and have equal merit (Martin, 2012).

3. ***Recruit more IBPOC mental health staff***

The Co-Investigators felt this recommendation would have helped somewhat to address their feelings of loneliness and that the healthcare system was not built for them. However, as noted previously, the Co-Investigators are quite aware that skin colour is not the sole approximation or an adequate approximation for whether or not colonial processes will be perpetuated by IBPOC clinicians. With that said, all of the Co-Investigators highlighted that either their most profound and "life-changing" therapeutic interactions have been with IBPOC mental health clinicians, or that they purposefully seek out IBPOC clinicians now for care. This recommendation is in line with Mai's (2024) findings that IBPOC youth wanted to see greater representation of IBPOC service providers.

4. ***Assessment that* meaningfully *includes the perspective of the youth being assessed***

The Co-Investigators advocated for assessments that truly see the youth as experts in their own lives, as people who are deserving of being heard and understood, with opinions and perspectives that are valuable. The Co-Investigators highlighted that collaboration during the assessment process is *required* for accurate assessment, and that they want to be active agents in the process of understanding themselves. It seems especially important to highlight how this continues to apply when assessing IBPOC youth, not only with adults. This is especially important in light of decades of research highlighting how easily inaccurate psychological and psychiatric assessment can be for cultural minority or racialized groups in North America (Jarvis et al., 2020; Lewis-Fernandez et al., 2016; Thomson et al., 2015).

5. ***Pay attention to requests that are made and be open to finding creative solutions to meeting them.***

The Co-Investigators shared how they did not make requests without reason. Even if the medical professional or service provider was unable to appreciate the urgency with which the request was being made, it took bravery and courage from the Co-Investigators to even voice that there was a request. Measham et al.'s (2014) presentation of case studies about refugee children in Canada highlighted the need for mental health care professionals to be open to cultural adaptations such as implementing the strategies that the client or family said were working for them. If professionals can respond in sensitive ways, this will go a long way with developing trust with IBPOC youth.

For example, Tonia had specifically requested that they not be left alone with any male staff during their in-patient stay at Ledger House – a request they was made because of their history of sexual assault. This request was initially accepted and acknowledged by the team though they did not know the reason why. However, in direct contravention of this request, Tonia found themselves in several situations where they were left alone with male staff (e.g., being woken in their bedroom by male staff or a psychological assessment being conducted with a male staff member in a small enclosed room, etc.). This was understandably detrimental to their sense of trust and safety with the staff and the program, and they exercised their agency to become even more resistant to the power dynamics at play.

6. ***Please be straightforward and kind.***

Taking the stance of the "expert knows best" is unhelpful. The Co-Investigators appreciated when service providers were direct and compassionate. There was no need to beat around the bush, hide elements of their treatment plan, or not explain why a diagnosis or process was being considered. In fact, the Co-Investigators wanted to be involved. The Co-Investigators also appreciated when professionals were straightforward with them, even if the Co-Investigators did not agree with their opinions. This is because they felt that they could better understand the stance that the professionals were taking. By giving clarity, this allowed the Co-Investigators to exert their agency in return, and clarify or resist power dynamics that they did not agree with.

7. ***Limit service provider turnover to prioritize continuity of care.***

While this is a recommendation for all mental health services that has been identified in the literature for many decades (Aarons et al., 2006; Glisson et al., 2008), this recommendation seems particularly important in the context of IBPOC youth who are entering the system with an inherent distrust of the medical system. The Co-Investigators recommended that service providers emphasize and create pathways where it is possible to offer long-term treatment as the standard, rather than short-term solutions like short-term counselling. The Co-Investigators discussed the importance of proactive intervention, and how short-term counselling should not be used as a one-size fits all approach.

The Co-Investigators also recommended some creative solutions of their own. If short-term solutions must be offered, then instead of calling a help line (which was often what they were told to do), options such as being able to book an urgent session within the next day or two through a resource like an app would better meet the needs of someone who is really in need but not in crisis. They highlighted that it is not helpful to receive a random call from a medical office "at some point in the future." They discussed how a solution like booking an urgent session is much more helpful, especially if the youth is trying to keep information private from others like parents or school staff.

8. ***Give youth choices whenever possible.***

This especially applies when matching them with service providers. One of the Co-Investigators recalled that their mental health care journey was "forever changed" when someone in leadership paired one of the IBPOC counsellors on the team with the Co-Investigator for counselling services, expressly because they were both IBPOC. This therapy relationship was strong and very helpful, even though the counsellor and the Co-Investigator were from different ethnic and racial backgrounds. The Co-Investigators discussed how helpful it would have been for them to be offered more choice in who they worked with (e.g., racial background, gender, queerness, etc.). The idea of choice also applies to choosing interventions, such as whether to include family members, which medications to trial, which program to choose (individual therapy, or group program), and more.

9. ***Create intentional community supports for youth without calling them "interventions" – especially no "group therapy."***

The Co-Investigators discussed how some of their most powerful experiences as youth happened in community services that were not explicitly deficit-based or categorized as clinical treatment (i.e., focused on mental health problems). This is also in line with research on positive development in youth (Catalano et al., 2004; Larson, 2000; Masten, 2001). They shared that if they were offered group therapy as a teenager, they often rejected it because of how scary and intimidating it felt, or because they felt so vulnerable that they did not want to be affected by hearing others' stories and struggles.

Instead, they shared that having groups for young people to go on outings together, or gathering together because of their shared cultural background or some other commonality or common interest would have been very helpful to them. For the Co-Investigators who did have that experience in their teen years, they shared that it was positively impactful on them.

For the Indigenous Co-Investigators in particular, there was a resounding sense that reconnecting with their culture and their community was an act of resistance and use of their agency, which is a sentiment that has been discussed by many Indigenous scholars (Hadjipavlou et al., 2018; King, Smith, & Gracey, 2009; Kirmayer, Simpson, & Cargo, 2003; Marsh et al., 2015; Menzies, 2008; Reeves & Stewart, 2017; Rowan et al., 2014). Some examples of community-based spaces that were brought up in the Co-Investigator discussion included: The Friendship Centre, Boys and Girls Club, or creating a Gay-Straight Alliance in the community (not based in schools).

This recommendation speaks to how different systems within the city can interact to positively affect mental health, and that mental health and wellbeing needs cannot solely be met by the healthcare system and public policy. Funding also needs to be provided to community services that are inherently protective from mental health symptoms, and which also promote well-being.

10. ***Create confidential ways to access care that can be kept private from school and family***

The Co-Investigators discussed how there were times in their journey when they were not comfortable with anyone who knew them in their everyday life knowing about the struggles they were facing, whether it was because they wanted to protect family members or because they did not want to experience stigma themselves. They discussed that had there been resources that were separate from the school or family that they could have accessed without anyone knowing, they would have certainly attended.

One Co-Investigator brought up The Foundry, a network with multiple sites across the province that is funded by the BC government, designed to address the gap in healthcare for youth. They shared that from their personal experience, while The Foundry is a wonderful resource in many ways, the Foundry only offers drop-in short-term counselling, which is inadequate to meet the needs of the community.

This recommendation highlights that youth may not understand that they may be “mature minors” who can consent to receiving mental health services without the knowledge of or permission from their guardians or school. A Co-Investigator recommended that professionals could go into schools to provide presentations about the mental health resources that are available to youth, with some psychoeducation about common mental health concerns so that youth are aware of what to look out for within themselves. Perhaps a professional in this role could also share information about what their rights are as a mature minor.

11. ***Making mental health content that is more culturally accessible***

The Co-Investigators discussed how they wanted mental health content that is applicable to other ways of knowing and being. They wanted their mental healthcare providers to be open to asking them, “How do you interpret life and its meanings?” They shared that they do not only want access to evidence-based therapies such as Cognitive Behavioural Therapy, but the flexibility to go beyond a Western ideology.

Some culturally-attuned interventions that come to mind are those of Dr. Fred Chou including *(Re)Cultivating Family Stories* (a family intervention; Chou et al., 2025), and Dr. Martin Brokenleg’s *Circle of Courage* (Brokenleg & Van Bockern, 2003). While the specific topics of the programs may not be relevant to all IBPOC youth, these programs highlight how it is possible to address mental health and well-being without only offering interventions that have been built on colonial and Western worldviews. Past research has identified that there is a continued need for further exploration of cultural adaptations in mental health services (Rathod et al., 2018; Wendt et al., 2015).

12. Mental health care needs to be free of charge

All of the Co-Investigators agreed that mental healthcare services for IBPOC youth need to be free and funded by public resources because families and youth may not have the means to find support through private services. When socioeconomic needs are decentered, this means that addressing socioeconomic needs is not seen as a prerequisite to treatment and recovery (Jones et al., 2021).

[Act V] Across All 5 Stories: The Researcher's Observations

Commonalities

There were interesting demographic commonalities across the Co-Investigators. As previously mentioned, all of the Co-Investigators came from backgrounds that included a history of colonization. All of the Co-Investigators had a serious mental health condition, whether it was bipolar II disorder, borderline personality disorder, severe OCD, or suicidality. From the research, we know that these are not the kinds of mental health issues that are expected to resolve without treatment.

Interacting systems

The Co-Investigators interacted with many different professionals across many different systems and institutions: psychiatrists, family physicians, psychologists, counsellors, nurses, social workers, school counsellors, teachers, principals, and the police – all of whom contributed to shaping their mental health journeys. The idea of many systems interacting to shape the experience of youth mental health has been discussed in the literature previously (Das et al., 2016; Dray et al., 2016; Fazel et al., 2014; Measham et al., 2014; Spencer, 2007; Velez &

Spencer, 2018), and many recommendations have been published on how to better address these complexities.

Education as a Means for Liberation

Every single narrative spoke of school, academics, or post-secondary education. All the Co-Investigators placed a high value on it. From their families' perspectives, education is a means of lifting both themselves and their parents' generations out of adverse situations (e.g., poverty or being in a war-torn country). The Co-Investigators discussed how their parents worked hard to receive their own post-secondary educations in spite of poverty and other adverse challenges. Hassan discussed how his father's education was a means of escaping a war-torn country through academic scholarship.

The Co-Investigators showed a desire and ambition for high academic achievement despite their struggles with mental health. All of the Co-Investigators are clearly highly educated, ambitious young people, who are critical thinkers. This was readily apparent in their narratives and in their dialogue when sifting through the themes of this project. Raven – who identifies as Indigenous and Two-Spirit – discussed that many of their Indigenous sisters and members of theTwo-Spirit community are often driven to achieve highly in society so that they can provide support to and uplift their communities, even at great cost to their personal well-being.

The Ability to See Nuance

Across all of the Co-Investigators' narratives, it was clear that each person was able to see the multiple complex nuances that shaped their stories. They did not see professionals or the system as "all good" or "all bad" and were able to see the limitations that practitioners are working within due to public policy or their own benevolent ignorance. They were not only critiquing the experiences they had; they were open to and openly celebrated the positive experiences too.

The Importance of Accurate Assessment

Across all of the stories it was clear how important an accurate and meaningful assessment was to each person. Each Co-Investigator discussed how their mental health journeys could have been improved by a more accurate assessment sooner, especially during their younger years as teenagers. They noted a difference between how their perspectives were valued as adolescents compared to when they became adults.

There are specific implications for the field of psychology. Their stories inform us of possible ways we can adjust the process of conceptualization during assessments (by considering their unique context, history, culture, racialization, their own meaning-making of their world, and more) and how to adjust the delivery of assessments by including IBPOC youth in the process and giving them as much choice as possible. If we take these learnings and apply them to how we conduct psychological assessments, then there are also many learnings we can apply to treatment planning and the implementation of psychotherapy. Their stories highlight how there is room for further collaboration between the psychologist and IBPOC youth, and room for further research on effective cultural adapations.

Self-Determination, Fortitude, and Resistance

Whether it was intentional or not, all of the Co-Investigators shared in their narratives about how they advocated for themselves by either disagreeing with medical professionals' opinions through withdrawing and not returning, or by resisting power through more covert means such as withholding information. Whether or not it was allotted to them, Co-Investigators *took* their agency.

Across all the stories, there was a clear desire for well-being, a resolve to be allowed to “be,” which is embodied by the word “fortitude.” There was a steady ability to continue, to push through, despite all of the challenges and adversities. By engaging with the research process, they continued to resist and actively fight against the assumptions that have been made about them. One Co-Investigator described how they have a desire to do more to lift their communities – even at great personal cost – and one way of doing so was by participating in this research. All of the Co-Investigators were explicit in expressing their hope that this research project would be able to create change to ameliorate the mental health experience for racialized youth in Victoria, BC.

The Co-Investigators thanked me for providing them with a space to discuss these topics. They particularly highlighted the amount of time and freedom given to them to discuss their individual stories – not feeling rushed, and feeling as though their time and voice were valued through the time allocated and the power to have full control over their narratives.

Using the CNM to Answer the Research Questions

I sought to explore answers to the research questions using the CNM. Given my positionality, it would have been impossible to attempt exploring these questions without seeing the Co-Investigators as active co-constructors. For that reason, I believe using a method that attempted to level power dynamics and create open space for the story-teller to tell their story was vital.

Through the narratives and the subsequent co-constructed themes, we were able to begin exploring answers to the research questions. We developed a sense of what it was like for each individual as they received mental healthcare as a racialized youth in Victoria. We heard them discuss who they perceived as important to their care and support. We listened to the meanings they made of their experiences. We gathered what care they wished they had received in their mental health care journeys and channelled those desires and needs into their recommendations to give back to the community. While the method was not meant to be exhaustive or uncover every facet of each individual's life, it certainly allowed for the opportunity to create a rich understanding into the lived experience of these specific questions. CNM did so in a way that was flexible and tailored enough to be a vessel of communication for each person, no matter how unique the story.

Unique Contributions

This research project was in part inspired by the innovative and thought-provoking creative art project "Profiling Black Excellence." The creator of the art, Nathan, describes it as, "A photo project exploring the experiences of racism and racial profiling felt by people of colour in Victoria, Vancouver, and the surrounding areas." In this project, individuals are photographed and given the space to share their stories of experiencing racism in their respective cities.

In my opinion, the most unique contribution of the present research study was how deeply situated it is in the context of the city of Victoria, BC. Each story gives a rich depiction of what it is like to navigate the public mental health system *specific to* Victoria. I have not heard of nor found other accounts in the literature that explores the experience of IBPOC youth in Victoria and their experience of the mental health system in such an explicit and detailed manner.

This embeddedness means that the recommendations made by the Co-Investigators speak *directly* to the Victoria mental health system, which will hopefully be a stronger impetus to create helpful change. As Donnelly et al. (2011) discussed, meaningful change of mental healthcare systems can only be done with the input of the people who are most affected by it – in essence, the service users. Researchers have been advocating for this kind of research that addresses systemic racism head-on by conducting research *with* racialized youth in Canada through research methodologies that are culturally safer than Western approaches (Gajaria et al., 2021; Weerasinghe et al., 2023).

While many of the findings of this study are not new (e.g., that IPBOC youth notice a difference in worldviews between themselves and service providers, feeling like services are not designed with them in mind, noticing a need for free mental health services, asking to increase representation of IBPOC providers, wanting community supports rather than "mental health" supports, noticing acculturation differences within families, needing to hide any vulnerabilities, etc.; Edwards, 2025; Islam et al., 2017; Mai, 2024; Salami et al., 2021), the narratives provide a rich context and application of these themes. As the reader, you can see how these themes came to life in each of their lives and *why* it is so important that we address them.

Coupled with this unique strength was the intentional effort to complete this study using an active participatory method. Due to the CNM, every step of the study considered why and how power dynamics could be levelled and addressed, so that the Co-Investigators could share their stories in a way that felt right to them and actively speak to the powers that affected their mental healthcare. Sharing their stories was an act of resistance. I believe that their desire to stay involved with the project over a few years speaks to the merit of these efforts made to prioritize relational ethics, and that there genuine relationships developed from this research process. By prioritizing relational ethics, the Co-Investigators and I were able to develop deeper, richer, and more detailed accounts of their experiences, in addition to gathering togehter to collaborate on a list of recommendations. I truly believe that the depth and richness of this project was only possible because of the trust that was built between us.

For next steps, the Co-Investigators and I have been brainstorming how to translate this knowledge to the community to create effective change. The Co-Investigators would like these stories to reach local service providers and policy makers so that the lessons learned from their experiences result in meaningful change in service provision. It would be invaluable for future research to track or measure any changes in client outcomes if culturally-attuned care is prioritized. If these changes result in positive and meaningful changes for clients, then research capturing this effect would help to legitimize the efforts that were made and provide evidence that further investments are worthwhile endeavors.

This study served to meet a gap in the current Canadian literature on IBPOC youth mental health. This dissertation project allowed for these stories to be added to the growing research literature that is capturing the lived experiences of IBPOC youth in Canada and can be an important work for future research to continue to build from. My hope is that future research continues to see the value in methods that intentionally and ethically co-create knowledge with participants, especially if the purpose of the research is liberation and freedom.

Limitations

As with any study, there were limitations here as well – the most salient of which was recruitment. Of note, there was approximately a year-long gap in recruitment, which picked up again very quickly once social media advertisements began. The Co-Investigators noted that they were looking for studies like this to participate in, and were unable to find them through traditional routes. This highlights a significant gap between traditional research recruitment methods and how there are likely many community members who want to participate in research but are unable to be connected to projects. This seems particularly relevant for youth who may not have the personal connections or resources to be connected with university researchers.

Similarly, Turuba and colleagues (2023) explored how youth in British Columbia use the social media app, TikTok, as a way of accessing psychoeducation about mental health topics. Another point of interest is that almost all of the Co-Investigators are currently enrolled in or are pursuing post-secondary education, meaning that they already have an understanding of how to access and navigate educational institutions.

An Indigenous community member recommended with respectful intentions that researchers physically go to community centres and hubs in the city with an audio recorder, gifts, and consent forms in hand, to ask potential participants on the spot if they would like to participate. They shared that this would greatly lower barriers because youth would likely be burdened with paperwork, coordination, and feeling as though using email is too formal. Often in participatory action research, researchers are cautioned to build relationships with organizations and communities first. However, this community member's input taken together with the perspectives of some of the Co-Investigators, signals that there may be a greater, pressing need for stories to be accessed and shared widely, and that "ethical" research procedures may inadvertently be making it more difficult for those who want to share their stories and participate.

Interestingly, there were many community members who wanted to share their stories but did not meet criteria for the study as they were first-generation newcomers or had a severity of mental illness that precluded their involvement. Many of these individuals highlighted that there continues to be a gap in the research focusing on the newcomer experience of navigating mental health services in Victoria, and/or having a serious mental illness as a racialized person in Victoria.

A second limitation was the potential threat to relational ethics due to the duration of study length when conducting this kind of research. The Co-Investigators also discussed how long the study had taken and expressed that they were invested throughout the process. They were understanding of the life events and personal mental health issues of the researcher and how it may have impacted the timing of the project. While I am grateful that the Co-Investigators granted me their grace and patience, the timeline was far from ideal. However, an interesting and unintentional cascade as a result of the delays was that the Co-Investigators had years to reflect on their stories and had an additional layer of meaning-making to contribute.

The Co-Investigators expressed that they felt their efforts and time were acknowledged and appreciated through honoraria, food, and gifts. I offered that any future knowledge translation activities would only occur with each Co-Investigator's input and permission. I also offered that for any future academic publications, their names could be added to the authors' list if they would like to be included. However, given confidentiality and anonymity issues, this would need to be a decision made with great care. The Co-Investigators expressed that they were thankful for and appreciative of this invitation of power-sharing, even if they do not end up accepting the offer in the future.

Third, I felt a desire for even more understanding – even though there was richness within each narrative, there was a desire to keep digging – to contextualize it even more within their respective race or culture, that time in history, or to explore their identity formation, and beyond. The narrative felt limited at times to the focus of the research. Narrative methodologies inspire the desire to couch stories in context, but it is still practically limited in scope because of the research questions.

Voice and Authorship

In traditional research spaces, authorship is usually dictated according to contribution to the initial research design, data collection, analysis, and manuscript drafting. While it is unorthodox to have had such involvement from participants in creation of the results of a dissertation, it has also allowed for a more authentic preservation of each person's voice and story. I follow in the footsteps of other scholars who have set the precedent of using the CNM as the basis of their dissertations (Beyer, 2022; Chou, 2019; Gendron, 2023; Mair, 2016), spurred on by the belief of the importance of having co-constructed narratives included in academia, to have co-constructed narratives be recognized as equal in value to traditional research, and to be recognized as requiring a sufficient demonstration of research skills by the researcher to meet the requirements of a PhD degree. The decision to intentionally build a stage to lift the voices of others was effortful and worthwhile. As the lead researcher, I was responsible for the vision of the project and completed the literature review and research design, conducted meetings with the Co-Investigators, manually transcribed the majority of the audio recordings, completed the writing of the story-drafting for each narrative, and the writing for each chapter of this dissertation. In order to protect Co-Investigators' privacies and to foster further trust, I did not have research assistants to help with administrative or time-consuming tasks. This was an intentional decision that I made in order to reassure Co-Investigators that no one else outside of our relationship would hear any portion of their story before they were ready to share it. Finally, given the participatory and collaborative nature of this dissertation, it was imperative to rely on the expertise and guidance of my committee, Co-Investigators, and Advisory Committee members.

For narrative methodologies, especially a methodology like the CNM which has an express belief in the participatory nature of the work and a focus on relational ethics, there is an inherent tension between protecting the privacy and anonymity of the Co-Investigators and highlighting that it is the Co-Investigators who decided to bring their experience into the academic environment. Their reasons for doing so might include trying to solve a problem, standing up against a misinterpretation of a process they lived through, to share information about an issue, or to convince others of the importance of something (Rojas, 2021). Indeed, their voices and stories provide a compelling argument for why policymakers and health care providers should consider why and how racialized youth make sense of their mental health care experiences in Victoria, and why their recommendations need to be taken seriously.

With their permission, it is solely my name on this dissertation. However, I understand that the true authorship of the narratives also includes the names of my Co-Investigators. I am so grateful to the Co-Investigators for gifting me with their stories in this format for the purposes of fulfilling my degree requirements. While I can never repay them fully for this gift, I hope that I have honoured their voices and helped them to achieve their aims through participating in this project. In any future works, co-authorship will be offered to the Co-Investigators as a genuine acknowledgement of our joint effort. Our collective intention is to continue our work beyond this dissertation, and we remain hopeful that their stories will be meaningful catalysts for change.

Conclusion

The purpose of the study was to co-create narratives of racialized youths' experiences of the public mental health system in Victoria, BC. The stories captured Co-Investigators' multi-layered and nuanced experiences of receiving mental healthcare in Victoria, BC, and highlight the importance of understanding stories within the context they have been embedded.

For these Co-Investigators, it was impossible to separate their mental health journeys from their historical, intergenerational, racial, cultural, relational, geographical, and personal contexts. Not only did the Co-Investigators speak to the harms they experienced in the mental health system, they also spoke of the ways in which they resisted colonial harms and asserted their agency.

While each Co-Investigator comes from a different racial and cultural background, they were united in their refusal to be passive in their mental healthcare experiences, and even through this research project, they continued to use their voices to express their agency with the hope that it would culminate in positive change for racialized youth who access mental healthcare in Victoria in the future.

This study underscores the continued need to find anti-racist and decolonial ways of creating research with IBPOC youth in Canada. It is clear that there are important learnings to be uncovered from a population of our society that has historically been overlooked.

I remain grateful to my Co-Investigators who were willing to take a chance on this project and allowed me the privilege of walking with them to share their stories with the world.

An Epilogue: My Personal Reflections

Sociohistorical Impetuses for the Project

Chimamanda Ngozi Adichie, who refers to herself as a storyteller, delivered a powerful Ted Talk in July 2009 titled, “The Danger of a Single Story.” She shared, “The Palestinian poet, Mourid Barghouti, writes that if you want to dispossess a people, the simplest way to do it is to tell their story and to start with, ‘Secondly.’” Hearing her thought-provoking and powerful speech was but one contributor to the momentum that set this project in motion in 2021.

This quote feels particularly apt given the spotlight that was directed toward the decades-long oppression of the Palestinian people (or Israeli-Palestinian conflict, depending on your perspective) from October 7, 2023, and onward. It is embodied in how the world was told various narratives about the events of that day, narratives about the events that occurred after that day, and narratives about the past that led up to that day.

The #MeToo movement that gained momentum in 2018 sparked deep conversations and a social and civic reckoning.

COVID-19 brought the world to a physical standstill in March of 2020 and changed the way the world has operated ever since.

The world witnessed the murder of George Floyd in America in May of 2020, and the subsequent civil unrest that was sparked worldwide in support of the Black Lives Matter movement.

The report, “In Plain Sight,” was released in parts from November 2020 to February 2021 and investigated the experiences of discrimination in the health care system experienced by Indigenous peoples in British Columbia.

During this study, the “Freedom Convoy” movement made waves across Canada in 2022, with a strong presence on Vancouver Island.

My Personal Experience of the Impetus for the Project

While these social and historical events were brewing from 2020-2021, I was working with a racialized youth client and their family members through the public mental healthcare system in Victoria. Through our work together, it became clear that multiple family members felt misunderstood by many of the mental health care professionals they had worked with, and that they may have even experienced benevolent racism in the process. I was so grateful that I had supervisors at the time who were open to me trying things in a radically different way than what would have been typical.

While I am certain that I did not practice “perfectly,” I felt a personal motivation to provide the most culturally-attuned care I could. I remember the youth sharing with me that working with someone who was a racialized Canadian had made a big difference to them, and at the end of our therapeutic relationship, they expressed that they hoped I never forgot them. I promised them that I never would.

I remember bumping into one of the parents a year later in a grocery store (cue: “Victoria is sooo small!”) and the parent quickly began sharing with me in rushed and hushed tones that both the parents and the youth were doing well and that the youth would have loved to bump into me too. I remember feeling my eyes welling up with tears, standing stock still in the middle of the store, while internally scrambling and fumbling in my mind through an ethical decision-making process of how to navigate this conversation. (Ha! Isn’t that so relatable for any other psychologists out there?) Even now as I write this, I am moved to tears again. Because this moment meant so much to me. We so rarely get to hear the follow-up about how our clients are doing after our work together ends. Even today, I cannot find the right words to express how much joy, gratitude, and awe I felt toward this family for the privilege they afforded me to walk with them during those turbulent years of their lives.

It is likely that this family will never know how powerfully they impacted and shaped my journey as a clinician and as a researcher. My experience of walking with this family was a very large impetus behind this research project. I figured there must be other youth out there in Victoria who had experienced something similar, and their stories deserved to be heard.

To my youth client and their parents: if you ever somehow read this, I hope you know that you had (and have) the power to shape the lives of the people around you in profound and inspiring ways.

The Experience of the Research Process

As you can see, this research project was deeply personal and meaningful to me. Completing it feels very full circle. The project itself was very emotional for me. It was always a mix of emotions – some heavy ones, but also many positive and rejuvenating emotions too. I was often overcome by emotion and burst into tears immediately after signing off of each meeting with a Co-Investigator from a mixture of disbelief, exasperation, joy, and more.

Every time I engaged with the project again after a break, I would feel another wave of motivation and passion being re-ignited. Every single time! My poor husband watched and listened to my reactions and held my heart together with me. I really learned again and again throughout this project that when we are trying to drive change for the community, it is simply impossible to do in isolation. Through community, we encourage one another, bolster one another, and better one another.

I felt so deeply privileged every time I met with a Co-Investigator. I was blown away that they were choosing to allow me to hear their story, and that they were giving me the honour of hearing their intimate thoughts and reflections about their experiences.

We talk about it in classes and read about it in ethics articles, but the experience of going through this project brought those theoretical teachings to life. This experience showed me how much power we can hold as researchers and clinicians. What if I had decided to stop the project? What if I had never finished it? What if I created an ethical misstep along the way and accidentally silenced the voice I was trying to amplify? It often made me wrestle with the idea that with this power and because of the values I hold, I have a personal responsibility to use my position of power to try to contribute in a way that will lead to liberation for all of us.

Putting on different hats

I found myself intentionally and sometimes unintentionally (and later realizing it upon further reflection) putting on different hats at different stages of the project. During the story-sharing meetings and discussion meetings, I intentionally tried to take off the "clinician" hat as much as I could. I really wanted to connect with each person as another human being and not analyze or formulate or conceptualize. I allowed myself to communicate my frank reactions to shocking parts of their story. We often found ourselves laughing together for one reason or another. I was candid and honest with each Co-Investigator about how struck I was by their eloquence and wisdom.

In the joint meeting at the end of the project, that was really when I (unexpectedly) felt the tension of "being a clinician," particularly when discussing the issue of mandated reporting. It really highlighted this conflict of interest within us as clinicians: wanting to provide *truly* client-centered care, but not *really* being able to fulfill that promise when our hands are legally tied or if we are worried about our own professional liability risk. This can automatically jar us out of the human-to-human connection that the Co-Investigators were asking for from their care teams. Hearing a Co-Investigator say, “Where is the humanity?” really hammered this tension home for me.

Knowing that these multiple hats exist put into perspective time and time again how much may be going on in the mind of a professional that a client may never know. For example, when the Co-Investigators shared how they were moved around from service to service, my clinician mind automatically started to make some guesses about why that might have happened, whether it was because of knowing about how overburdened a certain clinic or hospital is, or because the organization is limited by their mandates. This made me wonder: why do we not communicate these limitations to our clients? Could we continue to level power dynamics by acknowledging to our clients what we are debating about within ourselves and inviting them to take part of the conversation? Would it truly be harmful to their care? Or would it actually be centering their experience because the act of doing so invites them in as collaborators?

It was quite fascinating to devellop these extra layers of perspective within me of being a service provider myself, while also having experienced my own journey of receiving mental health services, and then hearing others’ journeys of receiving mental health services. I also felt that I was inadequately assessed at first – even though I was someone who provided mental health assessments and knew what information my clinicians needed to come to an accurate conclusion. This occurred even when I advocated that some of my symptoms might not look like the classic presentation of a disorder due to cultural or family factors.

And now…

The stories we have co-created have already shaped and changed how I practice. I try to be more intentional in including the client's perspective during assessment processes by making meaning together, including clients in the treatment planning process, and explaining why we are doing what we are doing. When working with IBPOC youth, I always make sure to ask if they want to include family members. I am now even more hesitant to pathologize signs of distress – while still remaining open to the possibility that someone may want a diagnosis because they find it validating – and knowing that I need to be willing to have an open discussion with them about it.

It drove home for me the importance of paying attention to the language and position of power I use with IBPOC youth clients and being even more intentional to level power dynamics. If I feel a need to withhold some of my conceptualizations, I try to pause and reflect on whether it would center their experience to explore with them what I am mulling over. The reflections about candor from their clinicians and feeling connected human-to-human has stuck with me – that maybe IBPOC youth want and need to know what my personal (and not just clinical) thoughts and positions are in order for them to make the determination of whether they see me as trustworthy. That it is *their right* to have the information they need to assess for themselves whether *I* am trustworthy.

Coming full circle

Because of my own story and my own background, in many ways, this project was a deeply healing process for me. It helped me to make sense of my own life journey, seeing how all of the different pieces and parts of my life came together to this moment in time, to be able to show up in this way, to create my own act of resistance by being a part of this project.

I expected this method to be time-consuming and challenging, and it was. However, given how collaborative the method felt, the extra time and investment felt more than worth it. It was a profoundly meaningful experience that I will carry with me for the rest of my life. I am hopeful that our efforts (the Co-Investigators' and mine) will create ripple effects that will have a lasting impact on Victoria (and maybe beyond!), so that we can all feel heard and seen in the ways that we need, when we need it.

In the spirit of narrative inquiry, now I ask you: what meaning did you make as you read through their stories? What messages will you take away?

References

Aarons, G. A., & Sawitzky, A. C. (2006). Organizational climate partially mediates the effect of culture on work attitudes and staff turnover in mental health services. *Administration and Policy in Mental Health and Mental Health Services Research*, *33*, 289-301.

Abouguendia, M., & Noels, K. A. (2001). General and acculturation-related daily hassles and psychological adjustment in first- and second-generation South Asian immigrants to Canada. *International Journal of Psychology*, *36*(3), 163–173. https://doi.org/10.1080/741930008

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*. American Psychiatric Pub.

Anthias, F. (2008). Thinking through the lens of translocational positionality: An intersectionality frame for understanding identity and belonging. *Translocations: Migration and Social Change*, *4*(1), 5-20.

Anthias, F. (2013). Hierarchies of social location, class and intersectionality: Towards a translocational frame. *International Sociology*, *28*(1), 121-138.

Arnett, J. J. (2007). Emerging adulthood: What is it, and what is it good for? *Child Development Perspectives*, *1*(2), 68–73. https://doi.org/10.1111/j.1750-8606.2007.00016.x

Arvay, M. (2003). Doing reflexivity: A collaborative narrative approach. *Reflexivity: A practical guide for researchers in health and social sciences*, 163-175.

Atallah, D. G. (2017). A community-based qualitative study of intergenerational resilience with Palestinian refugee families facing structural violence and historical trauma. *Transcultural Psychiatry*, *54*(3), 357–383. https://doi.org/10.1177/1363461517706287

Auclair, G., & Sappa, M. (2012). Mental Health in Inuit Youth from Nunavik: Clinical Considerations on a Transcultural, Interdisciplinary, Community-oriented Approach. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, *21*(2), 124–126.

Barbic, S. P., Leon, A., Manion, I., Irving, S., Zivanovic, R., Jenkins, E., Ben-David, S., Azar, P., Salmon, A., Helps, C., Gillingham, S., Beaulieu, T., Pattison, R., Talon, C., Oyedele, O., Tee, K., & Mathias, S. (2019). Understanding the mental health and recovery needs of Canadian youth with mental health disorders: A Strategy for Patient-Oriented Research (SPOR) collaboration protocol. *International Journal of Mental Health Systems*, *13*(1), 6. https://doi.org/10.1186/s13033-019-0264-0

Beiser, M. (2009). Resettling refugees and safeguarding their mental health: Lessons learned from the Canadian Refugee Resettlement Project. *Transcultural Psychiatry*, *46*(4), 539–583. https://doi.org/10.1177/1363461509351373

Berry, J. W., & Hou, F. (2017). Acculturation, discrimination and wellbeing among second generation of immigrants in Canada. *International Journal of Intercultural Relations*, *61*, 29–39. https://doi.org/10.1016/j.ijintrel.2017.08.003

Berry, J. W., & Hou, F. (2021). Immigrant acculturation and wellbeing across generations and settlement contexts in Canada. *International Review of Psychiatry*, *33*(1–2), 140– 153. https://doi.org/10.1080/09540261.2020.1750801

Block, S. Galabuzi, G-E., & Tranjan, R. (2019). *Canada's colour coded income inequality.* Canadian Centre for Policy Alternatives.

Bokore, N. (2013). Suffering in silence: A Canadian-Somali case study. *Journal of Social Work Practice*, *27*(1), 95–113. https://doi.org/10.1080/02650533.2012.682979

Bombay, A., Matheson, K., & Anisman, H. (2009). Intergenerational trauma: Convergence of multiple processes among First Nations peoples in Canada. *International Journal of Indigenous Health*, *5*(3), 6-47

Borshuk, C. & Eljdupovic, G. (2019). The criminalization and incarceration of mothers in Canada and the United States. In O'Brien Hallstein, L, O'Reilly, A., & Vandenbeld Giles, M. (Eds.), *The Routledge Companion to Motherhood* (451-461). Routledge. https://doi.org/10.4324/9781315167848

Boydell, K. M., Pong, R., Volpe, T., Tilleczek, K., Wilson, E., & Lemieux, S. (2006). Family perspectives on pathways to mental health care for children and youth in rural communities. *The Journal of Rural Health : Official Journal of the American Rural Health Association and the National Rural Health Care Association*, *22*(2), 182–188. https://doi.org/10.1111/j.1748-0361.2006.00029.x

Bracken, P. (2002). *Trauma: Culture, Meaning and Philosophy*. Wiley.

Brokenleg, M., & Van Bockern, S. (2003). The science of raising courageous kids. *Reclaiming Children and Youth*, *12*(1), 22-26.

Caine, V., Estefan, A., & Clandinin, D. J. (2013). A return to methodological commitment: Reflections on narrative inquiry. *Scandinavian Journal of Educational Research*, *57*(6), 574–586. https://doi.org/10.1080/00313831.2013.798833

Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: A model of care. *Journal of Transcultural Nursing*, *13*(3), 181-184.

Carter, C., Lapum, J., Lavallée, L., Schindel Martin, L., & Restoule, J.-P. (2017). Urban First Nations Men: Narratives of Positive Identity and Implications for Culturally Safe Care.

Journal of Transcultural Nursing, *28*(5), 445–454. https://doi.org/10.1177/1043659616659348

Carter, R. T., & Pieterse, A. L. (2019). *Measuring the effects of racism: Guidelines for the assessment and treatment of race-based traumatic stress injury*. Columbia University Press.

Catalano, R. F., Berglund, M. L., Ryan, J. A., Lonczak, H. S., & Hawkins, J. D. (2004). Positive youth development in the United States: Research findings on evaluations of positive youth development programs. *The Annals of the American Academy of Political and Social Science*, *591*(1), 98-124.

Cénat, J. M. (2020). How to provide anti-racist mental health care. *The Lancet Psychiatry*, *7*(11), 929–931. https://doi.org/10.1016/S2215-0366(20)30309-6

Chan, A., Pullen Sansfaçon, A., & Saewyc, E. (2023). Experiences of discrimination or violence and health outcomes among Black, Indigenous and People of Colour trans and/or nonbinary youth. *Journal of Advanced Nursing*, *79*(5), 2004–2013. https://doi.org/10.1111/jan.15534

Chan, W., & Chunn, D. (2014). *Racialization, Crime, and Criminal Justice in Canada* University of Toronto Press.

Chen, A. W., Kazanjian, A., & Wong, H. (2009). Why do Chinese Canadians not consult mental health services: Health status, language or culture? *Transcultural Psychiatry*, *46*(4), 623–641. https://doi.org/10.1177/1363461509351374

Chiu, M., Amartey, A., Wang, X., & Kurdyak, P. (2018). Ethnic differences in mental health status and service utilization: A population-based study in Ontario, Canada. *Canadian*

Journal of Psychiatry. Revue Canadienne de Psychiatrie, *63*(7), 481–491. https://doi.org/10.1177/0706743717741061

Chou, F. (2019). *Stories of our ancestors: Intergenerational trauma and Chinese-Canadian families.* [Unpublished doctoral dissertation]. University of British Columbia.

Chou, F., & Huang, C. (2023). Witnessing the shared story of intergenerational trauma in a chinese canadian family: An autoethnographic narrative. *Canadian Journal of Counselling & Psychotherapy/Revue Canadienne de Counseling et de Psychothérapie*, *57*(1).

Chou, F., Black, T., Huang, C., Tran, A., Yan, M., & Boothroyd, S. (2025). The development of a dyadic family life review intervention for the Asian diaspora: A practice article. *Journal of Marital and Family Therapy*, *51*(1), e12750.

Chou, F., Buchanan, M. J., McDonald, M., Westwood, M., & Huang, C. (2023). Narrative themes of Chinese Canadian intergenerational trauma: Offspring perspectives of trauma transmission. *Counselling Psychology Quarterly*, *36*(2), 321-349.

Clandinin, D. J., Lessard, S., & Caine, V. (2018). *The relational ethics of narrative inquiry*. New York, NY: Routledge.

Clarkson, L., Morrissette, V., & Régallet, G. (1992). *Our responsibility to the seventh generation: Indigenous peoples and sustainable development* (p. 63). Winnipeg: International Institute for Sustainable Development.

Costigan, C. L., & Dokis, D. P. (2006). Similarities and differences in acculturation among mothers, fathers, and children in immigrant Chinese families. *Journal of Cross-Cultural Psychology*, *37*(6), 723–741. https://doi.org/10.1177/0022022106292080

Das, J. K., Salam, R. A., Lassi, Z. S., Khan, M. N., Mahmood, W., Patel, V., & Bhutta, Z. A. (2016). Interventions for adolescent mental health: An overview of systematic reviews. *Journal of Adolescent Health*, *59*(4), S49–S60. https://doi.org/10.1016/j.jadohealth.2016.06.020

Davin, A. (1879). Report on industrial schools for Indians and Half-Breeds. https://ehprnh2mwo3.exactdn.com/wp-content/uploads/2021/01/Davin-Report.pdf

Delfish, M., & Chadha, P. (2025). From competence to humility: Advancing culturally responsive mental health care. *Psychiatric News*, *0*(0). https://doi.org/10.1176/appi.pn.2025.01.1.39

Denov, M., Fennig, M., Rabiau, M. A., & Shevell, M. C. (2019). Intergenerational resilience in families affected by war, displacement, and migration: "It runs in the family." *Journal of Family Social Work*, *22*(1), 17–45. https://doi.org/10.1080/10522158.2019.1546810

Donnelly, T. T., Hwang, J. J., Este, D., Ewashen, C., Adair, C., & Clinton, M. (2011). If I was going to kill myself, I wouldn't be calling you. I am asking for help: Challenges influencing immigrant and refugee women's mental health. *Issues in Mental Health Nursing*, *32*(5), 279–290. https://doi.org/10.3109/01612840.2010.550383

Dray, J., Bowman, J., Campbell, E., Freund, M., Wolfenden, L., Hodder, R. K., McElwaine, K., Tremain, D., Bartlem, K., Bailey, J., Small, T., Palazzi, K., Oldmeadow, C., & Wiggers, J. (2017). Systematic review of universal resilience-focused interventions targeting child and adolescent mental health in the school setting. *Journal of the American Academy of Child & Adolescent Psychiatry*, *56*(10), 813–824. https://doi.org/10.1016/j.jaac.2017.07.780

Durie, M., Milroy, H., & Hunter, E. (2009). Mental health and the Indigenous peoples of Australia and New Zealand. In *Healing traditions: The mental health of Aboriginal peoples in Canada* (pp. 36-55). UBC Press.

Edwards, F. (2025*)*. Black youth mental health: Reconstructing identity through art-based research. *Journal of Critical Research Methodologies*.

Erikson, E. H. (1950). *Childhood and society*. New York: Norton.

Erikson, E. H. (1967). *Identity and the life cycle*. WW Norton & company.

Esaki, N., Reddy, M., & Bishop, C. T. (2022). Next steps: applying a trauma-informed model to create an anti-racist organizational culture. *Behavioral Sciences*, *12*(2), 41.

Fante-Coleman, T., & Jackson-Best, F. (2020). Barriers and facilitators to accessing mental healthcare in Canada for Black youth: A scoping review. *Adolescent Research Review*, *5*(2), 115–136. https://doi.org/10.1007/s40894-020-00133-2

Fante-Coleman, T., Jackson-Best, F., Booker, M., & Worku, F. (2023). Organizational and practitioner challenges to Black youth accessing mental health care in Canada: Problems and solutions. *Canadian Psychology / Psychologie Canadienne*, *64*(4), 259–269. https://doi.org/10.1037/cap0000370

Fazel, M., Hoagwood, K., Stephan, S., & Ford, T. (2014). Mental health interventions in schools in high-income countries. *The Lancet Psychiatry*, *1*(5), 377–387. https://doi.org/10.1016/S2215-0366(14)70312-8

Feng, R. Y., Krygsman, A., Vaillancourt, T., & Vitoroulis, I. (2023). Experiences of racial microaggression among immigrant and Canadian-born young adults: Effects of double stigma on mental health and service use. *International Journal of Social Psychiatry*, *69*(7), 1723–1735. https://doi.org/10.1177/00207640231174374

Fenta, H., Hyman, I., & Noh, S. (2006). Mental health service utilization by Ethiopian immigrants and refugees in Toronto. *The Journal of Nervous and Mental Disease*, *194*(12), 925–934.

First, M.B., Williams, J.B.W., Karg, R.S., & Spitzer, R.L. (2016). Structured Clinical Interview for DSM-5 Disorders, Clinician Version (SCID-5-CV). Arlington, VA, American Psychiatric Association

Flavin, L., Hammoud-Milad, M., Labinger, K., Wimberger, N., Stork, C., & Hansen, H. (2022). Using principles of trauma-informed care to address structural racism in psychiatric care. *American Journal of Psychiatry*, *179*(2), 94-97.

Fung, K., & Wong, Y.-L. R. (2007). Factors influencing attitudes towards seeking professional help among East and Southeast Asian immigrant and refugee women. *International Journal of Social Psychiatry*, *53*(3), 216–231. https://doi.org/10.1177/0020764006074541

Gajaria, A., Guzder, J., & Rasasingham, R. (2021). What's race got to do with it? A proposed framework to address racism's impacts on child and adolescent mental health in Canada. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, *30*(2), 131.

Ganesan, S., Mok, H., & McKenna, M. (2011). Perception of mental illness: Preliminary exploratory research at a cross-cultural outpatient psychiatric clinic. *International Journal of Social Psychiatry*, *57*(1), 81–89. https://doi.org/10.1177/0020764009104286

Glisson, C., Schoenwald, S. K., Kelleher, K., Landsverk, J., Hoagwood, K. E., Mayberg, S., ... & Research Network on Youth Mental Health. (2008). Therapist turnover and new program sustainability in mental health clinics as a function of organizational culture, climate, and service structure. *Administration and Policy in Mental Health and Mental Health Services Research*, *35*, 124-133.

Government of Canada (2021, May 6a). Multiculturalism. https://www.canada.ca/en/services/culture/canadian-identity-society/multiculturalism.html

Government of Canada. (2020, September 8). *Social determinants and inequities in health for Black Canadians: A snapshot.* https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health/social-determinants-inequities-black-canadians-snapshot.html

Government of Canada. (2021, April 15b). *Jordan's Principle*. https://www.sac-isc.gc.ca/eng/1568396042341/1568396159824

Green, A. E., Miller, E. A., & Aarons, G. A. (2013). Transformational leadership moderates the relationship between emotional exhaustion and turnover intention among community mental health providers. *Community Mental Health Journal*, *49*, 373-379.

Griner, D., & Smith, T. B. (2006). Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training*, *43*(4), 531–548. https://doi.org/10.1037/0033-3204.43.4.531

Groleau, D., & Kirmayer, L. J. (2004). Sociosomatic theory in Vietnamese immigrants' narratives of distress. *Anthropology & Medicine*, *11*(2), 117–133. https://doi.org/10.1080/13648470410001678631

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. *Handbook of Qualitative Research*, *2*(163-194), 105.

Gur, O. M. (2010). Persons with Mental Illness in the Criminal Justice System: Police Interventions to Prevent Violence and Criminalization. *Journal of Police Crisis Negotiations*, *10*(1–2), 220–240. https://doi.org/10.1080/15332581003799752

Hadjipavlou, G., Varcoe, C., Tu, D., Dehoney, J., Price, R., & Browne, A. J. (2018). "All my relations": experiences and perceptions of Indigenous patients connecting with Indigenous Elders in an inner city primary care partnership for mental health and well-being. *CMAJ*, *190*(20), E608-E615.

Haggarty, J. M., Ryan-Nicholls, K. D., & Jarva, J. A. (2010). Mental health collaborative care: A synopsis of the Rural and Isolated Toolkit. *Rural and Remote Health*, *10*(3), 1314.

Han, H. R., Miller, H. N., Nkimbeng, M., Budhathoki, C., Mikhael, T., Rivers, E., ... & Wilson, P. (2021). Trauma informed interventions: A systematic review. *PloS one*, *16*(6).

Healey, P., Stager, M. L., Woodmass, K., Dettlaff, A. J., Vergara, A., Janke, R., & Wells, S. J. (2017). Cultural adaptations to augment health and mental health services: A systematic review. *BMC Health Services Research*, *17*(1), 8. https://doi.org/10.1186/s12913-016-1953-x

Herati, H., & Meyer, S. B. (2020). Mental health interventions for immigrant-refugee children and youth living in Canada: A scoping review and way forward. *Journal of Mental Health*, 1–14. https://doi.org/10.1080/09638237.2020.1818710

Hilario, C. T., Oliffe, J. L., Wong, J. P.-H., Browne, A. J., & Johnson, J. L. (2015). Migration and young people's mental health in Canada: A scoping review. *Journal of Mental Health*, *24*(6), 414–422. https://doi.org/10.3109/09638237.2015.1078881

Hilario, C. T., Oliffe, J. L., Wong, J. P., Browne, A. J., & Johnson, J. L. (2018). "Just as Canadian as anyone else"? Experiences of second-class citizenship and the mental health of young immigrant and refugee men in Canada. *American Journal of Men's Health*, *12*(2), 210–220. https://doi.org/10.1177/1557988317743384

Hilario, C. T., Vo, D. X., Johnson, J. L., & Saewyc, E. M. (2014). Acculturation, gender, and mental health of southeast asian immigrant youth in Canada. *Journal of Immigrant and Minority Health*, *16*(6), 1121–1129. https://doi.org/10.1007/s10903-014-9978-x

Hilario, C., Louie-Poon, S., Taylor, M., Gill, G. K., & Kennedy, M. (2023). Racism in health services for adolescents: a scoping review. *International Journal of Social Determinants of Health and Health Services*, *53*(3), 343–353. https://doi.org/10.1177/27551938231162560

Hopkins, P. (2019). Social geography I: Intersectionality. *Progress in Human Geography*, *43*(5), 937-947.

Hou, F., & Picot, G. (2004). Visible minority neighbourhoods in Toronto, Montréal, and Vancouver. *Canadian Social Trends*, *72*, 8-13.

Huey Jr, S. J., Park, A. L., Galán, C. A., & Wang, C. X. (2023). Culturally responsive cognitive behavioral therapy for ethnically diverse populations. *Annual Review of Clinical Psychology*, *19*(1), 51-78.

Jarvis, G. E., Kirmayer, L. J., Gómez-Carrillo, A., Aggarwal, N. K., & Lewis-Fernández, R. (2020). Update on the Cultural Formulation Interview. *FOCUS*, *18*(1), 40–46. https://doi.org/10.1176/appi.focus.20190037

Jenkins, E. K., Slemon, A., & Haines-Saah, R. J. (2017). Developing harm reduction in the context of youth substance use: Insights from a multi-site qualitative analysis of young people's harm minimization strategies. *Harm Reduction Journal*, *14*(1), 53. https://doi.org/10.1186/s12954-017-0180-z

Johnson, R. B., & Christensen, L. B. (2024). *Educational research: Quantitative, qualitative, and mixed approaches*. Sage publications.

Johnstone, M. J., & Kanitsaki, O. (2007). An exploration of the notion and nature of the construct of cultural safety and its applicability to the Australian health care context. *Journal of Transcultural Nursing*, *18*(3), 247-256.

Jones, N., Kamens, S., Oluwoye, O., Mascayano, F., Perry, C., Manseau, M., & Compton, M. T. (2021). Structural disadvantage and culture, race, and ethnicity in early psychosis services: International Provider Survey. *Psychiatric Services*, *72*(3), 254–263. https://doi.org/10.1176/appi.ps.202000211

Joseph, S. (1993). Connectivity and patriarchy among urban working-class Arab families in Lebanon. *Ethos (Berkeley, Calif.)*, *21*(4), 452–484. https://doi.org/10.1525/eth.1993.21.4.02a00040

Kang, H., & Larson, R. W. (2014). Sense of indebtedness toward parents: Korean American emerging adults' narratives of parental sacrifice. *Journal of Adolescent Research*, *29*(4), 561–581. https://doi.org/10.1177/0743558414528979

Kang, H., Okazaki, S., Abelmann, N., Kim-Prieto, C., & Shanshan Lan. (2010). Redeeming immigrant parents: How Korean American emerging adults reinterpret their childhood. *Journal of Adolescent Research*, *25*(3), 441–464. https://doi.org/10.1177/0743558410361371

Kellermann, N. P. (2013). Epigenetic transmission of holocaust trauma: Can nightmares be inherited. *The Israel Journal of Psychiatry and Related Sciences*, *50*(1), 33-39.

Kerig, P. K. (2005). Revisiting the construct of boundary dissolution: A multidimensional perspective. *Journal of Emotional Abuse*, *5*(2–3), 5–42. https://doi.org/10.1300/J135v05n02_02

Kincheloe, J. L., & McLaren, P. (2011). Rethinking critical theory and qualitative research. In *Key works in critical pedagogy* (pp. 285-326). Brill Sense.

King, M., Smith, A., & Gracey, M. (2009). Indigenous health part 2: The underlying causes of the health gap. *The Lancet*, *374*(9683), 76–85. https://doi.org/10.1016/S0140-6736(09)60827-8

Kirmayer, L. J. (2012). Rethinking cultural competence. *Transcultural Psychiatry*, *49*(2), 149–164. https://doi.org/10.1177/1363461512444673

Kirmayer, L. J., & Young, A. (1998). Culture and somatization: Clinical, epidemiological, and ethnographic perspectives. *Psychosomatic Medicine*, *60*(4), 420–430. https://doi.org/10.1097/00006842-199807000-00006

Kirmayer, L. J., Fung, K., Rousseau, C., Lo, H. T., Menzies, P., Guzder, J., ... & McKenzie, K. (2021). Guidelines for training in cultural psychiatry. *The Canadian Journal of Psychiatry*, *66*(2), 195-246.

Kirmayer, L. J., Groleau, D., Guzder, J., Blake, C., & Jarvis, E. (2003). Cultural consultation: A model of mental health service for multicultural societies. *The Canadian Journal of Psychiatry*, *48*(3), 145-153.

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., Hassan, G., Rousseau, C., & Pottie, K. (2011). Common mental health problems in immigrants and refugees: General approach in primary care. *CMAJ : Canadian Medical Association Journal*, *183*(12), E959–E967. https://doi.org/10.1503/cmaj.090292

Kirmayer, L. J., Simpson, C., & Cargo, M. (2003). Healing traditions: Culture, community and mental health promotion with Canadian Aboriginal peoples. *Australasian Psychiatry*, *11*(1), S15–S23. https://doi.org/10.1046/j.1038-5282.2003.02010.x

Kirmayer, L. J., Weinfeld, M., Burgos, G., Fort, G. G. du, & al, et. (2007). Use of health care services for psychological distress by immigrants in an urban multicultural milieu. *Canadian Journal of Psychiatry*, *52*(5), 295–304.

Koslofsky, S., & Domenech Rodríguez, M. M. (2017). Cultural adaptations to psychotherapy: real-world applications. *Clinical Case Studies*, *16*(1), 3–8. https://doi.org/10.1177/1534650116668273

Kumas-Tan, Z., Beagan, B., Loppie, C., MacLeod, A., & Frank, B. (2007). Measures of cultural competence: examining hidden assumptions. *Academic Medicine*, *82*(6), 548-557

Kurzawa, J., Danseco, E., Lucente, G., Huang, C., Sundar, P., & Allen-Valley, A. (2022). Advancing racial equity, diversity, and inclusion in Ontario’s child and youth mental health sector: Perspectives of agency leaders. *Canadian Psychology / Psychologie Canadienne*, *63*(4), 500–510. https://doi.org/10.1037/cap0000336

Lal, S., Ungar, M., Malla, A., Leggo, C., & Suto, M. (2017). Impact of mental health services on resilience in youth with first episode psychosis: A qualitative study. *Administration and Policy in Mental Health and Mental Health Services Research*, *44*(1), 92–102. https://doi.org/10.1007/s10488-015-0703-4

Landry, D. (2017). Survivor research in Canada: ‘talking’ recovery, resisting psychiatry, and reclaiming madness. *Disability and Society*, *32*(9), 1437–1457. https://doi.org/10.1080/09687599.2017.1322499

Larson, R. W. (2000). Toward a psychology of positive youth development. *American Psychologist*, *55*(1), 170.

Leblanc, S., & Kinsella, E. A. (2016). Toward epistemic justice: A critically reflexive examination of "Sanism" and implications for knowledge generation. *Studies in Social Justice*, *10*(1), 59–78. https://doi.org/10.26522/ssj.v10i1.1324

Lewis-Fernández, R., Aggarwal, N. K., Lam, P. C., Galfalvy, H., Weiss, M. G., Kirmayer, L. J., Paralikar, V., Deshpande, S. N., Díaz, E., Nicasio, A. V., Boiler, M., Alarcón, R. D., Rohlof, H., Groen, S., Dijk, R. C. J. van, Jadhav, S., Sarmukaddam, S., Ndetei, D., Scalco, M. Z., … Vega-Dienstmaier, J. M. (2017). Feasibility, acceptability and clinical utility of the Cultural Formulation Interview: Mixed-methods results from the DSM-5 international field trial. *The British Journal of Psychiatry*, *210*(4), 290–297. https://doi.org/10.1192/bjp.bp.116.193862

Li, H., & Browne, A. (2000). Defining mental illness and accessing mental health services: Perspectives of Asian Canadians. *Canadian Journal of Community Mental Health*, *19*(1).

Lijtmaer, R. (2017). Untold stories and the power of silence in the intergenerational transmission of social trauma. *The American Journal of Psychoanalysis*, *77*(3), 274-284

Logie, C., James, Ll., Tharao, W., & Loutfy, M. (2013). Associations between HIV-related stigma, racial discrimination, gender discrimination, and depression among HIV-positive African, Caribbean, and Black women in Ontario, Canada. *AIDS Patient Care and STDs*, *27*(2), 114–122. https://doi.org/10.1089/apc.2012.0296

Loh, J. (2013). Inquiry into issues of trustworthiness and quality in narrative studies: A perspective. *The Qualitative Report, 18*(33), 1-15. Retrieved from http://search.proquest.com.ezproxy.library.uvic.ca/scholarly-journals/inquiry-into-issues-trustworthiness-quality/docview/1505321022/se-2

Louie-Poon, S., Hilario, C., Scott, S. D., & Olson, J. (2022). Toward a moral commitment: Exposing the covert mechanisms of racism in the nursing discipline. *Nursing Inquiry*, *29*(1), e12449. https://doi.org/10.1111/nin.12449

MacMullin, L., Mvunga, J., & VanderLaan, D. (2024). Risk and resilience among BIPOC trans youth: An interpretative phenomenological study. *Bulletin of Applied Transgender Studies*, *3*(3-4).

Mai, I. (2024). *IBPOC youth perspectives on anti-racist and mental wellness programming in schools.* [Unpublished master's thesis]. University of Victoria.

Manzi, C., Vignoles, V. L., Regalia, C., & Scabini, E. (2006). Cohesion and enmeshment revisited: Differentiation, identity, and well-being in two European countries. *Journal of Marriage and Family*, *68*(3), 673–689.

Marsh, T. N., Coholic, D., Cote-Meek, S., & Najavits, L. M. (2015). Blending Aboriginal and Western healing methods to treat intergenerational trauma with substance use disorder in Aboriginal peoples who live in Northeastern Ontario, Canada. *Harm Reduction Journal*, *12*. https://doi.org/10.1186/s12954-015-0046-1

Martin, D. H. (2012). Two-Eyed Seeing: A framework for understanding Indigenous and non-Indigenous approaches to Indigenous health research. *Canadian Journal of Nursing Research Archive*, 20–43.

Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist*, *56*(3), 227.

Masten, A. S., & Cicchetti, D. (2010). Developmental cascades. *Development and Psychopathology*, *22*(3), 491–495. https://doi.org/10.1017/S0954579410000222

McCuistian, C., Kimball, S. L., Buitron de la Vega, P., Godfrey, L. B., Fortuna, L. R., & Valentine, S. E. (2022). Consideration of racism experiences in the implementation of trauma-focused therapy in primary care. *Health services research*, *57*, 235-248.

McDonald, J. T., & Kennedy, S. (2004). Insights into the 'healthy immigrant effect': Health status and health service use of immigrants to Canada. *Social Science & Medicine*, *59*(8), 1613–1627. https://doi.org/10.1016/j.socscimed.2004.02.004

Measham, T., Guzder, J., Rousseau, C., Pacione, L., Blais-McPherson, M., & Nadeau, L. (2014). Refugee children and their families: Supporting psychological well-being and positive adaptation following migration. *Current Problems in Pediatric and Adolescent Health Care*, *44*(7), 208-215.

Menzies, P. (2008). Developing an Aboriginal healing model for intergenerational trauma. *International Journal of Health Promotion and Education*, *46*(2), 41–48. https://doi.org/10.1080/14635240.2008.10708128

Murray, K. E., Davidson, G. R., & Schweitzer, R. D. (2010). Review of refugee mental health interventions following resettlement: Best practices and recommendations. *American Journal of Orthopsychiatry*, *80*(4), 576–585. https://doi.org/10.1111/j.1939-0025.2010.01062.x

Noh, S., Kaspar, V., & Wickrama, K. A. S. (2007). Overt and subtle racial discrimination and mental health: Preliminary findings for Korean immigrants. *American Journal of Public Health*, *97*(7), 1269–1274. https://doi.org/10.2105/AJPH.2005.085316

O'Mahony, J. M., Donnelly, T. T., Raffin Bouchal, S., & Este, D. (2013). Cultural background and socioeconomic influence of immigrant and refugee women coping with postpartum depression. *Journal of Immigrant and Minority Health*, *15*(2), 300–314. https://doi.org/10.1007/s10903-012-9663-x

Olawo, O., Pilkington, B., & Khanlou, N. (2021). Identity-related factors affecting the mental health of African immigrant youth living in Canada. *International Journal of Mental Health and Addiction*, *19*(3), 701–713. https://doi.org/10.1007/s11469-019-00177-z

Organization for Economic Cooperation and Development. (2021). Where: Global reach. https://www.oecd.org/about/members-and-partners/

Oriola, T., Neverson, N., & Adeyanju, C. T. (2012). 'They should have just taken a gun and shot my son': Taser deployment and the downtrodden in Canada. *Social Identities*, *18*(1), 65–83. https://doi.org/10.1080/13504630.2012.629514

Ortiz, D. (2024). *The intergenerational transmission of colonial mentality within Filipino Canadian families.* [Unpublished doctoral dissertation]. University of Victoria.

Ospina, S. M., & Dodge, J. (2005). It's about time: Catching method up to meaning—The usefulness of narrative inquiry in public administration research. *Public Administration Review*, *65*(2), 143-157.

Piper, K. N., Elder, A., Renfro, T., Iwan, A., Ramirez, M., & Woods-Jaeger, B. (2022). The importance of anti-racism in trauma-informed family engagement. *Administration and Policy in Mental Health and Mental Health Services Research*, *49*(1), 125-138.

Polkinghorne, D. E. (1995). Narrative configuration in qualitative analysis. *International Journal of Qualitative Studies in Education*, *8*(1), 5–23. https://doi.org/10.1080/0951839950080103

Pomeroy, E., Mushrif-Tripathy, V., Cole, T.J. *et al.* Ancient origins of low lean mass among South Asians and implications for modern type 2 diabetes susceptibility. *Sci Rep* **9**, 10515 (2019). https://doi.org/10.1038/s41598-019-46960-9

Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of counseling psychology*, *52*(2), 126.

Ranjbar, N., Erb, M., Mohammad, O., & Moreno, F. A. (2020). Trauma-informed care and cultural humility in the mental health care of people from minoritized communities. *Focus*, *18*(1), 8-15.

Rathod, S., Gega, L., Degnan, A., Pikard, J., Khan, T., Husain, N., Munshi, T., & Naeem, F. (2018). The current status of culturally adapted mental health interventions: A practice-focused review of meta-analyses. *Neuropsychiatric Disease and Treatment*, *Volume 14*, 165–178. https://doi.org/10.2147/NDT.S138430

Reaume-Zimmer, P., Chandrasena, R., Malla, A., Joober, R., Boksa, P., Shah, J. L., ... & Lal, S. (2019). Transforming youth mental health care in a semi-urban and rural region of Canada: A service description of ACCESS Open Minds Chatham-Kent. *Early intervention in psychiatry*, *13*, 48-55.

Reeves, A., & Stewart, S. (2017). Healing the spirit: Exploring sexualized trauma and recovery among Indigenous men in Toronto. *American Indian & Alaska Native Mental Health Research: The Journal of the National Center*, *24*(1), 30–60. https://doi.org/10.5820/aian.2401.2017.30

Rousseau, C., Measham, T., & Nadeau, L. (2013). Addressing trauma in collaborative mental health care for refugee children. *Clinical Child Psychology and Psychiatry*, *18*(1), 121–136. https://doi.org/10.1177/1359104512444117

Rowan, M., Poole, N., Shea, B., Gone, J. P., Mykota, D., Farag, M., ... & Dell, C. (2014). Cultural interventions to treat addictions in Indigenous populations: Findings from a scoping study. *Substance abuse treatment, prevention, and policy*, *9*(1), 1-27.

Ryerson, E. (1847). Report of Dr. Ryerson on industrial schools. https://ehprnh2mwo3.exactdn.com/wp-content/uploads/2021/01/Ryerson-Report.pdf

Salam, Z., Carranza, M., Newbold, B., Wahoush, O., & Joseph, A. (2024). Racialized immigrants' encounters of barriers and facilitators in seeking mental healthcare services in Ontario, Canada. *Community Mental Health Journal*. https://doi.org/10.1007/s10597-024-01362-8

Salam, Z., Odenigbo, O., Newbold, B., Wahoush, O., & Schwartz, L. (2022). Systemic and individual factors that shape mental health service usage among visible minority immigrants and refugees in Canada: A scoping review. *Administration and Policy in Mental Health and Mental Health Services Research*, *49*(4), 552–574. https://doi.org/10.1007/s10488-021-01183-x

Salami, B., Denga, B., Taylor, R., Ajayi, N., Jackson, M., Asefaw, M., & Salma, J. (2021). Access to mental health for Black youths in Alberta. *Health Promotion and Chronic Disease Prevention in Canada*, *41*(9), 245–253. https://doi.org/10.24095/hpcdp.41.9.01

Salami, B., Idi, Y., Anyieth, Y., Cyuzuzo, L., Denga, B., Alaazi, D., & Okeke-Ihejirika, P. (2022). Factors that contribute to the mental health of Black youth. *Canadian Medical Association Journal*, *194*(41), E1404–E1410. https://doi.org/10.1503/cmaj.212142

Sanders, R. (2020, July 21). A layered look at Canadian and U.S. immigration. https://www.wilsoncenter.org/article/layered-look-canadian-and-us-immigration

Sangalang, C. C., & Vang, C. (2017). Intergenerational trauma in refugee families: A systematic review. *Journal of Immigrant and Minority Health*, *19*(3), 745–754. https://doi.org/10.1007/s10903-016-0499-7

Shaia, W., Bailey, T. S., Beegle, C., & Tennor, M. (2024). Critiques of Trauma-Informed Systems. In *Encyclopedia of Social Work*.

Sheikhan, N. Y., Henderson, J. L., Halsall, T., Daley, M., Brownell, S., Shah, J., Iyer, S. N., & Hawke, L. D. (2023). Stigma as a barrier to early intervention among youth seeking mental health services in Ontario, Canada: A qualitative study. *BMC Health Services Research*, *23*(1), 86. https://doi.org/10.1186/s12913-023-09075-6

Shevell, M. C., & Denov, M. S. (2021). A multidimensional model of resilience: Family, community, national, global and intergenerational resilience. *Child Abuse & Neglect*, 105035. https://doi.org/10.1016/j.chiabu.2021.105035

Sim, A., Ahmad, A., Hammad, L., Shalaby, Y., & Georgiades, K. (2023). Reimagining mental health care for newcomer children and families: A qualitative framework analysis of service provider perspectives. *BMC Health Services Research*, *23*(1), 699. https://doi.org/10.1186/s12913-023-09682-3

Simpson, A. (2007). On ethnographic refusal: Indigeneity, ‘voice’ and colonial citizenship. *Junctures: The Journal for Thematic Dialogue*, (9).

Slemon, A., Jenkins, E. K., Haines-Saah, R. J., Daly, Z., & Jiao, S. (2019). “You can’t chain a dog to a porch”: A multisite qualitative analysis of youth narratives of parental approaches to substance use. *Harm Reduction Journal*, *16*(1), 26. https://doi.org/10.1186/s12954-019-0297-3

Smith, T. B., Rodríguez, M. D., & Bernal, G. (2011). Culture. *Journal of Clinical Psychology*, *67*(2), 166–175. https://doi.org/10.1002/jclp.20757

Soto, A., Smith, T. B., Griner, D., Rodríguez, M. D., & Bernal, G. (2018). Cultural adaptations and therapist multicultural competence: Two meta-analytic reviews. *Journal of Clinical Psychology*, *74*(11), 1907–1923. https://doi.org/10.1002/jclp.22679

Spencer, M. B. (2007). Phenomenology and ecological systems theory: Development of diverse groups. *Handbook of child psychology*, *1*.

Stafford, M., Newbold, B. K., & Ross, N. A. (2011). Psychological distress among immigrants and visible minorities in Canada: A Contextual Analysis. *International Journal of Social Psychiatry*, *57*(4), 428–441. https://doi.org/10.1177/0020764010365407

Statistics Canada (2015, November 30a). Income: Median total income is lower for Aboriginal people. https://www150.statcan.gc.ca/n1/pub/89-645-x/2010001/income-revenu-eng.htm

Statistics Canada (2015, November 30b). Section 1: Census metropolitan areas. https://www150.statcan.gc.ca/n1/pub/91-214-x/2015000/section01-eng.htm

Statistics Canada (2019, August 9c). Census Profile, 2016 Census, Greater Vancouver, Regional district [Census division], British Columbia and Saskatchewan. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/page.cfm?Lang=E&Geo1=CD&Code1=5915&Geo2=PR&Code2=47&SearchText=Greater+Vancouver&SearchType=Begins&SearchPR=01&B1=All&TABID=1&type=1

Statistics Canada (2019, August 9d). Census Profile, 2016 Census, Victoria, City [Census subdivision], British Columbia and Canada [Country]. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/page.cfm?Lang=E&Geo1=CSD&Code1=5917034&Geo2=PR&Code2=01&SearchText=victoria&SearchType=Begins&SearchPR=01&B1=All&TABID=1&type=1

Statistics Canada. (2009, June 29). *Immigrants in rural Canada: 2006.* https://www150.statcan.gc.ca/n1/pub/21-006-x/21-006-x2008002-eng.htm

Statistics Canada. (2017, October 25). Aboriginal peoples in Canada: Key results from the 2016 Census. https://www150.statcan.gc.ca/n1/daily-quotidien/171025/dq171025a-eng.htm?indid=14430-1&indgeo=0

Statistics Canada. (2019, August 9b). Census Profile, 2016 Census, Visible minority. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/page.cfm?Lang=E&Geo1=PR&Code1=01&Geo2=PR&Code2=01&Data=Count&SearchText=Canada&SearchType=Begins&SearchPR=01&B1=Visible%20minority&TABID=1

Statistics Canada. (2019, June 28a). *Suicide among First Nations people, Métis and Inuit (2011-2016): Findings from the 2011 Canadian Census Health and Environment Cohort (CanCHEC)*. https://www150.statcan.gc.ca/n1/pub/99-011-x/99-011-x2019001-eng.htm

Statistics Canada. (2020, April 17). First Nations people, Métis and Inuit and COVID-19: Health and social characteristics. https://www150.statcan.gc.ca/n1/daily-quotidien/200417/dq200417b-eng.htm

Stergiopoulos, V., Gozdzik, A., Misir, V., Skosireva, A., Sarang, A., Connelly, J., Whisler, A., & McKenzie, K. (2016). The effectiveness of a Housing First adaptation for ethnic minority groups: Findings of a pragmatic randomized controlled trial. *BMC Public Health*, *16*(1), 1110. https://doi.org/10.1186/s12889-016-3768-4

Stewart, S. L. (2008). Promoting Indigenous mental health: Cultural perspectives on healing from Native counsellors in Canada. *International Journal of Health Promotion and Education*, *46*(2), 49–56. https://doi.org/10.1080/14635240.2008.10708129

Tardif, C. Y., & Geva, E. (2006). the link between acculturation disparity and conflict among Chinese Canadian immigrant mother-adolescent dyads. *Journal of Cross-Cultural Psychology*, *37*(2), 191–211. https://doi.org/10.1177/0022022105284496

Taylor, D., & Richards, D. (2019). Triple jeopardy: Complexities of racism, sexism, and ageism on the experiences of mental health stigma among young Canadian Black women of Caribbean descent. *Frontiers in Sociology*, *4*. https://doi.org/10.3389/fsoc.2019.00043

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, *9*(2), 117-125

Thomson, M. S., Chaze, F., George, U., & Guruge, S. (2015). Improving immigrant populations' access to mental health services in Canada: A review of barriers and recommendations. *Journal of immigrant and minority health*, *17*(6), 1895-1905.

Turpel-Lafond, M.E. (2020). *In plain sight: Addressing Indigenous-specific racism and discrimination in B.C. health care.* Government of British Columbia. https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Full-Report.pdf

Turuba, R., Cormier, W., Zimmerman, R., Ow, N., Zenone, M., Quintana, Y., Jenkins, E., Ben-David, S., Raimundo, A., Marcon, A. R., Mathias, S., Henderson, J., & Barbic, S. (2024). Exploring how youth use tiktok for mental health information in British Columbia: Semistructured interview study with youth. *JMIR Infodemiology*, *4*, e53233. https://doi.org/10.2196/53233

United Nations. (n.d.). Global issues: Youth. https://www.un.org/en/global-issues/youth#:~:text=There%20is%20no%20universally%20agreed,resolution%2036/28%20of%201981.

Van Ngo, H. (2009). Patchwork, sidelining and marginalization: Services for immigrant youth. *Journal of Immigrant & Refugee Studies*, *7*(1), 82–100. https://doi.org/10.1080/15562940802687280

Vang, Z. M., Sigouin, J., Flenon, A., & Gagnon, A. (2017). Are immigrants healthier than native-born Canadians? A systematic review of the healthy immigrant effect in Canada. *Ethnicity & Health*, *22*(3), 209–241. https://doi.org/10.1080/13557858.2016.1246518

Velez, G., & Spencer, M. B. (2018). Phenomenology and intersectionality: Using PVEST as a frame for adolescent identity formation amid intersecting ecological systems of inequality. *New Directions for Child and Adolescent Development*, *2018*(161), 75-90.

Weerasinghe, N., Wright, A. L., VanEvery, R., & Mohammed, S. (2023). A narrative review of mental health services for indigenous youth in Canada: Intersectionality and cultural safety as a pathway for change. *Journal of Recovery in Mental Health*, *6*(2), 33–55. https://doi.org/10.33137/jrmh.v6i2.39353

Wells, J. C., Pomeroy, E., Walimbe, S. R., Popkin, B. M., & Yajnik, C. S. (2016). The elevated susceptibility to diabetes in India: An evolutionary perspective. *Frontiers in Public Health*, *4*, 145. https://doi.org/10.3389/fpubh.2016.00145

Wendt, D. C., Gone, J. P., & Nagata, D. K. (2015). Potentially harmful therapy and multicultural counseling: Bridging two disciplinary discourses. *The Counseling Psychologist*, *43*(3), 334-358. https://doi.org/10.1177/0011000014548280

Williams, M. T., Khanna Roy, A., MacIntyre, M.-P., & Faber, S. (2022). The traumatizing impact of racism in Canadians of colour. *Current Trauma Reports*, *8*(2), 17–34. https://doi.org/10.1007/s40719-022-00225-5

Woltmann, E. M., Whitley, R., McHugo, G. J., Brunette, M., Torrey, W. C., Coots, L., ... & Drake, R. E. (2008). The role of staff turnover in the implementation of evidence-based practices in mental health care. *Psychiatric Services*, *59*(7), 732-737.

Woods-Jaeger, B. A., Cho, B., Sexton, C. C., Slagel, L., & Goggin, K. (2018). Promoting resilience: Breaking the intergenerational cycle of adverse childhood experiences. *Health Education & Behavior*, *45*(5), 772–780. https://doi.org/10.1177/1090198117752785

Wu C., & Chao R. K. (2017). Parent–adolescent relationships among Chinese immigrant families: An indigenous concept of Qin. *Asian American Journal of Psychology,* 8, 323-338.

Wu, Z., Hou, F., & Schimmele, C. M. (2011). Racial diversity and sense of belonging in urban neighborhoods. *City & Community*, *10*(4), 373-392.

Yehuda, R., Daskalakis, N. P., Bierer, L. M., Bader, H. N., Klengel, T., Holsboer, F., & Binder, E. B. (2016). Holocaust exposure induced intergenerational effects on FKBP5 methylation. *Biological Psychiatry*, *80*(5), 372-380.

Yehuda, R., Daskalakis, N. P., Lehrner, A., Desarnaud, F., Bader, H. N., Makotkine, I., ... & Meaney, M. J. (2014). Influences of maternal and paternal PTSD on epigenetic regulation of the glucocorticoid receptor gene in Holocaust survivor offspring. *American Journal of Psychiatry*, *171*(8), 872-880.

Yoo, G. J., & Kim, B. W. (2010). Remembering sacrifices: Attitude and beliefs among second-generation Korean Americans regarding family support. *Journal of Cross-Cultural Gerontology*, *25*(2), 165–181. https://doi.org/10.1007/s10823-010-9116-8

Yuval-Davis, N. (2015). Situated intersectionality and social inequality. *Raisons Politiques*, (2), 91-100.

Appendix A

Story-Sharing Prompts

Your mental health story:

- How do you believe your mental health problems developed?
    - What mental health problems were you experiencing?
    - Do you remember at what age you began to notice the mental health problems?
- Who did you communicate your problems to, why and how?
- Who did you not communicate your problems to and why?
- What services did you access (or not access) and what was the experience like?
    - What prompted you to seek care?
    - Did you experience any barriers in accessing care or gaps in the care you received?
    - What other services do you think would have been helpful to you?
- How did you cope with your mental health problems? What are you proud of regarding your coping?

[If family does not come up with the previous prompts.] Your family's story. Sometimes there can be silence around these topics in families because of how sensitive they are.

- Do you have a family history of mental health problems?
- Does your family have historical trauma/intergenerational trauma/racial trauma? If so, do you know the stories of your family/people?
- Do you know stories of your family's intergenerational resilience?

In your ideal world, what would mental healthcare look like?

- What did you like/appreciate about the mental health care you receive(d)?
- What do you wish your mental health care was like?

Appendix B

Informed Consent Form: Story-Sharing Meeting

A Narrative Exploration of the Experience of Racialized Youth Who Receive Mental Health Services in Victoria, BC

Principal Investigator:

Erica Woodin, PhD.
Department of Psychology
University of Victoria
Email: ewoodin@uvic.ca

Co-Investigator:

Pauline Song, MSc
Doctoral Candidate
Department of Psychology
University of Victoria
Email: psong@uvic.ca

Dear Participant,

Thank you for your interest in this study. You are invited to be part of this study because you identify as being a young person of colour and you have accessed public mental health services in the Greater Victoria Area in British Columbia.

Your participation is voluntary. You have the right to not participate in this study. If you decide to participate, you may still choose to withdraw from the study at any time without any negative consequences.

Overview of the Study

The purpose of this study is to explore your experiences of going through the public mental health system as a racialized youth (e.g., Indigenous, Black, person of colour) in Victoria, BC. To understand your experiences, this will involve telling your mental health story and sharing about any factors that may be related. As well, we want to centre your voice, which means that you have the option of collaborating with the interpretation and construction of your story, and that you have final say over how your story is written.

Who is Conducting this Study?

The research team includes the principal investigator and Co-Investigator (you!) and is guided by consultations with the community. This study is being conducted for Pauline Song's doctoral dissertation.

Study Procedures

Over the period of a few months, Pauline Song will meet with you to understand and document your story (approximately 3 to 7 hours of your time):

1. Story-sharing: Pauline will talk with you about your mental health journey and your experience of the public mental health system in Victoria. It is important to capture your story in the way that you want it to be told. This discussion can take anywhere from 30 minutes to two hours. The meeting will be audio taped if done in person, and it will be audio and video recorded if done over Zoom.

2. The meeting will be transcribed using a transcription service and Pauline will provide you with a copy to review it. If the meeting was recorded over Zoom, then Zoom transcription services will be used to automatically generate a transcript and/or transcribed using an additional transcription service. You will be invited to read over the transcript a few times using different questions to guide you (about 1 hour of your time).

3. Pauline will meet with you again to have a collaborative discussion about your interpretation, feedback, and reflections on the transcript (again, anywhere from 30 minutes to two hours). This input will be used to guide how Pauline writes your narrative/story.

4. Finally, you are invited to be the final editor of your narrative. As you read over your story, please ensure that it feels true to you and your experience (about one to two hours of your time).

5. Pauline will analyze the stories of the participants and look for common themes. A summary of these findings will be provided to you.

Results of the Study

Results of the study will be used across various contexts for knowledge translation, including: for the fulfillment of Pauline's dissertation, presentations at scholarly and community meetings, via the internet (e.g., social media, UVicSpace, etc.), and directly to you and other stakeholders.

Potential Risks and Benefits

As this study explores your personal subjective experiences related to the mental health system in Victoria, you might experience emotional discomfort during or after the interviews. You will be provided with referral sources for professional support. As this may be an emotionally sensitive topic, please let the researcher know if you are feeling uncomfortable or distressed. A debriefing session with a registered psychologist can be provided after the interview or the collaborative discussion session. In between and after the sessions, if you experience continued emotional distress and are in need of immediate psychological relief, please contact the Vancouver Island Crisis Line (1-888-494-3888). At the end of this form, there is a list of support resources in case you want to access them.

If you have any concerns about the research procedures, you are welcome to contact Dr. Erica Woodin directly without letting Pauline Song know.

Study Withdrawal

Whether you participate in this study will always be your choice. There are no consequences of withdrawing from the study. You can decide to stop/withdraw at any time by letting any member of our research team know. If you do decide to discontinue, you will be asked in writing (e.g., an email or a signed form) whether you want your information/story removed from the study completely, or if you want your story to be included (e.g., Pauline continues to write the story based on the interview). If you do not indicate that you want your story to be included, then all of your information will be removed from the study.

COVID-19

All study activities can be done online (e.g., via secure UVic Zoom, or over the phone). However, we can also meet in-person if you would prefer. Given that the COVID-19 pandemic is ongoing, meeting in-person will come with risks, such as possible exposure to COVID-19. Researchers and participants agree to not attend in-person meetings if feeling unwell and/or have developed symptoms of COVID-19. Masks and hand sanitizer will be available for all participants who wish to meet in-person. If meeting indoors, masks/face coverings will be mandatory.

Contact tracing will be conducted in case it is discovered that there has been exposure to COVID-19. Participants will be advised if they have or may have come into contact with an individual who has tested positive for COVID-19. Contact information for participants will be stored in a separate file from research data in the event that follow up is needed.

Compensation/Remuneration

To show you our appreciation for taking part in this study, you will be given a $50 honorarium at the end of the interview, and $50 at the end of the collaborative discussion session, for a total of $100.

There are possible benefits to participating in this study. You may experience a greater awareness of your own personal story, and you may also gain a sense of satisfaction knowing that your story may help professionals better understand the experience of racialized youth who are receiving mental health services in Canada.

You will also receive a written copy of your narrative, and a summary of the themes that are consistent across the narratives of the participants. You are also welcome to be involved in the knowledge translation process with the community if you wish.

Confidentiality

To make sure that your privacy is protected, any identifying information will be kept separate, and your name, address, email, and phone number will not be linked with the report. Your name will not be associated with the information you report, and all information will be kept confidential and will not be shared with other participants. To ensure your confidentiality, a pseudonym (i.e., fake name) will be used for transcripts and in the communication of findings. Electronic data will be kept in password protected hard drives and will be encrypted. Only the principal investigator and Co-Investigator will have access to the information. Recordings and transcripts will be destroyed after your final stamp of approval on the narrative. Further consent will be sought if these research materials are used for future research projects.

Please note that despite using a pseudonym, as the written analysis of your story will be available to the public, there is the possibility that there may be enough identifying information that either of you and/or your family may be recognized by others within the community. You will have final editorial say over what is included in your story, which may help to lower this risk.

Limits to Confidentiality

Confidentiality cannot be maintained when:

1. You tell us of a plan to cause serious harm to yourself or others, and the researcher believes you have the intent and ability to carry out this threat in the very near future.
2. A child, including yourself, is at risk of harm or has been harmed.

In these situations, appropriate people will be told about this risk of harm in order to keep everyone safe.

Age of Consent

If you are under the age of 19, you are considered a minor in BC. If you are able to provide informed consent for your own health care, then you are considered a "mature minor" (usually over the age of 13), and as such, you do not need your parent or legal guardian's consent to participate. It is up to you if you would like your parents/guardian to know that you are participating in this research. If you would like to provide them with information about this study, or for your parent/guardian to sign on your behalf, please feel free to share this consent form with your parent/guardian.

Contact for Information About the Study

If you have any concerns or complaints about your rights as a research participant, and/or your experiences while participating in this study, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca).

Consent

Your signature below indicates that you have had your questions about the study answered to your satisfaction and have received a copy of this consent form for your own records. Your signature indicates that you consent to participate in this study, be audiotaped for the purposes of the study, and that your responses may be put into anonymous form.

Name (Print) ____

Date ________________________

Signature ____

Support Resources

Emergency Services

Call 911

Or

Vancouver Island Crisis Line:
24/hours call 1-888-494-3888
6-10pm: text 250-800-3806

Private Services

Vancouver Island Counselling Centre for Immigrants and Refugees (VICCIR)
Phone: 778-404-1777
Email: info@viccir.org

Victoria Native Friendship Centre:
Phone: 250-384-3211

Victoria Youth Empowerment Society:
http://www.vyes.ca/
Phone: 250-383-3514

Kiwanis Emergency Youth Shelter:
http://www.vyes.ca/programs/#2
Phone: 250-386-8282

CREAN Society:
https://creansociety.ca/team

Public Services

Ministry of Children and Family Development Child and Youth Mental Health Services Child and Youth Mental Health

CYMH Saanich Office
201-4478 W. Saanich Road
250-952-5073

CYMH Victoria
302-2955 Jutland Road
250-356-1123

CYMH West Shore
2nd fl. 345 Wale Road
250-391-2223

CYMH Indigenous Child and Youth Mental Health: 250-952-4073

Eating Disorders Program for South Vancouver Island: 250-387-0000

High Risk Services/Project Alive for teens struggling with suicidal thoughts: 250-952-5073

The Foundry
https://foundrybc.ca/victoria/
Phone: 250-383-3552

Discovery Youth and Family Substance Use Services
discovery.southisland@viha.ca
Esquimalt Health Unit
530 Fraser St, 2nd Floor
Phone: 250-519-5313

Appendix C

Consent Form for Co-Investigator Focus Group

A Narrative Exploration of the Experience of Racialized Youth Who Receive Mental Health Services in Victoria, BC

Principal Investigator:

Erica Woodin, PhD.
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University of Victoria
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Co-Investigator:

Pauline Song, MSc
Doctoral Candidate
Department of Psychology
University of Victoria
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Purpose:

You are invited to be a part of this second chapter of the study, where 'Co-Investigators' are welcome to share your perspectives on the themes that emerged from individual stories of young people of color who have accessed public mental health services in the Greater Victoria Area in British Columbia.

Your participation is voluntary. You have the right to not participate in this part of the study. If you decide to participate, you may still choose to withdraw from the study at any time without any negative consequences.

Study Procedures:

You will be part of a focus group of approximately 1-2 hours where you will be given a summary of the themes across the stories and asked to contribute your thoughts and perspectives on whether they resonate with you and feel true to your story. The focus group will be conducted in person, with the option to participate on Zoom. Written notes will be taken during the meeting.

Project Outcomes:

This part of the project will guide the development of discussion themes for knowledge translation to the wider community. Results of the study will be used across various contexts for knowledge translation, including: for the fulfillment of Pauline's dissertation, presentations at scholarly and community meetings, via the internet (e.g., social media, UVicSpace, etc.), and directly to you and other stakeholders.

Potential Risks and Benefits

As this study explores your personal subjective experiences related to the mental health system in Victoria, you might experience emotional discomfort during or after the focus group. n the case that you are feeling distressed during the focus group, there is no obligation to participate in the discussion, and you are welcome to leave the focus group. Further, if you are visibly distressed, Pauline Song will reach out to you to see if you would like to debrief the session. You are also welcome to contact Pauline Song if you become distressed and would like to debrief the session.

A debriefing session with a registered psychologist can be provided. If you experience continued emotional distress and are in need of immediate psychological relief, please contact the Vancouver Island Crisis Line (1-888-494-3888). At the end of this form, there is a list of support resources in case you want to access them.

If you have any concerns about the research procedures, you are welcome to contact Dr. Erica Woodin directly without letting Pauline Song know.

There are possible benefits to participating in this study. You may experience a greater awareness of your own personal story and others', and you may also gain a sense of satisfaction knowing that your story may help professionals better understand the experience of racialized youth who are receiving mental health services in Canada.

Confidentiality:

Electronic data will be kept in password protected hard drives and will be encrypted. To make sure that your privacy is protected, any identifying information will be kept separate from any public dissemination of the results. Your name will not be associated with the perspectives you share. Results of this focus group will be presented in any public findings as discussed by the group and not shared by any specific individuals.

If you choose to take part in a focus group, only limited confidentiality can be offered. By participating in the focus group, the other members will know that you identify as a young person of color and participated as a 'Co-Investigator' in sharing your story of your experiences of accessing the public mental health system in Victoria. Although we encourage all participants to refrain from disclosing the contents of the discussion outside of the focus group, we cannot control what other participants do with the information discussed.

Remuneration/Compensation:

To show you our appreciation for taking part in this part of the study, you will be given a $25 honorarium in addition to food and drinks provided at the meeting.

Age of Consent

If you are under the age of 19, you are considered a minor in BC. If you are able to provide informed consent for your own health care, then you are considered a "mature minor" (usually over the age of 13), and as such, you do not need your parent or legal guardian's consent to participate. It is up to you if you would like your parents/guardian to know that you are participating in this research. If you would like to provide them with information about this study, or for your parent/guardian to sign on your behalf, please feel free to share this consent form with your parent/guardian.

Contact for Information About the Study

If you have any concerns or complaints about your rights as a research participant, and/or your experiences while participating in this study, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca).

Consent

Your signature below indicates that you have had your questions about the study answered to your satisfaction and have received a copy of this consent form for your own records. Your signature indicates that you consent to participate in this study, and that your responses may be put into anonymous form.

Name (Print) ____

Date ________________________

Signature ____

Appendix D

Summary of Themes Presented to Co-Investigators

Area A: The experience of the mental health system

Theme 1: There are differences in who I am vs. how I am perceived

1. Racist assumptions (toward me or my family)
2. My understanding of what's causing my mental health problems is different than professionals' understandings
3. My understanding of my family dynamics is different than professionals' understandings
4. I am 'othered' – racially/culturally; feeling like this system was not meant/designed for me to navigate
5. I am suffering but all they see is "high functioning"

Theme 2: My background/story shapes my experiences

1. Everyone comes from a background where there was a history of colonization (to me, my family, my people)
2. Family members influence my mental health journey
3. There are not many people of colour who were providing me with care/not many people who understood my background and story – when they do, it's a positive experience in a profound way

Theme 3: The meaning I make of my experience:

1. They think I am not deserving of input, care, attention, a voice; I am not entitled to agency
1. I resist these assumptions they make of me (whether outright, or 'even if I can navigate your world, that doesn't mean that I agree with it or have bought into it')
2. I need to be on the lookout for signs that I will be treated differently or not understood
3. I have to, and I will find my care elsewhere then
4. It is possible to receive good care from practitioners who are white
5. It means so much to me when I find a professional who cares for me, human to human
6. I value straightforwardness that is kind and compassionate, even if it's not 'professional'
7. IBPOC can come together (personally and professionally) – I can feel understood without needing to use words to explain it with someone who is IBPOC
8. The importance of family, community (including cultural community), and relationship in well-being

Area B: Commonalities across the stories:

Theme 4: Commonalities across the stories:

2. 'Serious mental illness' – not the types or severity of mental illness that we would expect to go away without treatment (from the research)

3. Interacted with many professions across different systems/institutions
4. The importance of good assessment
5. There is an ability to see complex nuance – not seeing practitioners or the system as all good or all bad
6. Post-secondary education, or plans on going to post-secondary education → highly educated, ambitious young people, who are critical thinkers
7. A clear resilience/a resolve to 'be'/a desire for well-being – fortitude

Area C: Recommendations

Theme 5: Recommendations for the mental health care system/service providers (all of which require some level of cultural attunement or humility)

1. Do not be racist or discriminatory (…sigh), even if you think you are being kind
2. Do not pathologize cultural differences
3. More IBPOC mental health staff
4. Better assessments that *meaningfully* includes the perspective of the person being assessed
5. Listen to requests when they are made – they are not made for no reason
6. Professionals, please be straightforward and kind
7. Limit service provider turnover → prioritize continuity of care with the same service providers when possible (and when there's a good relationship)
8. More group interventions, community, or social connections
9. Frequent and regular therapy appointments during times of need (not only in crisis moments!) – or else things won't really get better
10. Include family (even conceptually) – even when it is complex, the relationsihps with family members are important to the well-being of the person; often the relationships are more positive than the clinician may think
11. There is a gap in care between child mental health services, and the transition to adult mental health services – we need more to bridge the gap (people do not stop having mental health problems when they turn 19)

Area D: The research experience

Theme 6: What was the experience of the research method like? (E.g., Sharing your story, reflecting on your story several times, having the group meeting today)

1. Appreciation for sharing your story, and having the space/opportunity to share it