Beyond the Barriers: First-Voice Perspectives on Facilitators of Leisure Participation

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ABSTRACT

Participation in community-based leisure activity can be beneficial for supporting recovery for people with mental illness, but many barriers are faced. Drawing on first-voice perspectives, this study examined personal, social, and organizational factors that facilitate community-based leisure participation and suggests practical ways to create leisure environments that they would find supportive and more accessible. Five focus groups were conducted with adults in urban and rural communities in Nova Scotia. Through thematic analysis, five types of facilitators were identified: self-management and self-care; finding meaning; active social supports and connections; welcoming environments; and, educating others. Implications for practice are presented.

Keywords: social inclusion, recreation, barriers, first voice, recovery

RÉSUMÉ

Participation à l'activité de loisir communautaire peut être bénéfique pour soutenir le rétablissement pour les personnes maladie mentale, mais de nombreux obstacles sont à surmonter. S'appuyant sur les perspectives de la première voix, cette étude examiner des facteurs personnels, sociaux et organisationnels et suggére façons pratiques de créer des environnements de loisir ils trouveraient soutien et plus accessible. Cinq groupes de discussion ont été menés avec des adultes dans les collectivités urbaines et rurales de la Nouvelle-Écosse. Cinq facilitateurs ont été identifiés: l'autogestion et l'auto-prise en charge; trouver un

sens; des soutiens sociaux actifs et des connexions; environnements accueillants; et, éduquer les autres. Les implications pour la pratique sont présentées.

Mots clés : inclusion sociale, loisirs, barrières, première voix, rétablissement

Contemporary approaches to mental health, highlighted in Canada's mental health strategy *Changing Directions, Changing Lives* (MHCC, 2012) and subsequent framework for action, *Advancing the Mental Health Strategy for Canada* (2016), include the *recovery* model, which supports "living a socially inclusive, productive, satisfying, hopeful, and meaningful life, even when there may be ongoing limitations related to mental health problems and illnesses" (p. 9). However, this approach is challenging given that many mental illnesses result in a range of losses, including the loss of engagement in community-based activities that make life meaningful (Baker & Procter, 2014). People with mental illnesses are among the most stigmatized, marginalized, and socially excluded citizens of our communities, making it difficult for them to regain a level of community participation supportive of recovery (Morgan, Burns, Fitzpatrick, Pinfold, & Priebe, 2007). Thus, there is a particular need to support meaningful engagement in the social life of their communities—that is, to promote social inclusion.

Recreation (a term often used interchangeably with leisure) has been identified as especially beneficial for promoting and supporting good mental health, recovery, and social inclusion (Fenton, White, Gallant, Hutchinson, & Hamilton-Hinch, 2016). Recreation is defined as "the experience that results from freely chosen participation in physical, social, intellectual, creative and spiritual pursuits that enhance individual and community wellbeing" (Interprovincial Sport and Recreation Council and Canadian Parks and Recreation Association, 2015, p. 5). There is growing evidence to suggest that participation in recreation/leisure, including physical, social, and creative pursuits, impacts both physical and mental health when living with a mental illness (Fenton et al., 2017). Iwasaki and colleagues suggest that recovery may be "strengthened in persons with serious mental illness if efforts to promote active living include enjoyable, expressive, and meaningful leisure experiences" (Iwasaki et al., 2014, p. 149).

Although leisure engagement holds much potential in supporting recovery, there are barriers to participation, and leisure remains "largely neglected (and perhaps undervalued)" (Iwasaki et al., 2014, p. 159) as a cost-effective contributor to mental health recovery. Drawing on the perspectives of adults living with mental illness, the purpose of this paper is to better understand the factors they identified as facilitators of community-based recreation/leisure participation. We offer a brief review of literature, the results of five focus groups that explored facilitators of community-based leisure participation, and implications for practice.

LITERATURE REVIEW

Leisure in Mental Health Recovery

Unemployment among people living with a chronic mental illness is estimated to be as high as 80–90% (Shankar et al., 2014), but as Blank, Harries, and Reynolds (2015) found, "non-work" activities can confer some benefits similar to those of employment, such as a sense of connection and belonging, and developing

an identity beyond one's mental illness. Leisure activities in particular can provide key contexts for experiencing recovery and promoting good mental and physical health. Leisure participation is more than just "not work" (Stebbins, 2018); in fact it is viewed as a "key domain of life (not just a trivial activity) that can help people gain valued meanings of life" (Shank, Iwasaki, Coyle, & Messina, 2015, p. 131).

The literature supports a wide range of recovery-oriented benefits from engaging in leisure activity (Iwasaki, Coyle, & Shank, 2010). In their integrative review, Fenton et al. (2017) found that community-based recreation increased self-esteem and self-confidence, expanded social networks and led to feelings of social inclusion, which contributed to recovery. Further synthesized evidence outlines how the social benefits of physical and creative activities enable individuals living with mental illness the opportunity to experience a sense of community (Eime, Young, Harvey, Charity, & Payne, 2013). Leisure provides a context in which to interact with others and to build relationships based on common interests (Sells et al., 2006). In their study of participation in a variety of "community arenas" or venues in which people with mental illnesses participated in meaningful community-based activities, Sells et al. (2006) concluded that:

> …community arenas appear to promote recovery to the extent that they foster an interplay between being with others who are supportive and/or receptive to support, and doing things that feel meaningful, ultimately kindling—and over time building—a favorable redefinition of self. (p. 15)

There is a need to continue to explore factors that impact participation in community-based leisure activities for people living with mental illness.

Barriers to Community-Based Leisure Participation

The literature outlines many barriers to community participation, including leisure, experienced by people living with mental illness. These arise from within the person (internal) or are imposed by, or perceived from, the environment (external). Internal barriers include symptoms or impacts associated with a mental illness or side effects of medications (e.g., depression, anxiety, fatigue, lack of confidence, fear, low motivation, and difficulty structuring time). External barriers include lack of companionship or social supports for participation, inability to pay for programs, lack of knowledge about available options, few facilities located nearby, limited or inflexible program options, or lack of access to transportation to get to recreation facilities (Heasman & Atwal, 2004; McDevitt, Snyder, Miller, & Wilbur, 2006; Pieris & Craik, 2004; Smyth, Harries, & Dorer, 2011).

Another pervasive barrier is perceived stigma. Even people with minimal signs and symptoms of mental illness can experience stigma and discrimination due to damaging stereotypes. As a result, they may feel vulnerable in public spaces, and choose to avoid them (McDevitt et al., 2006). Smyth et al. (2011) discussed how their participants felt excluded, due to experiencing "unfriendly, hostile and bullying reactions…" which included being ignored and a "certain coldness from people" (p. 327). Related to stigma is the self-stigma that results when people internalize the attitudes they perceive from others, underestimate their capabilities, and anticipate rejection, resulting in "pre-emptive self-exclusion" whereby they are reluctant to step forward to pursue opportunities (Fieldhouse, 2012, p. 422).

Facilitators of Leisure Participation

In spite of barriers, a range of facilitators that support participation have been identified, including practices that contribute to people living with mental illness feeling welcomed and included in recreation spaces or programs (Gallant et al., 2019; Hutchinson & Fenton, 2018). For example, having people who could help with organizing and accompany one to participate was a facilitator, serving to "break the ice" in a new situation and share the burden of conversation (Pieris & Craik, 2004).

Staff or peers are frequently key facilitators of participation. As one example, Heasman and Atwal (2004) reported on a "leisure enhancement" project whereby participants were supported to overcome barriers by participating in an assessment of interests, education about the benefits of leisure, action planning and goal setting related to leisure interests, skills training and rehearsal, and then actual participation with support (staff, peers or volunteers).

Rebeiro (2001) discussed the environment as a facilitator, making reference to "affirming environments" (p. 80) characterized by feeling safe and supported in a non-judgmental setting. Rebeiro found that being with others who had similar experiences (in this case, the experience of a mental illness), unconditional acceptance, and having a safe place to belong were key factors supporting participation. Related to this, Hutchinson and Fenton (2018) identified organizational and leadership practices associated with creating welcoming and supportive recreation environments for people living with mental illness, such as greetings by trained staff and peer program leadership. Similarly, participants in the Gallant et al. (2019) study identified supportive people and places, embedded opportunities for socialization, flexibility, inclusive leaders, and supports to feel prepared as factors that contributed to the sense that a recreation setting was welcoming and inclusive.

Summary and Statement of the Problem

While it is clear that leisure can be beneficial for supporting mental health recovery, internal and external barriers to community-based participation are experienced by people living with mental illness. As a result, we believe there is value in looking more closely at facilitators: the things that can serve to make participation possible or easier. Therefore, the purpose of this study was to examine personal, social, and organizational factors that might (a) reduce or ameliorate barriers to community-based leisure participation, and (b) suggest practical ways to create leisure environments that are supportive and accessible to people with mental illness. To align with the recovery approach, it is vital to include the perspectives of those living with mental illness ("first-voice"; Lauckner, Fenton, Gallant, White, & Taylor, 2018). This study addressed the question: From the perspectives of people living with mental illness, what are the key facilitators to accessing leisure activities within their communities?

RESEARCH APPROACH AND METHODOLOGY

Context

This qualitative study, deriving from the social constructionist paradigm, sought first-voice perspectives within focus groups throughout Nova Scotia, Canada. It was one of several initiatives of a collaborative known as the Recreation for Mental Health (R4MH) project, which engaged university-based researchers,

representatives from Recreation Nova Scotia, related non-profit organizations, and individuals with lived experience of mental health challenges, with a goal of increasing opportunities for leisure participation and social inclusion for people with mental health challenges.

Study participants, recruitment, and data collection

Following university ethics board approval, a "first-voice research associate" was identified within each of five community-based centres serving people with mental health challenges (drop-in centres or clubhouses) throughout the province to assist with recruiting (using convenience sampling) and organizing focus groups. Participants were recruited through posters, verbal announcements, and invitations to participate by the first-voice research associates. Eligible participants were adults who self-identified as living with mental health challenges. Although not a requirement of participation, all participants had existing connections with the organizations that hosted the focus group they attended. Focus groups were conducted in rural towns (n = 3) and urban locations (n = 2). In each setting, the first-voice research associate joined one or two researchers to assist with facilitation of the focus groups. This was very helpful in attuning the researchers to culturally sensitive needs and other requirements of the group. For example, one focus group was held with a group of Indigenous participants. The research associate requested that a "smudging" occur at the outset to validate the importance of the event and to put participants at ease, and the researchers were happy to oblige.

With written participant consent (n = 34), each of five focus groups (60–90 minutes in length) was audio-recorded, and later transcribed. Focus groups took place from 2014–2017. Open-ended questions explored the role of leisure in recovery, and the internal and external factors that both supported and prevented leisure participation and social inclusion. The process of thematic analysis as outlined by Braun and Clarke (2006) was implemented by two members of the research team. This process included familiarizing themselves with the data, initial coding, collaborating to resolve queries, collating codes into potential themes, and developing a thematic "map" representative of the data.

RESULTS

As in the literature, participants confirmed the value of leisure participation in support of recovery. As one participant pointed out:

> …whether it's volunteering or doing other activities for recovery, it is normalizing again, getting back to new or old activities instead of being lost in your mind with all you have experienced. It is a positive detachment where you engage again…it is a good energy channeller.

Likewise, participants confirmed facing barriers aligning with those in the literature, including both internal and external, and these formed the basis on which to engage participants in discussing facilitators. The following are the key internal, social, and organizational facilitators identified across the five focus groups. The individual facilitators of self-management and self-care and finding meaning are presented first, followed by social facilitators consisting of active social supports and connections. Organizational facilitators included welcoming environments and educating others. Within each, representative quotes are provided to illustrate the theme.

Self-Management and Self-Care

In response to internal barriers, participants described the things they did to self-manage their illness or to take care of themselves more generally. The importance of taking medications and their key role in making other aspects of recovery possible was pointed out. "[T]he medication I was taking made a big difference. I don't think I would have been able to do very much of anything on my own without the medication, without the different treatments." Participants also talked about being careful to only put themselves in environments where they perceived they would be welcomed, or where they were comfortable self-disclosing their illness. As one person said, "I judge where I'd probably be welcomed or not depending on how someone there was received."

Self-monitoring symptoms, being okay to leave a program when experiencing distress, and giving themselves permission to slowly get back into activities were also identified as important illness-management strategies. As one person said, "If I do have a panic attack I just leave." Related to this was the importance of not overcommitting oneself: "The balancing things is, I find, not over-committing or not taking on too much." Not being too hard on themselves when experiencing poor mental health was also emphasized: "But I just think there should be a caution sign not to feel badly about yourself because you 'should' do it, because we should stop 'shoulding' ourselves." Some participants highlighted the importance of intentionally avoiding situations that may trigger mental health or addiction problems, like not going to a bar or nightclub where temptations may exist.

Self-management strategies involved participants developing self-efficacy in speaking for themselves or being self-advocates. As one participant said, "I just come out and say I suffer from depression and anxiety. That's why I'm not able to come in and do this or promise to do this. I'm becoming more and more open about it." Another added, "I've decided to open up about it. I found it very liberating." Collective activities such as volunteering as a group to share personal experiences of mental illness (e.g., in university classes) helped participants to be increasingly comfortable in doing so.

Finally, some participants talked about how, with the onset of their illness, they had lost energy, interest, and social connections, and how their leisure interests had now shifted to more reflective and soothing activities, such as meditating by a lake, connecting with nature, having time to themselves, writing poetry, or taking time to "listen to birds, listen to the breeze, listen to water." Overall, participants indicated a self-awareness of what they needed personally, which included a synergy between medical management, symptom monitoring, and self-efficacy in self-management, such as choosing soothing activities in environments where they felt comfortable.

Finding Meaning

Much of the discussion during the focus groups focused on the importance of meaning as it related to participation. For some people, it was meaningful to be around others and feel accepted by them, regardless of the activity. For others, meaning was derived from pursuing specific interests or talents either individually, or in concert with others. "If you get a passion, if you find something that you enjoy, you tend to get involved in a responsibility to the other people with that passion…." Participation was also meaningful when people felt they were needed or had something to contribute. "Giving back" or volunteering were valued, both as

therapeutic and growth opportunities. As one example, "I started teaching and then I had to go to class because people were relying on me and that really, really pulls you out. Then you don't have time to be depressed." Supporting this, one peer leader noted, "I think people need to feel not only that they're giving back but that they need to feel that what they're doing is worthwhile, and that there's a purpose."

Participation was also meaningful when there were a variety of different ways for all people to participate (including being an observer). The following is a longer excerpt from one of the peer leaders who facilitates participant-driven music and dance programming. The program evolved by building on talents/interests of participants and providing opportunities to participate in a variety of ways:

> We found out that a couple of members played…used to play ukulele, that's how we started to incorporate the ukulele…so we slowly started incorporating songs with the support of [name] who was open to it… either starting the group or ending the group with a song or two, and it was wonderful… So the music, the sing-alongs and the jams came out of that…. [And] because people have said we like to move around, we like to dance, we found a space because of that, because of that feedback, for the winter where we have permission to bring in music and we can just flail around to our heart's desire, dance, or move or just sit and listen or whatever we want... So it's that kind of feedback, and things are kind of evolving slowly.

Seeing activity evolve from the interests and input of those attending the centres created meaningful opportunities for both leadership and participation, and enabled participants to try new things or take part in previously enjoyed activity in a safe environment.

Welcoming Environments

Participants described characteristics of the *context* or *setting* that enabled them to feel welcomed, accepted, and included. While some mentioned appreciation of free coffee, or no or low costs to attend, most frequently they talked about being accepted by peers and staff. Speaking about a Clubhouse environment specifically, one participant said "Yeah. We feel accepted here." Two others noted "It's a safe place" where people "have to be treated like anyone else." Being with people who were positive or happy and being treated respectfully was also emphasized. Building on each other's perspectives, participants in one focus group mentioned they valued "happy looking people," "people who are compassionate," "[people who] actually look at you and listen to you when you're talking."

Many of these ideas were intertwined. For example, it was an "open door policy," with low or no costs, that enabled people to first get through the door. Then, it seemed that flexible programming (e.g., not having to commit to being there every week) and the social environment—particularly the other participants and staff—helped people to feel comfortable to stay or give a program a try. One participant noted, "We go when we want…and we don't have to go. We don't have to say anything." Speaking about his experience within a community-based setting another said, "community band is just community band, but you're not obligated to go every week… That's another policy that's really helpful."

The physical environment also made a difference to creating a welcoming environment; music to create a mood and spaces structured to enable people to sit quietly by themselves or to engage in self-directed activities were emphasized. Programming such as art or music workshops, cooking groups/collective meals, education sessions and planned outings and activities offered within some of the centres (especially when required supplies and equipment were provided) were highly valued.

Active Social Support and Connections

Beyond feeling welcomed and accepted, there were specific things peers and staff did to help facilitate social connections and participation, both within the context of the centres and within their broader communities. Participants mentioned how a personal invitation to visit the centre was instrumental for getting them through the door or trying a new activity. As an example, one person shared:

> [M]y daughter has had mental illness…she's a very capable person but she tends not to join things. She needs to have an invitation. "I'd like to see you come, please come." And I think that maybe someone who has low self-esteem because they feel that they're different or inferior or whatever needs that invitation. Not just a welcome, but an invitation to come and join.

Participants also described how being with others who they perceived to be the same as them, having someone to do things with and, especially, having someone to go with them the first time, were all important facilitators of participation. As one person noted, "It's a lot easier to do things you might not be able to do on your own if you belong to a group. It really makes a big difference. You have people to help you out." Another commented, "There's always that first connection, breaking that ice or breaking that barrier, or whatever. But if someone went with you and you made the connection…then the next time you'd be okay to go by yourself, wouldn't you?" The idea that participation in activities in mental health centres could be a stepping stone to build confidence and skills for more self-directed community participation was also noted. As one participant mentioned after experiencing activities at one of the centres, "Later on I was able to, on my own, take my own initiative to do any number of things."

Active support was also demonstrated by showing concern (e.g., being asked about how they were doing and if there was anything that could be done to help) and building in time for "check-ins." For example, speaking about her time at one of the centres, one person noted, "If we're at home doing that [solitary activity] it's not good, but if you're here and you're in the corner it's okay because still someone is there checking on you." Participants appreciated the consistent interaction opportunities and knowing there would always be someone readily available to talk with at these centres.

Finally, although participants talked about the importance of family support, they also mentioned that families could be a source of stress; in contrast, most talked positively about the active support they received from peers and centre staff to participate in recreation. However, as one group discussed, sometimes they felt as if they connected more with centre staff, but this did not create a sustainable social relationship. These interactions were appreciated as "practice" but there was a certain artificial nature to them. For example, asking a staff member to socialize after work would be considered inappropriate.

Being Informed and Educating Others

As noted above, participants identified a number of actions—all of which were related to educating themselves and others in some way—to reduce or remove barriers to participation. It appears that the strategies related to what others could do were focused on supporting access to services and programs through information sharing, and in knowing more about the needs of people with mental illness. For example, one participant suggested "Your doctor, your welfare office, even your community service centres, employment centres, should have a pamphlet on where a person could go…and they don't." Participants also shared ideas

about how they might become more aware of programs, services and activities that currently exist, within and beyond the centre they already attend. Knowing more about what certain activities entail, or for whom these activities would be appropriate was also suggested. For example, one participant noted, "If you are young and early in your recovery, and you attend an activity with older people with more chronic conditions, it can be very discouraging."

Additional strategies for action revolved around what participants could do individually and collectively to reduce or eliminate stigma-related barriers. One focus group participant suggested, "To educate, to educate, to just openly say this is what it's like for me and it's a terrible, terrible illness, you know, what a lot of people suffer from" with the suggestion that the content of this education come from those with lived experience. "Oh, if we're going to develop programs to educate the public the content has to come from the mentally ill."

DISCUSSION

The findings of this study, which drew on first-voice perspectives, go beyond the identification of barriers. First, participants described how they might take responsibility to employ self-management and self-care strategies to access community-based leisure and recreation in a manner that supports their well-being. They highlighted the importance of meaningful participation, welcoming environments, and the need for social connections. Finally, they pointed out the need to educate others so that their needs can be better met in a range of environments, not just those geared toward people with a mental illness. In doing so, they conclude with a poignant point that relates to all recovery-oriented programming—that is, the importance of first-voice involvement, not just as recipients of service, but at all stages of program development and delivery.

Self-management strategies, which focus on collaborative relationships to support self-efficacy, share a common perspective with recovery, given that both draw attention to self-direction and living well in spite of the ongoing impacts of an illness (Sterling, von Esenwein, Tucker, Fricks, & Druss, 2010). Participants of this study confirmed the importance of knowing themselves and their own bodies and needs and pointed out the many ways they adapted their lives accordingly. As with self-management approaches, collaboration with health professionals was identified as one sector of a constellation of recovery supports. As discussed by White (2011), in self-management as in recovery, the individual is viewed as an active agent—a key decision maker rather than a passive recipient of services. Medical management remains in the picture, but other aspects of meaningful participation gain prominence. In this study, participants described the evolution of their leisure participation, which entailed coming to know which activities and settings supported their wellness. Although they confirmed perceptions of stigma, the discussion of which is widespread in the literature (e.g., Kondrat, Sullivan, Wilkins, Barrett, & Beerbower, 2018), they quickly shifted to demonstrate insight regarding their perceptions and appreciation of safe spaces where sharing mental health details would be acceptable. They also gave examples of feeling empowered enough to come out and say they have a mental illness, to leave a setting if they felt uncomfortable, and to implement boundaries by saying "no" to some things without feeling guilty about it. This shift is reflective of self-determination, whereby participants demonstrated the ability to respond to both internal and external events, take responsibility, and make decisions for themselves, as discussed by Picton et al. (2018).

While feeling accepted was one component of personally meaningful activity, meaning was also derived from finding like-minded others with whom to pursue activities of interest. Furthermore, more reciprocal relationships, and having opportunities to "give back" or contribute in some way (sometimes to the group itself, and sometimes to the community) were an important sources of meaning, aligning with the work of Topor et al., who discuss the need for people to move away from dependency toward autonomy and reciprocity (2006). Andonian (2010) also pointed out that reciprocal relationships support health and well-being and are an important predictor of recovery. This aspect of leisure participation is not always emphasized, perpetuating perceptions of recipients of mental health programs as needy and having little to offer.

Given that recovery includes "social (re)engagement," highlighting the need for accepting and enabling social environments within which to engage is key (Tew et al., 2012, p. 444). Welcoming environments and social inclusiveness experienced within the various settings where this research took place was identified as the most highly valued aspect for most participants of this study. Our other research similarly emphasized the need for active welcoming, particularly when people with mental health challenges are visiting a new setting or program for the first time (Gallant et al., 2019). In the absence of a welcoming environment, social exclusion, sometimes conveyed through stigma, can be experienced, with highly detrimental effects. As Hocking (2003) cautioned, "stigma and its associated prejudice form a very real barrier to recovery and may even be fatal" (p. S47). Providing personal invitations, having a companion with whom to attend an activity, and providing check-ins were identified as helpful features of the social environment that facilitated a feeling of inclusion.

Models of "peer support" are growing in popularity as a recovery-oriented strategy that can offer this more individualized approach. Peer supporters (in this case, those with a common history of a mental illness), may be formally or informally engaged in supportive roles. With a focus on the development of personal resourcefulness and self-belief, peer support is associated with increased social support, community integration, and overall improvements in quality of life (Cyr, McKee, O'Hagan, & Priest, 2016). Fieldhouse (2012) provides an expanded view of how people can be supported to enhance community participation, focusing on the idea of "scaffolding"—whereby people are temporarily provided certain supports, which are gradually reduced (or faded) as the individual gains competency and comfort in specific activities and settings. While participants in our study identified that some aspects of scaffolding (such as becoming comfortable in activities within settings that are designed for individuals with mental health challenges, then, with increased confidence, branching out to mainstream activities) are helpful, there are challenges. As Fieldhouse reported, social relationships are enacted and developed through doing things together. In both peer support, and in scaffolding, much of the social interaction, and thus, the relationship building, is with the peer supporter or the service provider. As our study found, participants do sometimes connect or "hit it off" with these individuals, but given the principles of boundary-setting, doing so will soon have them labelled as inappropriate. The Mental Health Commission of Canada has advanced a set of "Guidelines for Recovery-Oriented Practice" (MHCC, 2015), which highlight how recovery-oriented practices must "give primacy to their identity beyond illness [and] strengthen their natural network of connections" (p. 38). As we seek future application of peer support models, it will be important to support the development of social connections that are healthy and sustainable, accessing natural supports within the community.

Finally, our participants discussed being informed, and informing others about specific needs. In keeping with a recovery approach, it is essential that individuals with mental health challenges be actively involved in the development of services that will best meet their needs (Davidson, Tondora, Lawless, O'Connell, & Rowe, 2009). In our study, we were particularly focused on supporting inclusiveness in leisure settings.

Moving forward, service providers can benefit from this study by better understanding the perspectives of those with first voice and what aspects of a leisure/recreation setting or activity may need to be adapted to be more welcoming and inclusive. Through integrated knowledge translation approaches, the findings of this study, and others in our larger project, contributed to the co-creation of contextually relevant principles, guidelines, and actions relevant to making recreation programs and places more mental health friendly (Gallant et al., 2020) which will provide additional tools for service providers. Future research might focus on what strategies work best, and for whom, in an effort to support increased leisure participation, mental health recovery and social inclusion for all.

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