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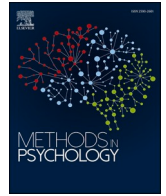
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Co-creating visual representations of safe spaces with mental health service users using photovoice and zoom

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ABSTRACT

This paper examines methodological issues related to an innovative online qualitative research project that explored 'safe spaces' with mental health service users. The project used photovoice and focus groups conducted via Zoom videoconferencing software. Eleven participants shared photographs, discussing their meaning and significance in relation to 'safe spaces'. The photographs were then synthesised into an artist's impression of a safe space and transcripts of the online photovoice discussion analysed thematically and triangulated with the artist's impression. The paper provides a reflexive discussion of the research process and explores methodological and ethical implications of conducting sensitive qualitative research in online spaces.

1. Introduction and objectives of the work

This paper offers an initial methodological reflection on an innovative online project that used videoconferencing software to explore mental health service users' ideas about 'safe spaces'. The study was part of a larger Western Australian project investigating a proposed Safe Space, intended as an alternative to hospital Emergency Departments for people experiencing mental health crises. In an earlier stage of the project, mental health service users' ideas about such a space had been explored in online focus groups. These early discussions highlighted practicalities such as opening hours, signage, facilities within the space, staffing etc. The next stage of the project, which this paper describes, worked with a different group of mental health service users to further explore ideas about 'safe spaces' and what 'feeling safe' look and feel like to people who have experienced mental health crises. For this part of the project, we had originally planned to hold face-to-face creative focus groups in a physical building, with a professional artist-researcher working alongside participants to co-create visual impressions of a safe space. However, restrictions due to COVID-19 meant that we had to re-think our approach and a decision was taken to conduct virtual creative focus groups using Zoom videoconferencing software. After lengthy discussions among the research team, it became clear that the most straightforward way of translating the creative aspect of the project

to a virtual space would be to use photovoice, with participants invited to submit photographs that captured their feelings about safe spaces, and to share these through focus groups hosted in a Zoom room.

Mindful of institutional review boards' and ethics committees' caution around both research with vulnerable groups and arts-based research approaches (National Health and Medical Research Council, 2018; Rice et al., 2020), we were unsure how the University Ethics Committee would respond to an application for the research to go online. Our revised research design was therefore meticulously planned and piloted, and the ethical implications of conducting research with mental health service users in an online space carefully considered. Our original ethics application had specified that a mental health counsellor would be present in the building (but not in the same room) where we were conducting the focus groups. Moving the project online meant that this arrangement was no longer possible. Our revised application therefore stated that a counsellor would be present in the online Zoom room where the focus group was taking place, and that a Zoom Breakout room would be used for the counsellor to meet individually with any participants who experienced distress. Ethical approval was granted on this basis, and the creative focus groups were conducted in what felt to the research team to be the uncharted research territory of the online Zoom room.

This paper offers an initial critical reflection on that process and its

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ethical implications. The objectives of the paper are as follows:

- To critically review the process of conducting an online photovoice project which used Zoom videoconferencing software to explore safe spaces with mental health service users;
- To extend discussion of space and its impacts on mental health to include the online research space.

The paper begins by providing background information on safe space alternatives to Emergency Departments for people experiencing mental health crises. It then goes on to outline our research approach and the use of visual methods in research. Discussion then turns to mental health and space and the ethics of research with groups who are deemed vulnerable. We then describe the research methods we employed and the process of conducting fieldwork in an online environment. The paper concludes by outlining our learning from the project and encouraging other researchers to consider using innovative digital methods in qualitative research with mental health service users.

2. Background

Although it is common for people to be brought to a hospital Emergency Department (ED) for assessment and management during a mental health crisis, hospitals are increasingly being recognised as offering poor treatment options for people experiencing such crises. In Australia, as in other countries, mental health service users identify the ED environment as requiring improvement in responding to their needs (Morphet et al., 2012). For example, a recent survey of people with lived experience of mental health crises, when asked what they needed most when attending the ED, 65% said “I wanted to be kept safe” (Consumers of Mental Health WA (CoMHWA), 2019, p. 19).

I have sat in distress in ED on multiple occasions. Between the bright lights, yelling, police, pain and chaos of the surroundings – and my distress – I begin pacing, humming, tapping ... just to try and block it out. Due to the long wait, I am either chemically restrained because of my distress, or repeatedly pressured to “calm down”, which funnily enough does not work. (Person with lived experience, Australasian College for Emergency Medicine, 2018, p. 3).

In Western Australia, during the 2017–18 financial year, mental health presentations accounted for 57,040 (5.5%) of ED attendances with a median ED episode of care of 210 min. Of these 56% were discharged into their own care following completion of the ED service event, 37% were admitted or transferred for admission to an inpatient unit, another hospital or an ED observation ward, while 6% of people left at their own risk or did not wait to see a medical officer (Chief Psychiatrist of Western Australia, 2018). In providing feedback to the Chief Psychiatrist, consumers and personal supporters have stated that that the ED is not a suitable environment for a person experiencing mental health issues (Chief Psychiatrist of Western Australia, 2018, p. 37). This has been further confirmed by the Australasian College of Emergency Medicine (2018) in an analysis of mental health presentations to Australian Emergency Departments. Moreover, while presentations at ED provide an indication of the size of the problem, it is likely to be an under-estimation given that, for the reasons outlined above, many people who have previously experienced ED presentations in crisis may choose not to attend when experiencing another crisis in the future (Australasian College for Emergency Medicine, 2018).

If not an Emergency Department, what is a ‘safe space’ and what do people who are experiencing mental health crises need to ‘feel safe’? In a recent review of the evidence-based design literature, DuBose et al. (2018) identified six aspects of environmental design that were associated with healing environments: a home-like space, access to views and nature, light, noise control, a barrier-free environment, and room layout. Consistent with these findings, when people in Western Australia

with lived experience of mental health crises were asked what was important in the design of an alternative service to ED, the most frequent responses were private spaces where conversations can’t be overheard (91%), comfortable seating/furniture (78%), gentle lighting (78%) and a non-clinical appearance (74%) (Consumers of Mental Health WA (CoMHWA), 2019).

Alternative community-based services for people experiencing mental health crises (not located in or linked to Emergency Departments) already exist. For example, in 2014 a Safe Haven service was launched in Aldershot, Hampshire (UK) as an evening and weekend drop-in service for people requiring out-of-hours mental health support. The goal of the service is to provide a ‘safe space’. It is staffed by three mental health professionals (two support workers and one clinician) and aims to promote self-management, prevent crisis escalation, improve access to other services and provide effective care planning. Between August 2016 and July 2017 the service provided for 4275 attendances (average of 12 people per shift) for 670 unique service users, with 13% attending in crisis, 56% attending to prevent escalation into a crisis, and 23% for social reasons (Wessex Academic Health Science Network, 2017). When asked where they would have gone had the service not been available that day, 27% said they would have gone to ED, while a further 24% said they did not know (Wessex Academic Health Science Network, 2017). Psychiatric admissions and mental health related police deployments also declined in that area, but other factors may have contributed as there was no control group. In addition, Section 136 detentions (as defined under the UK Mental Health Act which provides the police the power to remove a person from a public place and take them to a place of safety) reduced in the local North East Hampshire area, which went against the trends both nationally as well as in the wider Surrey Borders Partnership NHS Foundation Trust (Wessex Academic Health Science Network, 2017). Of people using the service, 94% agreed or strongly agreed the service provided a safe place to go and 85% agreed or strongly agreed the service prevented them from being in crisis (Wessex Academic Health Science Network, 2017).

3. Research approach

Founded on positivist values of objectivity, neutrality and distance, historical research in the area of mental health was concerned with identifying differences between those deemed mentally ill and the rest of the population (Davey, 2019; Scull, 2019). This produced a very narrow (epistemologically constraining) view of human experience of mental and emotional distress, which excluded social, cultural and political influences. Sociologist Erving Goffman (1984 [1963]) later explored the social construction of mental illness in interactions between so-called ‘stigmatised’ and ‘normals’. However, Goffman’s analysis downplayed the role of power in these interactions, and also failed to account for the politicisation of mental health service users. In contrast, more recent, ‘user-led’ research has seen mental health service users fully engaged in, and leading, research (Rose, 2017; Staddon, 2013).

Our research does not lie within a user-led paradigm, but seeks instead to understand the perspectives of the mental health service users with whom we are undertaking research. The wider project research team includes researchers with a broad range of disciplinary and professional affiliations including medicine, nursing, professional arts practice, psychology, public health, and social work, and who have expertise across qualitative, quantitative and mixed methods research approaches. Biomedical understandings of mental illness, which locate pathology within the individual, tend to dominate in some of these disciplines and professions; they also have widespread credence amongst the general public (Brinkmann, 2016; Gambrell, 2012; Rogers and Pilgrim, 2014). In project discussions, understandings of what may be perceived as mental illness, which take account of social and cultural contexts, were offered by colleagues with creative arts, public health and social work affiliations. Such perspectives are also offered in the literature. For example, Walker and colleagues (2018, p. 160) argue that:

Well-being and distress may be better understood not as internalised qualities of individuals but instead as sets of effects produced in specific times and places; complex assemblages of relations not only between people but also between people and places, material objects and less material components like atmospheres, histories and values.

One member of the research team also has ongoing connections to consumer activist networks and research (Boxall and Beresford, 2013; Newman et al., 2019). The project team therefore had a multifaceted position on researching safe spaces for people experiencing mental health crises, which took account of medical, social, political and personal perspectives on mental health and wellbeing and which did not seek to identify or emphasise differences between research team members and research participants. One of the ways in which this was achieved, was by the two university researchers (from social work and public health) and the professional artist-researcher working on this part of the project, choosing to share aspects of our experience within the online focus groups, as we explain below. Reflexive location of researchers' subjective experience within qualitative research methodologies is not a new approach. For example, 20 years ago, Fine et al. (2000, p. 109) wrote about "a call for the inclusion of subjective experience of the researcher into what has traditionally been conceived of as subject matter." Similarly, Carolyn Ellis and Bochner (2000, p. 741) explained how some researchers "incorporate their personal experiences and standpoints in their research by starting with a story about themselves, explaining their personal connection to the project, or by using personal knowledge to help them in the research process."

4. Visual methods in research

The use of visual techniques such as photography, film and video to observe, measure and validate research is well established in disciplines such as psychology and the social sciences (Banks, 2019; Reavey, 2011). However, less often have such visual images been prioritised in the process of analysis, with 'data' to be analysed often more focused on the spoken or written words derived through focus groups and individual interviews (Catalani and Minkler, 2010; Reavey, 2011). Taking account of visual, verbal and text-based data in the analysis process can, however, facilitate richer insights into the research topic than can be accessed through traditional text-based approaches (Reavey, 2011). Visual data can incorporate existing images such as photographs, images from popular culture and advertising that are sourced by the researcher, or photographs, drawings and other static visual images, as well as video and film. This visual data can be provided by the researcher, or generated as part of a specific research project by participants, or participants collaborating with researchers to co-produce images. Research that incorporates these various forms of visual 'data' is based on an understanding that people experience their world, and make sense of their everyday experiences, through "multi-modal forms of expression and communication" (Reavey, 2011, p. 5).

Visual methods may demand a higher level of reflexivity from researchers, particularly when the research is informed by feminist theoretical perspectives, and the goal is to work with participants in "art-making spaces [in ways that] attenuate hierarchy between researcher and researched" (Rice et al., 2020, p. 228). For example, Rice and colleagues highlighted the "inherently inter-relational" nature of their multimedia storytelling method (p. 235) that enabled them to connect in "emotional and personal-political ways" with their participants (p. 224). A common form of visual method is photo-elicitation, which at its simplest, involves the use of photos in interviews to stimulate discussion (Harper, 2002). This method has the potential to add significantly to insights that might be gained through traditional 'talk-based' interviews. The benefits that photo-elicitation can offer are summed up by Harper, who observed - "when two or more people discuss the meaning of photographs they try to figure out something together. This is, I believe, an ideal model for research" (2002, p. 23).

This suggests the inclusion of photos into the research process can be instrumental to the co-generation of new knowledge. Photo-elicitation can be used to evoke memories and emotions (Banks, 2019; Silver and Reavey, 2010), facilitate the expression of tacit knowledge, and encourage participant reflection (Salmons, 2014). This method can also provide a platform to generate abstract ideas and discussions (Banks, 2019), and "prompt talk about different things, in different ways" (Rose, 2012, p. 305). In addition, using photos as a central focus in the research process can reduce awkwardness between researcher and participant by minimising direct eye contact (Collier & Collier, cited in Banks, 2019), and enable individuals to articulate their emotions through creative rather than verbal means (Silver and Reavey, 2010).

While photo-elicitation can yield important insights to a range of issues, the related method of photovoice developed by Wang and Burris has a more explicit aim of influencing social change (1997). Photovoice is increasingly used in a range of disciplines including public health (Catalani and Minkler, 2010; Golden, 2020), social psychology (Reavey, 2011) and sociology (Catalani and Minkler, 2010), to address issues as diverse as homelessness, the experience of illness (see Catalani and Minkler, 2010) and intercultural relationships (Migliorini and Rania, 2017). Wang and Burris described photovoice as having three goals: "(1) to enable people to record and reflect their community's strengths and concerns, (2) to promote critical dialogue and knowledge about important issues through large and small group discussion of photographs, and (3) to reach policymakers" (1997, p. 369). Photovoice is based on three theoretical frameworks - "empowerment education for critical consciousness, feminist theory, and documentary photography" (Sutton-Brown, 2014, p. 170). In photovoice projects, individual and interpersonal empowerment can be achieved through the creation and sharing of photos and discussion among participants; together, these can be the catalyst for participants to think critically about factors influencing their lives (Wang and Burris, 1997). To reach policymakers, photos and related narratives produced through photovoice projects are often displayed in exhibitions and presentations (Becker et al., 2014), where, as Teti suggested, they act as "communication bridges" (2019, p. 1) to more effectively influence policy (Foster-Fishman et al., 2005; Wang and Redwood-Jones, 2001). In this way, photovoice projects can also contribute to community empowerment. In line with feminist theory, photovoice can also provide a voice to marginalised groups and promote "active participation in decision making while honouring knowledge through lived experience" (Sitter, 2017, p. 40). As such, photovoice is particularly relevant for research conducted with groups who may be considered vulnerable such as people who have experienced mental and emotional distress (Becker et al., 2014).

5. Mental health and space

Most Western countries have historically institutionalised people deemed mentally ill, with many individuals entering asylums during the middle third of the last century living out the remainder of their lives in institutional settings. It was not until the final third of the last century that deinstitutionalisation policies came into play, with some countries resettling long stay patients to community settings more slowly than others (MacKinnon and Coleborne, 2003; Scull, 1990). People experiencing mental health crises continue to be placed in hospitals or other residential institutions, but they tend to stay for much shorter periods than in previous years. Mental health services (for example, supported housing and monitoring services) are now predominantly situated in community settings, although adherence to outdated institutionalised ways of being and knowing can lead to some of these spaces being physically and epistemologically constraining (for both service users and staff) as the historical institutions they have replaced (Uttarkar, 2018). More innovative community-based supports such as the Bristol-based 'Bike Minded' group in the UK, which offers group cycling for people experiencing mental health difficulties (Walker et al., 2018), create spaces which accommodate mental and emotional distress

without the constraints of formal service provision. [Graham et al. \(2018\)](#) similarly describe a community meal in Hamilton, New Zealand as a socially valued ritual which both values and supports its volunteers and diners. “Here, at the meal, mundane food-related practice acts as a humanising force and is itself an act of resistance to dominant discourses” (p. 130).

Scholarship on the social psychology of place considers the impact of place on mental health; for example, quiet workplaces and being in nature have been found to foster positive mental health ([Hodgetts et al., 2020](#)). Geographers such as Sarah [Curtis \(2010\)](#) also explore the relationship between space, place and mental health, arguing that some spaces (for example, natural landscapes) appear to support positive mental health, whereas others (for example, busy roads or built up environments) may not. Understandings of mental illness may therefore be shaped and constrained by the spaces in which mental and emotional distress is contained or enacted. The language used to refer to mental health or illness also plays a part in influencing understandings of mental health, and in reinforcing the dividing practices of the mental health system which can marginalise mental health service users in institutionalised or isolated spaces ([Foucault, 1965](#); [Rogers and Pilgrim, 2014](#)). Mindful of these practices, we opted to refer to (mental and emotional) distress rather than mental illness ([Boxall and Beresford, 2013](#)) in the focus group discussions for this project.

Our research is concerned with mental health in safe spaces; spaces which may be located in social rather than medical settings. It is important therefore that we are open to understandings of mental health and illness which are not divorced from social context ([Horwitz, 2020](#)). The team was also open to understandings of both mental health (and space) as socially and relationally produced. This nuanced approach was particularly apparent at the research design stage when applying for initial ethical approval for the project. For example, there was considerable debate about the information we would require from potential participants in the application form we devised for them to complete. Our discussion ranged from an individualised medical approach that argued for information about participants’ mental health diagnoses, to a social approach ([Beresford, 2002](#)) which suggested that the only information required was for participants to confirm that they had at some point used mental health services. It was this latter position that we eventually adopted when recruiting participants for this part of the project via consumer networks.

When COVID-19 hit, we found it challenging to imagine the implications of moving our research into an online space, and our discussions focussed on ways in which we could adapt our research methodology. What we hadn’t anticipated, however, was that our consideration of space would also need to include the virtual space of the online Zoom room. This raised multiple questions. Is the Zoom room a space? It isn’t a physical space; but it is a socially, relationally (and electronically) produced ‘container’. Would it be possible to talk about safe spaces from within the virtual space of a Zoom room? What if that virtual space did not feel safe? What about the physical spaces in which the participants and researchers would be situated? How safe would those spaces be for the people within them? How would the physical spaces, in which we (researchers, participants and counsellor) were individually located, influence the virtual space we occupied together? What could we do to make our shared (virtual) space as safe as possible? If we understand mental illness to be socially and relationally produced, what impact would the use of virtual research methods have on that social and relational production? Our earlier discussions regarding the information we required from potential research participants had made visible the role of research in adhering to, or challenging, epistemologically constraining ideas about mental illness. The process of operationalising our online photovoice approach alerted us to the possibility of creating a virtual research space which could perhaps minimise such epistemological constraints. It also raised questions about how we could begin to theorise virtual research spaces and their implications for epistemologies of mental health and illness.

6. The ethics of research with groups deemed vulnerable

A number of researchers have highlighted ethical concerns around the use of photovoice with population groups who are viewed as vulnerable, and have developed recommendations to minimise risks to participants and others (see for example [Becker et al., 2014](#); [Creighton et al., 2018](#); [Wang and Redwood-Jones, 2001](#)). Typically, these recommendations include strategies to ensure ethical practice when taking photos of other people (such as gaining consent), providing participants with clear information about the project goals and use of photos, and ensuring ownership of images is retained by the participants ([Wang and Redwood-Jones, 2001](#)). More recent research has highlighted ethical challenges when digital images can be easily downloaded, shared, reappropriated and misrepresented ([Creighton et al., 2018](#); [Teti, 2019](#)), and the risk of power imbalances between researchers and participants during analysis and interpretation of images ([Boxall and Ralph, 2009](#); [Teti, 2019](#)). This literature suggests that careful consideration should be given when developing photovoice projects with population groups such as those who have experienced mental health crises. In order to maximise benefits and minimise potential harms, early planning is important, as is the development of an ethical framework which enables researchers to critically self-reflect throughout the research process. This is particularly important where the research design is changed suddenly, as in our case due to COVID-19.

[Liegghio and Caragata \(2020\)](#) argue that remote access photovoice can enable individuals who do not usually have access to research to be heard, and also privilege their knowledge and ways of knowing. However, conducting photovoice research using videoconferencing software also adds an additional layer of ethical and technological issues, such as the security and vulnerability of data which is digitally collected and the exclusion of populations who lack access to the technology required to participate in research ([Nehls et al., 2015](#)). In addition, a systematic review which compared qualitative data collected using traditional and online methods found that online approaches “were reported to result in lower levels of relational satisfaction and consensus development” when compared with face-to-face interviews and focus groups conducted in a physical building ([Davies et al., 2020](#), p. 8).

The ethical position adopted by the project team was to comply with national ethical requirements for research with populations deemed vulnerable in Australia ([National Health and Medical Research Council, 2018](#)), whilst at the same time respecting the autonomy of participants who may reject the designation ‘vulnerable’ ([Holland, 2007](#)). Photovoice as an online visual method enabled the application of a relational ethics approach which endeavoured to demonstrate the trustworthiness of the research by drawing on “a mutual and respectful exchange of information between the [research team] and the prospective community under study” ([Wallace, 2011](#), p. 71). The COVID-19 pandemic forced the world to adapt rapidly as schools, businesses and government services shifted to remote online service delivery within a matter of days. In this study, Zoom software (www.zoom.us) was used as it appeared to offer privacy and security and required minimal personal information from participants to join the sessions. The free licensing meant that participants were able to download and use the software at no personal cost. The option to enable authentication to join a group ensured only those participants who received an invitation from researchers were able to join the session (<https://zoom.us/privacy-and-security>). As we planned to make audio-recordings of the photovoice sessions using Zoom’s ‘record’ function, we would need to explain to participants that although Zoom records everything (audio, video and chat), the project would only use the audio-recordings and chat, which would be saved to a researcher’s password-protected computer, rather than the Zoom cloud. We planned to explain this in the information sessions which (apart from recording participants’ verbal consent at the beginning of the sessions) would not be recorded.

7. Description of methods

This section begins with a description of steps taken to move the project from its original setting to the online environment in response to COVID-19 restrictions. Our discussion highlights the research team's 'on the job' learning while planning the online focus groups. We then provide an overview of the recruitment process and outline the structure of the focus groups and data collected.

7.1. Re-designing the project for the online environment

Given our unfamiliarity with using Zoom as a research environment, three members of the research team began by piloting our online photovoice approach. We each took photographs of images that represented what a 'safe space' meant to us and wrote accompanying captions. We then met in a Zoom room to 'role play' a photovoice session, playing the parts of both participants and researchers. Because we found this process so helpful, we planned a demonstration roleplay to share with participants in the online information sessions. We realised that if we were to capture a range of different perspectives on 'feeling safe', it would be important to model differing opinions and respectful disagreements. Our roleplay therefore included screen sharing of each of the researchers' photographs in turn, with the other researchers offering alternative interpretations of the photographs and whether or not they felt the photo in question conveyed a personal feeling of safety. Through this demonstration roleplay, we also developed guidelines for participants on taking their photographs and an informal 'script' to prompt discussion in the photovoice sessions where participants' photos would be shared.

The piloting process highlighted a range of ethical and practical issues – for example, we were aware that many mental health service users live on low incomes and may not have access to computers or digital cameras. However, approximately 88% of the Australian population own a smartphone with a camera (Deloitte, 2017) and even though ownership rates were unlikely to be this high amongst mental health service users (Wong et al., 2020) we felt that asking participants to take photos was probably realistic. Additionally, at the time we were re-drafting our research design, Australia was in lockdown and people were largely restricted to their own homes. This meant that for many participants, their home may be the only place they could take photographs. We were mindful that some participants may not feel comfortable sharing photos of their home. In addition, we were aware of homelessness levels among mental health service users (Cook, 2019), and that some participants may not have homes to photograph, so we modified our guidelines to include a range of options for taking photos. We also realised that participants may wish to take photographs of people who had helped them feel safe. This would, however, require consent from the people who were the subject of photos, and could potentially also compromise participants' anonymity. Since our project was about safe spaces rather than people, our guidelines were further revised to encourage participants to take photos of spaces and objects rather than people. Our final guidelines for participants are listed below.

Guidelines for taking photographs

The aim of this creative focus group is to find out about the perspectives of mental health consumers who have lived experience of mental health crises.

- We're interested in finding out what feeling safe looks like to you.
- Please think about times when you've felt safe and what it was that helped you feel safe.
- Please try and think of the spaces, and the furniture and objects in those spaces, that helped you feel safe – think about colour too, what colours help you feel safe?
- Other people can sometimes help us feel safe – but in this research, we're interested in spaces rather than people.

- Please take photos of spaces, furniture or objects that help you feel safe.
- You don't have to take photos of your own home if you don't want to – you could take photos of other places, or of photographs in magazines, or things on the internet, or on TV.
- Please think of some words (up to 30) to go with each photo.

7.2. Recruiting participants

Once ethical approval for the online project had been granted, we began the process of recruiting participants via mental health consumer networks. Our recruitment email asked participants to confirm (a) they had used mental health services (there was no requirement to have used Emergency Departments); (b) they had access to a digital camera and computer (or smartphone with camera); and (c) to provide basic demographic information, which was used when planning for diversity in focus groups. The email also asked applicants to commit to attending two online focus group sessions (one information session and one photovoice session) and to give details of any support they may need to participate fully. Recruitment was initially slow, but a follow up email, clearly indicating that places were still available, led to considerable interest in the project. In retrospect, a comment in the initial email indicating that 'places are limited' may have discouraged some potential participants, and led to the slow take up. The recruitment email also stated that a researcher would telephone each participant prior to the information session. The initial purpose of this telephone call had been to provide a friendly introduction and allay any nervousness people may have about participating. The calls also proved useful for troubleshooting potential technical issues, as well as identifying those participants who would be connecting with a smartphone or tablet.

We recruited a total of 12 participants who were allocated to two groups. Four 'staff' also participated in and facilitated these groups – two university researchers, one artist-researcher and a counsellor. Conscious of research suggesting the optimum size for an online focus group is five participants (Lang and Hughes, 2004), we discussed whether we should reduce the number of people in the Zoom room by having fewer staff, but decided to proceed with six participants and four staff in each group.

7.3. Online focus group structure

The revised online method required each participant to attend a Zoom information session, followed two weeks later, by a Zoom photovoice session. The purpose of the information session was to:

- (a) confirm that all participants had read and understood the information letter and consent form that had been previously emailed to them, and to verbally confirm their consent to participate;
- (b) provide an opportunity for all focus group members (participants, researchers, artist-researcher and counsellor) to 'meet' each other;
- (c) explain the counsellor's role in the focus group;
- (d) agree 'ground rules' to facilitate a safe and respectful online environment;
- (e) demonstrate the photovoice process through a role play, with research team members sharing their own photos and captions and providing feedback on each other's photos;
- (f) provide guidance to participants on taking photographs and writing accompanying captions, and arrange for participants to email their photos with captions by a specified date, indicating which photo they felt best conveyed a feeling of safety; and
- (g) provide an opportunity to resolve technical issues.

A two-week gap was scheduled between the information session and photovoice session. During this gap, participants, research team members and the counsellor prepared photos and captions to be shared with each other in the photovoice session. In some photovoice research,

researchers work with research participants to devise captions for photographs collaboratively (Becker et al., 2014). However, as we only had limited time in the Zoom room (2.5 h), we asked participants to prepare their own captions and email them to us beforehand. Once all the photos and captions had been received, they were collated in a PowerPoint presentation. The purpose of the photovoice session that followed was to enable everyone – participants, research team members and the counsellor – to take turns in sharing the photo and caption that best conveyed feeling safe for them. An informal script was used to prompt discussion about the photos among focus group members. This script involved a researcher identifying whose photo was being shared, reading the accompanying caption and asking the participant if they would like to say what it was about their photo that helped them feel safe. The researcher then asked other focus group members if they felt the photo conveyed a sense of safety to them. Finally, the researcher asked if there was anything about the photo that could be used to help create a physical ‘safe space’.

Notably, our plan to engage fully in the photovoice sessions not just as researchers and facilitators, but also through sharing our own photos and talking about what feeling safe meant to us, reflected our desire to foster reciprocity by acknowledging participants as more than just a useful source of data (Oakley, 1981), and to minimise a researcher-participant hierarchy (Rice et al., 2020). An approach which also underpinned and facilitated reflexivity – “how the researcher[s] relate to the research and the researched, and how that shapes the interpretation” (Chamberlain, 2000, p. 292).

7.4. Data

Three types of data were collected – visual data (the photographs), text-based data (the accompanying captions submitted by participants, and the Zoom ‘chat’ thread), and audio data (audio recordings of discussions in the photovoice sessions). The audio recordings were later transcribed verbatim. Professional artist XX (who also participated as a researcher in the online photovoice sessions) worked with all of the photos submitted by participants, plus the raw transcripts of the photovoice sessions and the chat, to create an artist’s impression of a safe space. Using this data, the artist-researcher produced a three-dimensional model of a safe space (a sculptural model, approximately 80 cm × 80 cm × 20 cm), which incorporates re-scaled versions of participants’ photos so that they fit within a scale model portraying both indoor and outdoor spaces. Words from the verbatim transcripts of the photovoice sessions are also written across the artwork. Analysis of the transcripts and text-based data was undertaken by university researchers, using a reflexive thematic analysis approach (Braun and Clarke, 2020), and emerging themes from the transcripts and text-based data were triangulated with the artist’s impression.

8. Discussion of virtual fieldwork

Twelve participants (eight aged 45–64 years, and four aged 25–44 years) took part in one of two Zoom information sessions. After the first information session, one participant (aged 45–64 years) withdrew, explaining that they would be looking for *people* in a safe space, and they did not feel motivated to take photos of spaces and objects. Two weeks after the information sessions, 11 participants, all of whom had emailed photographs and captions beforehand, took part in one of the two photovoice groups. We received a total of 32 photographs from participants:

- 12 photos of outside spaces (gardens and countryside views including lakes, rivers and sea)
- 7 photos of inside spaces (indoor rooms)
- 12 photos of objects (artworks, art materials, music players, phone, plant, lantern)
- 1 photo of an animal (dog)

The Group 1 photovoice group consisted of six participants (all female), plus three female members of the research team and a female counsellor (a total of 10 people in the Zoom room). The Group 2 photovoice group consisted of five participants (3 male, 2 female), three female members of the research team and a female counsellor (a total of 9 people in the Zoom room).

A key difference between a virtual focus group and one held in a building was that, rather than interjecting in the discussion, participants needed to use the ‘Hands up’ icon or wave their arms to attract researchers’ attention. Using the ‘Hands up’ icon was not dissimilar to the convention of using a baton or ‘talking-stick’ in a group meeting in a building, and we found that taking turns to speak in this way resulted in good quality audio recordings, as people weren’t speaking over each other. Whilst conversation might have been slightly more fluent in a building, using Zoom did not seem to discourage participants from speaking; they had a lot to say about a subject that was clearly very important to them. We discussed reducing the number of ‘staff’ in the Zoom room, but decided to proceed with all participants and staff, which proved to be the right decision because of the complexity of running an online focus group (Greenspan et al., 2021). For example, keeping an eye on the ‘Chat’ function in Zoom, while also looking for the ‘Hands up’ function, and observing participants in case they appeared distressed or were indicating they wanted to speak; whilst at the same time, viewing the photos and captions *and* listening to the discussion was too much for one, or even two, researchers to do on their own.

We now go on to discuss some of the technical and ethical issues that arose when we implemented photovoice using Zoom online videoconferencing software. As mentioned earlier, piloting our research had alerted us to possibilities for creating a virtual research space that did not itself promote or perpetuate epistemologically constraining ideas about mental illness. Our aim in this virtual space was to minimise any such constraints. One of the key ways in which we attempted to do this was by de-emphasising perceived differences between researchers, participants and the counsellor in the virtual research space. Rather than being an observer, the counsellor (who was in the Zoom room alongside researchers and participants) remained visible to participants and joined in discussion, as did the researchers – though we were all careful not to dominate that discussion. We also shared our personal photos and captions. In this way, we hoped that the similarities between the research participants, and the researchers and counsellor were foregrounded, rather than our differences.

8.1. Technical challenges

As a result of lockdown, most participants had some familiarity with Zoom or similar videoconferencing software but we still experienced a range of technical difficulties, including a campus-wide internet dropout during the first information session! Fortunately, research team members were not all located on the same campus and, because we had assigned co-hosts, the session was able to continue. Other technical difficulties arose because we were connecting to Zoom via a range of different devices – desktop and laptop PCs (with 1 or 2 screens), desktop and laptop Macs, tablets and smartphones. Early on in the first photovoice session it became apparent that sharing our photos (through a PowerPoint presentation with captions) was not going to be straightforward, as different devices displayed Zoom in different ways, and not everyone could see both photo and caption. In addition, some people could not see the person speaking whilst at the same time viewing the photo they were discussing. Recording was paused while we tried to resolve these issues. We were very fortunate in that several participants proved to be exceptionally adept at resolving technical problems on a range of different devices, offering their advice to researchers by explaining orally, or via the Chat function.

8.2. Creating a safe online research space

Given the project was about safe spaces, we were particularly aware of the need to foster a safe environment in the Zoom room. At the beginning of each session, we ensured the counsellor was assigned as a 'co-host' in the Zoom room and participants were given an opportunity to practise sending her private messages. The counsellor also asked for permission to have all participants' email addresses, so she could send follow-up emails after the Zoom session finished. In addition, we discussed Ground Rules at the beginning of each information and photovoice session, inviting participants to suggest their own rules so these could be discussed and agreed by the group. These ground rules developed over the course of the research to encompass:

- Confidentiality in the Zoom Room
- Respectful communication and respectful disagreement
- Take turns – please don't talk over each other
- Also, please don't talk too much, so everyone gets a chance to say something
- Scheduled break mid-way through
- Anyone can request that the group takes a short break at any other time

The three researchers felt strongly that we should not ask participants to open themselves up to what may be deeply felt emotions in an online research space, without being prepared to do the same ourselves. During the piloting stage, we had each role-played research participants, providing photographs of spaces or objects that conveyed a personal sense of safety and speaking about our feelings about the photographs. We repeated this role-play as a demonstration for participants in the information sessions, doing it in such a way as to question each other's ideas about safety, so that participants were aware that we were not all in agreement. This was because we wanted the participants to feel able, in a respectful way, to disagree with each other. It also served to challenge the idea that researcher or 'staff' views were aligned or 'correct'. We included ourselves in the photovoice sessions in a similar way, sharing photographs and captions that participants had not previously viewed, as did the counsellor. We began each photovoice session by sharing one of the artist-researcher's photographs. This was a photo of an object (artwork) that had deep meaning for her, and she spoke openly about her feelings and the sense of safety the artwork conveyed. Discussion was then opened up to participants, researchers and the counsellor, before viewing and discussing everyone else's photographs and captions in turn.

Our guidance had asked participants not to take photographs of people. However, discussion of people was prevalent in both focus groups, though this did not refer to specific individuals. For example, participants talked about wanting to have people around them in the safe space; they also spoke about wanting to make the safe space welcoming to other people.

8.3. Women-only online space

Our recruitment email had included an application form in which participants were asked to provide basic demographic information (age, sex etc) to be used when planning for diversity in focus groups. After the second information session however, we received an email from a female participant indicating she wasn't comfortable being in an online space with men. Though we were alert to the possibility of some participants preferring a women-only domain in a physical research space, it was not something we had anticipated in an online research space; this raised led us to question our assumptions about participant safety in physically distant but virtually shared spaces. Following this feedback, we were able to make arrangements for one of the groups to be a women only online space.

8.4. Ethics and shared virtual research space

Prior to the photovoice sessions, we had discussed the spaces in which participants may be physically located, but we had not fully thought through the ethical implications of conducting sensitive research via Zoom. Having experienced some technical difficulties when connecting to Zoom in an earlier stage of the project, we developed a protocol of switching off microphones and cameras during breaks, rather than completely disconnecting and reconnecting each time. In retrospect, this may not have been wise, as cameras were sometimes left on inadvertently. The researcher who was hosting the Zoom session remained available throughout the break, which meant that the physical spaces in which some participants were located were occasionally (unintentionally) visible and if microphones were switched off, it was difficult to attract participants' attention to alert them to this. Although nothing untoward was observed, and the breaks were not recorded, this still raised a myriad of potential confidentiality and anonymity issues in a research space. Another issue was confidentiality in the physical spaces in which participants were located. By the time the Photovoice sessions took place, because of lockdown restrictions due to COVID-19, many of us had become used to using Zoom in our everyday lives – in our living rooms or kitchens, from our cars as we were driving, or wherever we happened to be. Some participants and researchers were living with other people who could potentially overhear the research discussions. In addition, several participants chose to join the Zoom photovoice session from their gardens, or from public spaces. Whilst they may have been comfortable about their own discussion being overheard in these spaces, if headphones were not being used, it was possible that other participants' voices would also be audible to people in the neighbouring gardens, or public spaces. We dealt with these issues as they arose, but if we were to repeat the research, we would specify that all researchers and participants should use headphones, unless located in a room or area where there is no risk they can be overheard. Whilst we were clear we were undertaking research rather than therapy, it is worth noting that guidelines for online therapy and counselling offer useful advice regarding the risk to privacy when people are participating from their own homes (see for example [Bolton, 2017](#)).

8.5. Terminology and language

We thought carefully about the language we would use to talk about mental health difficulties within the virtual research space. Rather than referring to mental illness, researchers spoke about mental health crises or mental and emotional distress. Even though we recruited participants via consumer networks where non-psychiatric terminology is often favoured, we could not assume that participants would be familiar with these terms due to the dominance of psychiatric discourse within the media and wider culture, as well as the mental health system. Whilst participants (and 'staff') would, of course, bring ideas reflected in the wider culture to the focus groups, our aim was to create a research environment where psychiatric discourse was less dominant. Just as [Graham and colleagues' \(2018\)](#) community meal was "an act of resistance to dominant discourses", our online focus groups sought to resist dominant psychiatric discourses which can serve to objectify and distance the people so-labelled. Some participants were involved in mental health advocacy or education and appeared well-versed in non-psychiatric language and terminology. A review of the transcripts revealed that most other participants also used non-psychiatric terminology. Psychiatric terms were used (twice) by only one participant, whilst the term "distress" or "distressed" was used a total of 13 times across the two focus groups. However, the extent to which we created a virtual research space together, where epistemological constraints were minimised, is debatable. But where discussion did turn to mental health, this was shared in a straightforward, non-pathologising manner. For example:

This photo I took because it was like one of those beautiful days that you can get in Kalbarri and it just, I just felt like it, I just felt like chilling. And when I say all of my parts, I'm talking about I have voices. And quite a lot of people when they're hearing voices ... relate to their voices as being parts. So I have 4 voices and they all feel at home and safe in Kalbarri. (Participant, Group 1)

I've had lived experience of being in psych wards or in situations where my phone has been taken away from me when I've been in distress and it just made me feel worse not having that. It was like a real control thing, like I'm going to take almost your lifeline away from you because you're too unwell or you might phone or do something that might damage your reputation because you're so unwell. And so, I think that was why this [photo of iPhone] was my number one photo and why it was really important to my feeling safe, that I had this photo here; thank you. (Participant, Group 2)

Participant feedback

We received positive feedback from research participants about using videoconferencing software. For example, one participant explained that although the voices she was hearing during the photovoice session prevented her from participating fully in the oral discussion, she had appreciated being part of the group, hearing about and learning from other people's experiences, and being able to communicate in the chat. As the following participant quotes indicate, the focus groups also appeared to act as a catalyst for participants to think more critically about their own safe spaces, in ways that echo Sutton-Brown's observation that the photovoice method can foster "critical consciousness" (Sutton-Brown, 2014, p. 170). In this way, our research process has fostered immediate benefits to participants, as well as contributing more broadly to the knowledge base on the dimensions of safe spaces among mental health users.

I found it helped me a lot as I was listening to others express their thoughts while my voices faded in the background. (Participant, Group 1)

I'm very, very busy at the moment with study and other stuff. But it was good to be reminded of where my safe space is. So that in itself was good and I didn't have a lot of time to go out and take wonderful photos So I just grabbed my phone and I went, well that's my safe space So thank you, thank you. (Participant, Group 1)

I just really enjoyed seeing other people's safe spaces and it gave me a few new ideas for my own ... So thanks so much, I really appreciated it and the opportunity. (Participant, Group 1)

We did not receive any negative feedback from participants regarding the focus groups. We did however receive feedback about the need for a women-only online space and problems with participants speaking over each other in the information sessions. Because we received this information in advance, we were able to respond to and address these issues in relation to the focus groups. We were, however, unable to accommodate one potential participant's feedback regarding taking photographs of people, and they decided not to participate. Had we had more time to modify the project and seek ethical approval for participants to take photographs containing people, we may have been able to do this. However, our previous experience with ethics committees and research with what they consider "vulnerable people" was that this would be a very lengthy and time-consuming process, and we did not have time to accommodate this.

9. Conclusions and recommendations

Without lockdown due to COVID-19, we may never have considered using videoconferencing software to conduct sensitive qualitative research with mental health service users. When we moved our creative

focus groups into an online space, we had little confidence that this approach would succeed. We have however learnt important lessons about the methodological pitfalls and potentials of using videoconferencing software in research, and also collected valuable research data. Rather than seeking to approach the project in an objective, neutral and distanced manner, we sought instead to include ourselves in the research by sharing our own photographs and feelings about safe spaces. It was because of our unfamiliarity with the Zoom research space and our desire to put research participants (and ourselves) at ease, that we adopted this approach.

The use of online methods not only caused us to 'think outside the methodological square', but also appeared to free participants from the constraints of a physical building. Our revised online research design asked people to take photos of spaces, furniture or objects that helped them feel safe. Something we hadn't anticipated was that participants would submit photos of outside spaces – lakes, forests, a field of flowers, an outside firepit etc. This shifted the idea of a safe space away from a physical building, such as the Safe Haven in Aldershot (UK), to embrace outdoor safe spaces – a model perhaps more suited to the Australian context. However, although online space offers the potential for new freedoms, it can never be liberated from the physical spaces that researchers and participants inhabit while they are working together in the online space. Our experience of conducting this research gave rise to a range of ethical issues which need to be considered when conducting sensitive research using videoconferencing software. The most important of these issues is confidentiality, which can easily be compromised by the inadvertent operation of cameras or microphones in participants' or researchers' own spaces during break times, or by people choosing to access Zoom research sessions from shared accommodation, gardens, public spaces, or when using public transport.

Undertaking research in a Zoom room has also made us think differently about some of the language we use to talk about research. For example, the term 'face-to-face' when used in relation to research interviews or focus groups can apply in both the physical context of a building and the virtual context of a Zoom room (where we also view each other's faces). Anything which causes us to stop and think about taken-for-granted understandings and terminology in a research context is helpful. This is also the case in relation to the language and terminology we use to refer to mental and emotional distress. The Zoom room enabled us to create a space that we hoped was as free as possible from the epistemological constraints of historical research which emphasised the deficits and differences of mental health service users (Davey, 2019; Scull, 2019). People with autism have for many years talked of the freedoms the internet can offer in terms of their ability to be themselves (Milton and Moon, 2012). It is possible that conducting mental health research within online spaces could offer similar freedoms and liberation from the constraints of mental illness epistemology. Previous research experience has taught us that people in physical buildings (for example, receptionists and janitors) may behave in ways that reinforce the perceived differences of mental health service users, so perhaps as researchers we do have more control over a virtual rather than a physical research environment – unless the internet drops out!

This paper has scratched the methodological surface of using videoconferencing software in sensitive research. We hope the unique insights offered by this project will encourage other researchers to use innovative digital approaches with mental health service users. The project also has implications for sensitive online research with people from other groups. Given the feedback received from one participant regarding her need to be in a women only online space, it is important that future researchers take account of the diverse needs of research participants. We cannot assume that the virtual research space is a safe space – particularly when working with people from minority or marginalised groups. Other researchers who have conducted online focus groups (for example Gray et al., 2020; Greenspan et al., 2021) identify some disadvantages of this approach. We were able to avoid or remedy many of these. Fortunately, our major technical disruption (a whole of

campus internet drop-out) occurred in one of our information sessions, rather than a focus group, and we had already provided a telephone number for people to use in the event of technical problems. We were also able to avoid people talking over each other or dominating discussion (Greenspan et al., 2021) by having clear ground rules and adopting a ‘talking stick’ approach using the ‘Hands up’ icon. Both of these strategies were developed iteratively during information sessions, as was the convention of using a Zoom ‘waiting room’, so that participants arriving late did not enter the main Zoom room unexpectedly. Issues we were unprepared for, however, were background noise and people participating from public spaces, or when driving (Greenspan et al., 2021). It could also be argued that a key shortcoming of our project was that mental health service users are less likely than the general population to have access to the technology required to participate (Wong et al., 2020). In our defence, the project was moved online at short notice (due to COVID-19); it will be important to seek funding to include participants who do not have personal access to such technology in future online projects.

In conclusion, we recommend that when undertaking future research of this nature, researchers take account of the needs of minority groups and access to technology. We also suggest holding an online information session with participants prior to the research itself, in order to:

- troubleshoot any technical or communication issues;
- explain the research, what’s expected of participants, and the process for consenting to participate;
- develop and agree ground rules for a safe and respectful online environment with participants (e.g. not talking over each other);
- identify potential risks to participants’ privacy if they are in a setting where they can be overheard (Bolton, 2017);
- clarify the expectation that they participate from a quiet space free from distractions (Greenspan et al., 2021); and
- that if they participate from a location where confidential focus group conversation could be overheard (e.g. shared accommodation, garden or outside space), headphones should be used.

Credit author statement

Julie Dare: Conceptualisation; Methodology; Writing – original draft and Revision, Helen Seiver: Writing – review & editing, Lesley Andrew: Conceptualisation; Project administration; Writing – review & editing, David Coall: Conceptualisation; Writing – original draft preparation, Shantha Karthigesu: Project administration; Writing – review & editing, Moira Sim: Conceptualisation; Writing – review & editing. Kathy Boxall: Conceptualisation; Methodology; Writing – original draft and Revision

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References

- Australasian College for Emergency Medicine, 2018. The Long Wait: an Analysis of Mental Health Presentations to Australian Emergency Departments. https://acem.org.au/getmedia/60763b10-1bf5-4fbc-a7e2-9fd58620d2cf/ACEM_report_41018.
- Banks, M., 2019. *Using Visual Data in Qualitative Research*, second ed. SAGE Publications.
- Becker, K., Reiser, M., Lambert, S., Covello, C., 2014. Photovoice: conducting community-based participatory research and advocacy in mental health. *J. Creativ. Ment. Health* 9 (2), 188–209. <https://doi.org/10.1080/15401383.2014.890088>.
- Beresford, P., 2002. Thinking about ‘mental health’: towards a social model. *J. Ment. Health* 11 (6), 581–584. <https://doi-org.ezproxy.ecu.edu.au/10.1080/09638230020023921>.
- Bolton, J., 2017. The ethical issues which must be addressed in online counselling. *Australian Counselling Research Journal* 11 (1), 1–15. <http://www.acrjournal.com.au/resources/assets/journals/Volume-11-Issue-1-2017/Volume-11-Issue-1-2017-FULL.pdf>.
- Boxall, K., Beresford, P., 2013. Service user research in social work and disability studies in the United Kingdom. *Disabil. Soc.* 28 (5), 587–600. <https://doi-org.ezproxy.ecu.edu.au/10.1080/09687599.2012.717876>.
- Boxall, K., Ralph, S., 2009. Research ethics and the use of visual images in research with people with intellectual disability. *J. Intellect. Dev. Disabil.* 34 (1), 45–54. <https://doi-org.ezproxy.ecu.edu.au/10.1080/13668250802688306>.
- Braun, V., Clarke, V., 2020. One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qual. Res. Psychol.* 1–25. <https://doi.org/10.1080/14780887.2020.1769238>.
- Brinkmann, S., 2016. *Diagnostic Cultures: A Cultural Approach to the Pathologization of Modern Life*. Routledge.
- Catalani, C., Minkler, M., 2010. Photovoice: a review of the literature in health and public health. *Health Educ. Behav.* 37 (3), 424–451. <https://doi.org/10.1177/1090198109342084>.
- Chamberlain, K., 2000. Methodology and qualitative health research. *J. Health Psychol.* 5 (3), 285–296. <https://doi-org.ezproxy.ecu.edu.au/10.1177/135910530000500306>.
- Chief Psychiatrist of Western Australia, 2018. Ensuring safe and high quality health care: Annual report of the Chief psychiatrist of Western Australia 01 July 2017 – 30 June 2018. <https://www.chiefpsychiatrist.wa.gov.au/wp-content/uploads/2018/09/Chief-Psychiatrist-Annual-Report-2017-2018.pdf>.
- Consumers of Mental Health WA (CoMHWa), 2019. Alternatives to emergency departments project report September 2019. <https://www.mhc.wa.gov.au/media/2993/alt-to-ed-and-safe-havens-final-report-2019.pdf>.
- Creighton, G., Oliffe, J.L., Ferlatte, O., Botorff, J., Broom, A., Jenkins, E.K., 2018. Photovoice ethics: critical reflections from men’s mental health research. *Qual. Health Res.* 28 (3), 446–455. <https://doi.org/10.1177/1049732317729137>.
- Curtis, S., 2010. *Space, Place and Mental Health*. Ashgate Publishing Ltd.
- Davey, G.C. (Ed.), 2019. *Clinical Psychology: Revisiting the Classic Studies*. SAGE Publications Limited.
- Davies, L., LeClair, K.L., Bagley, P., Blunt, H., Hinton, L., Ryan, S., Ziebland, S., 2020. Face-to-face compared with online collected accounts of health and illness experiences: a scoping review. *Qual. Health Res.* 30 (13), 2092–2102. <https://doi-org.ezproxy.ecu.edu.au/10.1177/1049732320935835>.
- Deloitte, 2017. Mobile Consumer Survey: the Australian Cut. <https://www2.deloitte.com/au/mobile-consumer-survey>.
- DuBose, J., MacAllister, L., Hadi, K., Sakallaris, B., 2018. Exploring the concept of healing spaces. *Health Environments Research & Design Journal (HERD)* 11 (1), 43–56. <https://doi-org.ezproxy.ecu.edu.au/10.1177/1937586716680567>.
- Ellis, C., Bochner, A.P., 2000. Autoethnography, personal narrative, reflexivity: researcher as subject. In: Denzin, N., Lincoln, Y. (Eds.), *Handbook of Qualitative Research*. Sage, pp. 733–768.
- Fine, M., Weis, L., Weseen, S., Wong, L., 2000. Qualitative research, representations and social responsibilities. In: Denzin, N., Lincoln, Y. (Eds.), *Handbook of Qualitative Research*. Sage, pp. 107–131.
- Foster-Fishman, P., Nowell, B., Deacon, Z., Nievar, M.A., McCann, P., 2005. Using methods that matter: The impact of reflection, dialogue, and voice. *Am. J. Community Psychol.* 36, 275–291. <https://doi.org/10.1007/s10464-005-8626-y>.
- Foucault, M., 1965. *Madness and Civilization: A History of Insanity in the Age of Reason*. Random House.
- Gambrell, E., 2012. *Propaganda in the Helping Professions*. Oxford University Press.
- [1963] Goffman, E., 1984. *Stigma: Notes on the Management of Spoiled Identity*. Penguin.
- Golden, T., 2020. Reframing photovoice: building on the method to develop more equitable and responsive research practices. *Qual. Health Res.* 30, 960–972. <https://doi.org/10.1177/1059732320905564>.
- Graham, R., Hodgetts, D., Stolte, O., Chamberlain, K., 2018. Sustaining spaces: community meal provision and mental well-being. In: McGrath, L., Reavey, P. (Eds.), *The Handbook of Mental Health and Space: Community and Clinical Applications*. Routledge, pp. 119–143.
- Gray, L.M., Wong-Wylie, G., Rempel, G.R., Cook, K., 2020. Expanding qualitative research interviewing strategies: Zoom video communications. *Qual. Rep.* 25 (5), 1292–1301. <https://search.proquest.com/scholarly-journals/expanding-qualitative-research-interviewing/docview/2405672296/se-2?accountid=10675>.
- Greenspan, S.B., Gordon, K.L., Whitcomb, S.A., Lauterbach, A.A., 2021. Use of video conferencing to facilitate focus groups for qualitative data collection. *American Journal of Qualitative Research* 5 (1), 85–93.
- Harper, D., 2002. Talking about pictures: a case for photo elicitation. *Vis. Stud.* 17 (1), 13–26.

- Hodgetts, D., Stolte, O., Sonn, C., Drew, N., Carr, S., Nikora, L.W., 2020. *Social Psychology and Everyday Life*. Red Globe Press.
- Holland, K., 2007. The epistemological bias of ethics review: constraining mental health research. *Qual. Inq.* 13 (6), 895–913. <https://doi.org/10.1177/1077800407304469>.
- Horwitz, A.V., 2020. *Creating Mental Illness*. University of Chicago Press.
- Lang, K.R., Hughes, J., 2004. Issues in online focus groups: lessons learned from an empirical study of peer-to-peer filesharing system users. *European Journal of Business Research Methods* 2 (2), 95–110. <https://ssrn.com/abstract=1070158>.
- Liegghio, M., Caragata, L., 2020. Covid-19 and youth living in poverty: the ethical considerations of moving from in-person interviews to a photovoice using remote methods. *Affilia* 1–7. <https://doi.org/10.1177/0886109920939051>.
- MacKinnon, D., Coleborne, C., 2003. Deinstitutionalisation in Australia and New Zealand. *Health and History* 5 (2), 1–16. <https://doi.org/10.2307/40111450>.
- Migliorini, L., Rania, N., 2017. A qualitative method to “make visible” the world of intercultural relationships: the photovoice in social psychology. *Qual. Res. Psychol.* 14 (2), 131–145. <https://doi.org/10.1080/14780887.2016.1263698>.
- Milton, D., Moon, L., 2012. ‘And that, Damian, is what I call life-changing’: findings from an action research project involving autistic adults in an on-line sociology study group. *Good Autism Practice* 13 (2), 32–39. <https://kar.kent.ac.uk/id/eprint/62637>.
- Morphet, J., Innes, K., Munro, I., O’Brien, A., Gaskin, C.J., Reed, F., Kudinoff, T., 2012. Managing people with mental health presentations in emergency departments: a service exploration of the issues surrounding responsiveness from a mental health care consumer and carer perspective. *Australas. Emerg. Nurs. J.* 15 (3), 148–155. <https://doi.org/10.1016/j.aenj.2012.05.003>.
- National Health and Medical Research Council, 2018. National Statement on Ethical Conduct in Human Research 2007 (Updated 2018). Commonwealth of Australia. <https://www.nhmrc.gov.au/about-us/publications/national-statement-ethical-conduct-human-research-2007-updated-2018>.
- Nehls, K., Smith, B.D., Schneider, H.A., 2015. Video-conferencing interviews in qualitative research. In: Hai-Jew, S. (Ed.), *Enhancing Qualitative and Mixed Methods Research with Technology*. Information Science Reference, pp. 140–157. <https://doi.org/10.4018/978-1-4666-6493-7.ch006>.
- Newman, J., Boxall, K., Jury, R., Dickinson, J., 2019. Professional education and Mad Studies: learning and teaching about service users’ understandings of mental and emotional distress. *Disabil. Soc.* 34 (9–10), 1523–1547. <https://doi.org/10.1080/09687599.2019.1594697>.
- Oakley, A., 1981. Interviewing women: a contradiction in terms. In: Roberts, H. (Ed.), *Doing Feminist Research*. Routledge, pp. 30–61.
- Reavey, P., 2011. The return to experience: psychology and the visual. In: Reavey, P. (Ed.), *Using and Interpreting Images in Qualitative Research*. Routledge, pp. 1–13.
- Rice, C., LaMarre, A., Changfoot, N., Douglas, P., 2020. Making spaces: multimedia storytelling as reflexive, creative praxis. *Qual. Res. Psychol.* 17 (2), 222–239. <https://doi.org/10.1080/14780887.2018.1442694>.
- Rogers, A., Pilgrim, D., 2014. *A Sociology of Mental Health and Illness*. Open University Press.
- Rose, D., 2017. Service user/survivor-led research in mental health: epistemological possibilities. *Disabil. Soc.* 32 (6), 773–789. <https://doi-org.ezproxy.ecu.edu.au/10.1080/09687599.2017.1320270>.
- Rose, G., 2012. *Visual Methodologies: an Introduction to Researching with Visual Materials*, third ed. SAGE Publications.
- Salmons, J., 2014. *SAGE Research Methods Cases: Visual Methods in Online Interviews*. SAGE Publications.
- Scull, A., 1990. Deinstitutionalization: Cycles of despair. *J. Mind Behav.* 11 (3–4), 301–311.
- Scull, A., 2019. *Psychiatry and its Discontents*. University of California Press.
- Silver, J., Reavey, P., 2010. He’s a good-looking chap ain’t he?: narrative and visualisations of self in body dysmorphic disorder. *Soc. Sci. Med.* 70, 1641–1647. <https://doi.org/10.1016/j.socscimed.2009.11.042>.
- Sitter, K.C., 2017. Taking a closer look at photovoice as a participatory action research method. *J. Prog. Hum. Serv.* 28, 36–48. <https://doi.org/10.1080/10428232.2017.1249243>.
- Staddon, P. (Ed.), 2013. *Mental Health Service Users in Research: Critical Sociological Perspective*. Policy Press.
- Sutton-Brown, C.A., 2014. Photovoice: a methodological guide. *Photogr. Cult.* 7 (2), 169–185. <https://doi.org/10.2752/175145214X13999922103165>.
- Teti, M., 2019. The murky ethics of visual qualitative methods: Picturing a clear path forward. *Int. J. Qual. Methods* 18, 1–4. <https://doi.org/10.1177/1609406919884810>.
- Uttarkar, V., 2018. Institutionalising people in the community: a reflection on distress. In: McGrath, L., Reavey, P. (Eds.), *The Handbook of Mental Health and Space: Community and Clinical Applications*. Routledge.
- Walker, C., Klein, O., Marks, N., Hanna, P., 2018. Caring spaces and practices: does social prescribing offer new possibilities for the fluid mess of ‘mental health’? In: McGrath, L., Reavey, P. (Eds.), *The Handbook of Mental Health and Space: Community and Clinical Applications*. Routledge, pp. 149–162.
- Wallace, S.A., 2011. Addressing health disparities through relational ethics: an approach to increasing African American participation in biomedical and health research. In: Trimble, J.E., Fisher, C.B. (Eds.), *The Handbook of Ethical Research with Ethnocultural Populations & Communities*. SAGE Publications, Inc, pp. 68–76.
- Wang, C., Burris, M.A., 1997. Photovoice: concept, methodology, and use for participatory needs assessment. *Health Educ. Behav.* 24, 369–387.
- Wang, C.C., Redwood-Jones, Y.A., 2001. Photovoice ethics: perspective from Flint photovoice. *Health Educ. Behav.* 28 (5), 560–572.
- Wessex Academic Health Science Network, 2017. Independent Evaluation of the North East Hampshire and Farnham Vanguard Aldershot Safe Haven Service. October 2017. https://wessexahsn.org.uk/img/projects/Safe%20Haven%20Evaluation_FI_NAL_October%202017.pdf.
- Wong, K.T.G., Liu, D., Balzan, R., King, D., Galletly, C., 2020. Smartphone and internet access and utilization by people with schizophrenia in South Australia: quantitative survey study. *JMIR Mental Health* 7 (1), e11551. <https://mental.jmir.org/2020/1/e11551/>.