Challenges in Implementing Recovery-Based Mental Health Care Practices in Psychiatric Tertiary Care

Lupin Battersby
Simon Fraser University

Marina Morrow
Simon Fraser University

ABSTRACT

Despite increased interest in the concept of recovery, not enough is known about the challenges of implementing recovery models in mental health care settings. Findings are presented from a 3-year feminist ethnographic study that followed recently deinstitutionalized women and men as they moved into psychiatric tertiary care facilities in British Columbia where a psychosocial rehabilitation model based on recovery principles was implemented. We found that inconsistent staff training and stretched community supports have resulted in uneven implementation that does not yet maximize opportunities for people's recovery. Further, care is organized and delivered in ways that emphasize individual needs as opposed to social and collective needs based on factors such as gender, ethnicity, and culture. These findings indicate that greater political will, as measured in commitments to community-based mental health services, is required to fully realize the philosophy of recovery and equitable mental health care.

Keywords: recovery, deinstitutionalization, psychosocial rehabilitation, psychiatric tertiary care, gender, social and structural determinants of mental health

In the last several decades mental health systems in the United States and Canada have adopted recovery-oriented models to guide policy development and the care of people with mental health problems[1] (Anthony, 1993; Bonney & Stickley, 2008; Everett et al., 2003). While much has been written on the subject of recovery in this context, scholars, decision-makers, and care providers continue to debate

Lupin Battersby, Centre for the Study of Gender, Social Inequities and Mental Health, Simon Fraser University, Vancouver; Marina Morrow, Faculty of Health Sciences, Simon Fraser University, Vancouver.

Correspondence concerning this article should be addressed to Lupin Battersby, Centre for the Study of Gender, Social Inequities and Mental Health, 515 West Hastings, Suite 3277, Vancouver BC V6B 5K3. Email: lbatters@sfu.ca

its meaning and to struggle with implementation (Dip, 2008; Farkas, Gagne, Anthony, & Chamberlin, 2005; Ramon, Healy, & Renouf, 2007). Indeed, few empirical studies have looked at how recovery models are taken up in mental health practice, especially in the context of psychiatric tertiary care, and what opportunities and barriers to this uptake are experienced by practitioners. In the Canadian context, where mental health care is receiving unprecedented political attention through the establishment of a federal Mental Health Commission (Mental Health Commission of Canada, 2009) and where mental health reforms and deinstitutionalization (including in the British Columbian context) are ongoing, such studies are needed to provide insight into the implementation of recovery models. If conducted with attention to gender and other intersecting social factors, these studies can also contribute to the growing literature on the differing impact of mental health care depending on the social location of individuals, and to the emergent literature on mental health equity.

In this paper we present findings from a three-year feminist ethnographic study of deinstitutionalization in British Columbia, Canada (Morrow et al., 2010). We discuss the challenges faced by mental health care staff at psychiatric tertiary care facilities in implementing a psychosocial rehabilitation (PSR), recovery-based model of care for individuals recently transferred out of a long-term institutional setting.[2] Our findings highlight that the conflation of PSR with recovery, insufficient training of staff, and stretched community resources have limited the actualization of recovery models in this context. We show how these insufficiencies are, in turn, linked to the dominance of psychiatric care over social care, which limits support for recovery. Although recovery models encompass social supports (like housing and income) for people with mental illness, our findings demonstrate that, in practice, an individualistic view of mental illness persists that works against recognizing the contribution of systemic social and structural inequities to people's experiences of mental illness and to their recovery journey.

BACKGROUND

Psychiatric Deinstitutionalization

While the deinstitutionalization of people from large psychiatric institutions began in the 1960s, and most of Canada's large institutions have been closed, British Columbia is somewhat unique in having maintained its one provincial psychiatric institution (Riverview Hospital), albeit much downsized, until it closed in 2012 (Goldner, 2005). Our study focused on the contemporary movement of people out of Riverview, some of whom had lived there for up to 35 years. Since the inception of deinstitutionalization, critics have argued that governments have not provided the supports needed for people to live in the community. Indeed, some have argued that life in community settings has been different only in degrees and that people's lives continue to be marked by stigma, poverty, and discrimination, while opportunities for social inclusion remain limited (Bertram & Stickley, 2005; Leff & Warner, 2006; Mental Health Commission of Canada, 2010; Nilsson & Lögdberg, 2008; Ware, Hopper, Tugenberg, Dickey, & Fisher, 2008). The movement of people from Riverview might be better understood as a form of reinstitutionalization as people have been transferred to smaller facilities, some of which retain aspects of institutional life (Morrow, Dagg, & Pederson, 2008). Research shows ongoing concerns about the lack of community-based supports, especially housing and employment supports for people struggling with chronic mental health problems (Morrow, Wasik, Cohen & Perry, 2009). Arguably, these limitations in community care could be attributable to insufficient political

will to address the needs and concerns of a highly stigmatized population, and to a series of social welfare reforms and cuts to services that have exacerbated the marginalization of people with mental health problems (Klein & Long, 2003; Morrow, 2004; Morrow et al., 2009).

In British Columbia (BC), the most recent developments in a long deinstitutionalization process[3] began in 1998 with the *BC Mental Health Plan.* The plan called for regional self-sufficiency through the devolution of tertiary services from the province's one large psychiatric hospital, Riverview Hospital, to five regional health authorities[4] (BC Ministry of Health, 1998). The "Riverview Redevelopment Project" began in 2000 and is ongoing. The project is focused on relocating the remaining occupants, and the resources associated with caring for them, from Riverview to cities and towns throughout the province. The downsizing of Riverview has been accompanied by a shift in the philosophy of care away from a custodial model toward a recovery orientation, operationalized through psychosocial rehabilitation (PSR) principles.

Developing psychiatric tertiary capacity in new regions has meant new resources to build or renovate tertiary care facilities, and to hire and train staff. However, community-based mental health services were required to shift their mandates to welcome new participants without any additional government funds or resources. Gender and other intersecting social and structural determinants of health, such as race and poverty, can contribute to or exacerbate mental health problems (Anderson & Chiocchio, 1997; Harris & Landis, 1997; Saraceno & Barbui, 1997). This knowledge prompts us to be aware of the ways in which the changes to care occurring through deinstitutionalization also affect people differently depending on these factors. For example, the literature shows that men and women signal and cope with distress differently, and that they access different kinds of services and supports (Rhodes, Goering, To, & Williams, 2002). By stirring up debates about care, deinstitutionalization has arguably forced the mental health care system to deal more consciously with the needs of people with chronic mental health problems. As such, deinstitutionalization can provide the opportunity for significant improvements in care that take account of social and structural factors.

Recovery

Increasingly, the idea of recovery is incorporated into professional literature and reflected in policy documents and frameworks (Barker, 2003; Calsaferri, Treherne, & van der Leer, 2002; Mental Health Commission of Canada, 2009; Trainor, Pomeroy, & Pape, 2004). A range of definitions and understandings of recovery now exist, and these are paralleled in the models proposed to facilitate it. In general, contemporary ideas describe recovery as fluid: "A person with mental illness can recover even though the illness is not 'cured'" (Anthony, 1993, p. 525). Ramon et al. (2007) build on this:

> Recovery is not about going back to a pre-illness state, and [it] means something very different from the "old" emphasis on controlling symptoms or cure. Rather, it is a complex and multifaceted concept, both a process and an outcome, the features of which include strength, self-agency and hope, interdependency and giving, and systematic effort, which entails risk-taking. (p. 119)

In the Canadian context the most recent articulation of the components of recovery can be found in the Mental Health Commission of Canada's (2009) framework for a mental health strategy, in which recovery is described as "a journey of healing that builds on individual, family, cultural and community strengths, and enables people living with mental health problems and illnesses to lead meaningful lives in the community, despite any limitations imposed by their condition" (p. 8).

These definitions share an emphasis on agency, hope, and interdependency in relationships. Each also sees recovery as multidimensional, and each makes a clear distinction between "complete recovery" (loss of psychotic symptoms, return to pre-illness functioning) and "social recovery" (regaining economic and residential independence; Jablensky et al., 1992). Recovery also includes attention to the larger social and systemic issues faced by people with psychiatric disabilities, including discrimination and the need for economic security (Jacobson & Farah, 2010; Rossiter & Morrow, 2011).

Psychosocial rehabilitation (PSR) is a set of principles and practices developed by community-based mental health organizations during the advent of psychiatric deinstitutionalization in the 1970s and 1980s. It included activities such as the establishment of Clubhouses, supported housing, and employment programs. PSR-based service organizations generally outline 12 to 15 principles as a means of defining their practice.[5] The principles affirm, for example, that recipients of mental health services have the right to "direct their own affairs"; that services should be maintained over time; and that family, if appropriate, should be involved maximally in care processes (PSR/RPS Ontario, 2010). Although PSR principles are compatible with a recovery orientation, PSR is not equivalent to a recovery model. Any recovery-oriented practice should also reflect a set of core values, defined by Farkas et al. (2005) as including person orientation, person involvement, self-determination/choice, and growth potential.

METHODS

The research project from which we draw our findings (Morrow et al., 2010) utilized feminist-informed ethnographic methods (see Dobson, 2001; Smith, 2006; Townsend, Langille, & Ripley, 2003). Methods included relationship building, especially with facility managers, and spending time in the communities of interest; attending planning and roundtable meetings at Riverview; including people on the research team from the community with lived experience of mental health problems; working in collaboration with researchers from Riverview; and conducting interviews and focus groups to produce descriptions of what happened in the transfer of people from Riverview and the ongoing process to integrate people into their new communities. We were interested in documenting the process from the perspective of a range of participants: mental health managers and staff, care recipients, family members, and community-based organizations.

The study was located in two towns (A and B[6]) in the interior of British Columbia. The Interior Health (IH) authority serves a geographic area covering nearly 215,000 square kilometres; towns A and B received most of the people transferred to the region from Riverview Hospital. Town A built a 46-bed psychiatric tertiary care facility with funds from the Riverview Redevelopment Project. The facility provides treatment and rehabilitation with the goal of preparing individuals for community reintegration. Town B used funds from the same source to renovate a smaller, pre-existing facility. Other existing community-based facilities in the two towns received a small number of transfers.

Beginning in 2006 the research team completed four site visits to both towns. The initial visit focused on establishing relationships with research participants and spending time developing a sense of the two communities. Two community-based researchers with lived experience of mental illness from the community, who were members of the research team, were integral in establishing relationships with community-based participants. Previous to these encounters, ethics applications were approved by the Research Ethics Boards at Simon Fraser University and Interior Health.

A number of ethical issues came up in the context of our research. First, we needed consent to interview individuals who had been highly institutionalized and whom we could access only through facility staff. We chose to approach only those individuals who were already participating in another clinical follow-up study (Goldner, Lesage, & Groden, 2007; Lesage, Groden, Ohana, & Goldner, 2006), and we benefited greatly from careful consultation with the two researchers who had developed a protocol for consent (Lesage, Groden, Goldner, Gelinas, & Arnold, 2008). In addition, care was taken to provide ample flexibility and support to residents who participated.[7] Second, we were concerned that the study would be seen as an evaluation of the changes the region was undergoing. Because the transfers of people from Riverview to this region were unprecedented, during the course of our study management and staff were under intense scrutiny from the Provincial Health Services Authority and the management of Riverview. To mitigate this concern, we spent time from the outset building relationships with management and assuring staff and other interview participants that our study was in no way an evaluation of the ongoing activities of the region, but rather was meant to document the process as it was unfolding.

Visits and relationship building also provided context for the development of the semi-structured interview guides. Individual interviews and focus groups took place during the next three visits. After each visit the interview guides were reviewed and adjusted based on the preceding interviews. In the project's third year, we undertook two additional visits (2007 and 2008) for knowledge-exchange activities. We invited participants to provide feedback on the results, and on our last visit we reported our final results. In total, we interviewed 68 participants and conducted four focus groups. For the purposes of this paper, we report only on data emerging from study participants who work as mental health managers and staff. These data come from 44 interviews (Table 1) and three focus groups, one held in Town A and two in Town B.

Table 1
Individual Interviews by Category, Number, and Interviewees

Category	#	Interviewees
Mental health directors and managers	18	• Interior Health officials overseeing psychiatric tertiary care development • Provincial Health Services Authority officials overseeing Riverview redevelopment
Tertiary mental health care providers	15	• occupational therapists • registered nurses • life skills workers • transitional care aides • other allied health care workers
Managers and staff of community-based organizations	11	• community mental health providers • social service providers • shelters • vocational support organizations
TOTAL	44	

Data (including interview transcripts, focus group transcripts, and field notes) emerging from this ethnography were organized and coded according to emergent themes. The data were also organized according to type of interview participant, although cross-comparisons were then made regarding convergent and divergent themes. The coding and analysis were done simultaneously. Analysis was cyclical and comprehensive with team members working independently and then collaboratively; earlier analysis was then informed by emerging analysis.

Gender-based and intersectional analytic frameworks were also applied. Gender-based analysis poses questions about the similarities and/or differences among the needs of women and men in service design, delivery, program planning, and policy making (Cuadraz & Uttal, 1999; Greaves et al., 1999; Health Canada, 2003; Johnson, Greaves, & Repta, 2007; Salmon, Poole, Greaves, Ingram, & Pederson, 2006; Spitzer, 2004). In the case of our research, we were interested both in the ways the practices of staff might be gendered and in how staff perceived the needs and concerns of men and women. In our analysis we were attentive to the ways in which gender intersects with race, ethnicity, culture, and sexual orientation (Burman, 2003; Burman & Chantler, 2003; Hankivsky & Cormier, 2009; Johnson et al., 2007; Kohn & Hudson, 2002; Smye & Browne, 2002) and as such were curious about whether staff understood and worked from perspectives that recognized these as important factors in mental health equity.

FINDINGS

The findings presented here represent what emerged as significant for staff, managers, and service providers, both in the tertiary and community-care system, in the process of transferring former residents of Riverview to recovery-oriented facilities and working to support them in the community. The following primary experiences and issues emerged: model and location of care, staff training and resources, resident involvement in care planning, gender and intersectionality, and community capacity and resources.

Model and Location of Care

The move from Riverview to community-based tertiary care facilities included both a change in the location of care and a change in the model of care.

The steps taken to change the model of care to psychosocial rehabilitation in the region included, in Town A, the development of a new psychiatric tertiary care facility with specific architectural features to make it more home-like and conducive to recovery, such as building private rooms organized in pods, each with its own kitchen space. Rather than stand-alone nursing stations, nurses mingled and interacted with patients in the same space, and the facility was built without a seclusion room. In Town B, an existing, much smaller, facility was renovated to provide more private space. Both facilities are located in close proximity to residential areas and to community-based mental health programs. One of the goals was to better integrate people into community activities, and residents were meant to obtain services, like haircuts and doctors' appointments, off-site rather than within the institution as had been previously the case at Riverview. Both existing and newly hired staff were required to take a PSR training course (described below) at a local college. The discrepancy between this training and what they encountered in practice became an important finding for our study.

Respondents who had been involved in the initial planning and development of the facilities described how they had hoped to implement a care model based on what they described as "pure" PSR. That is, they had hoped to implement PSR within the context of a recovery philosophy that created space for maximum patient autonomy and decision making. However, they reported that their ability to do so was hampered, in part, by the unanticipated level of need among people who had experienced long-term institutionalization.

> I would say over time that people that are coming are much more symptomatic, much more institutionalized, have been in and out of hospital for many, many times and many, many different circumstances.… So as our population has become more diverse, we have had to really modify that kind of more ideal PSR philosophy and practice.... I mean I always relate this to one example because, we had a woman … [who] had been institutionalized for many, many years … maybe 30, 35 years … at RVH [Riverview Hospital] and truly didn't know how to do a thing. And I can remember about 18 months into her stay here, her key worker, coming to my office, just like practically in tears with excitement, because that woman, that day had made her own tea and toast. You know, so it's like, this isn't getting people job ready, you know. We've had to kind of really pare back our expectations. (Facility Manager)

This passage reflects the difficulty staff had in reconciling what they had learned through their training about recovery models with the level of life skills that former Riverview residents had been able to develop at Riverview.

At the same time, staff themselves struggled to move away from a more custodial model of care and to practice PSR with more comprehensive recovery-oriented values. For example, service providers were aware that their personal values and beliefs sometimes resulted in evaluative language to describe residents' choices as "good" or "bad."

> Don't we all make relational mistakes, and don't we all learn through our mistakes? So we have lots of discussions around why don't we allow our clients with mental illness to make mistakes? Why don't we allow them to also fail? Also, about standards, you know, how clean is clean, how organized is organized, and is this what we expect of our families at home, or is this a notch or two above? And I think that's the big friction in-between custodial and the PSR approach. (Facility Manager)

Residents were expected to keep their rooms clean, to not smoke cigarettes, and to never get intoxicated. The interviews thus revealed that care under the newly implemented PSR model maintained some of the traditional paternalistic aspects of custodial care.

Discussion with care providers turned to choices residents make that run against the moral beliefs of staff members. In particular, staff experienced conflict with respect to patient decision-making about sexual behaviour. In one case, when a woman resident, while delusional, expressed a desire to have unprotected sex with men, it was unclear to staff what their roles and responsibilities were in relation to informed consent.

> So just because you are certified under the Mental Health Act doesn't imply that you cannot give consent to sex. So it gets very difficult…. (Psychiatrist)

In this particular case, staff sought legal advice. But the quote illustrates how staff members, especially those in management or senior roles, have struggled with letting individuals make decisions while assessing their own risk management and legal responsibilities. In addition, staff felt responsible for the behaviour and choices of residents.

Ongoing Training and Resources for Staff

As described, newly hired staff and staff of the already existing facility were all required to take a PSR training course. A review of the course curriculum revealed that there was little emphasis on recovery values and concepts, potentially leaving staff without the foundation of values on which the PSR principles are based (Morrow et al., 2010). The result was a conflation in understanding between PSR and recovery, which were often used as interchangeable terms. As well, study participants reported that over time training requirements for staff became more lenient. New hires were accepted with PSR "equivalent" education or experience (for example, an undergraduate psychology course), but no specific PSR or recovery training. According to our correspondents, this has contributed to inconsistent understanding and practice between staff members.

The initial emphasis on universal training in PSR was admirable but was not supported over the long term with follow-up training opportunities in PSR or mentoring by experienced persons. As indicated above, staff received general training as community, residential, and semi-independent living mental health support workers. As such, interviews with staff reflected inconsistencies in the understanding of recovery and the PSR model. For example, staff believed that PSR did not apply to patients who were too ill. This attitude, although understandable, conflicts with the principles of PSR and the values of recovery.

> I think the first three-week orientation … was more around the philosophy of PSR and trying to get people to understand that we are bringing folks into a different level of care, that we are promoting hope, we are promoting recovery. We have the expectation that people will move back into [the] community, and people will move on.… That was the philosophy, but then when you come to actually implement that, the level of care that people required was quite a shock. (Facility Staff Member)

The literature suggests that changing a model of care is challenging in part because of the potential conflict with personal values as well as the tendency for individuals to return to what they know or are most comfortable with (Bedregal, O'Connell, & Davidson, 2006; Felton, Barr, Clark, & Tsemberis, 2006; Song, 2007). Our findings affirm the reality of these challenges and suggest that training and ongoing mentoring could mitigate them when implementing model of care changes.

Overall, it appears that there were very few opportunities to access information about recovery and PSR models and that existing curriculum for staff training was inadequate. Absent as well were opportunities for ongoing professional development and mentoring.

Resident Involvement in Care Planning

As mentioned earlier, recovery models are premised on the belief that people experiencing mental illness should have maximum control over their treatment and care. Our study endeavoured to understand how much residents were involved in the decision-making leading up to their move (Morrow & Jamer, 2008) and whether the newly developed destination facilities in Towns A and B had concrete mechanisms to involve them in ongoing decision-making. We also explored the degree to which patients understand their rights under involuntary committal laws.

The Riverview Hospital protocol for preparing residents for moving was to consult with the individual being moved and to discuss the move with any family members or other support people. It appears that this

protocol was followed.[8] In some instances, residents had the opportunity to visit the new facility prior to making a decision.

We also investigated whether the newly developed tertiary facilities had any formal mechanism to apprise residents of their rights. This was important given that patient advocates at Riverview had developed a Patient's Charter of Rights in the late 1990s in consultation with residents (McCallum, 1994). The Charter alerted individuals living at Riverview (most of whom were involuntarily committed) as to their rights with respect to quality of care, legal rights, and privacy. It was logical that some kind of rights mechanism would follow residents into the new regional settings. But our participants reported that, although there were initial attempts to develop involvement mechanisms, these were not maintained.

> So ... there used to be, I think before, quite a number of advisories and community kind of consumer advisories and mechanisms for input in that way. And I think the thought was if you're going to have those mechanisms, they need to really be meaningful. I don't think they were very effective. So I think our philosophy is certainly to listen to clients in terms of what they want for care, and really work with that PSR model. And so we don't have formal structures around advisories or consumer input in that way. But it certainly happens, I think, on a daily kind of practice model. (Community Mental Health, Manager)

The implementation and maintenance of programming that encouraged resident involvement was also affected by funding cuts.

> We had trouble getting people on committees.... We tried training a bunch of people that were in peer support, which we did. And right at the time that people were kind of finishing, looking at going on practicum, the funding was cut for the program. (Facility, Project Manager)

Thus, on an individual level staff endeavoured to incorporate residents' personal goals; however, ongoing meaningful engagement of residents in the facilities' planning and programming were not apparent.

Gender and Intersectionality

We also asked staff and management to reflect on their experiences of working with men and women and to discuss how the needs of different genders and cultural groups were being met. It should be noted that male patients at Riverview have historically predominated; however, we interviewed equal numbers of men and women. Although both towns had sizable Aboriginal communities and smaller South Asian, Japanese, and Chinese populations, the majority of staff with whom we had contact were from Euro-Canadian backgrounds. We observed that staffing followed traditional gendered configurations with most of the upper management being male and the majority of front-line care staff being female.

Staff and management generally did not discuss gender and other social locations as social processes, or more specifically, as relevant to equity in mental health. Repeatedly, our respondents returned to the notion that each person was an individual and should be treated as such. For example, staff and management typically cited the client-centred principle of PSR as the means of addressing gender and cultural diversity. Wider social constructs and disparities were rarely addressed.

> I don't go as much by culture as much as … what is the client's need. Because you can't assume that they're enmeshed in a certain culture because of their background, you know what I mean? (Community, Staff)

Similarly, in the following passage the respondent acknowledges that broader structural issues are not addressed in the PSR model of care.

> I don't think any of the things that we were trying to take into account were of that scale [i.e., gender, diversity]. It was more of the micro-scale. You know, is this person vegetarian, do they have particular religious needs.… We don't have a synagogue in [Town A], you know. (Facility Manager)

Despite the lack of awareness surrounding the significance of gender and culture, respondents did note that there were different care requirements for men and women, especially in relation to sex, safety, risk management, and relationships. One facility we visited had previously been a residence for men only. Staff members were therefore in a position to note the differences in their work experiences when women moved into the facility. In the view of some, women were more work because they were more interested in social interaction and meaningful engagement than male residents.

> Well, I would have to say that … some of the women that we have are actually, yes, a little more disruptive. I think it's because, you know, the social thing with women, they want to be around people, where men generally, not everybody, but men generally are more insular.… They're at ease to do whatever.… They don't need to be occupied for every minute of the day when they're here. (Facility Staff)

This perception, that women are more "needy" or "difficult" than men because they desire social interaction with staff, was consistent with our finding that, among care recipients, women were more concerned than men with maintaining relationships with staff, children, friends, and family and had a greater capacity to do so (see Morrow & Jamer, 2008). The fact that relational contact with residents was seen as burdensome by staff suggests that staff do not see relational work as integral to care or recovery. Our analysis suggests that gender and culture are understood at the individual level and not as social structures. Indeed, PSR (and arguably recovery) does not adequately address social and structural determinants of health (Weisser, Morrow, & Jamer, 2011).

Community Capacity and Resources

The move of individuals from Riverview was meant to give people care in smaller, more home-like settings and to facilitate greater interaction and access to community-based programs and resources. However, in the transfer of patients from Riverview to other communities, government resources went exclusively into the tertiary care system (Health Systems Research and Consulting Unit, 2007), leaving the community-based mental health service sector struggling to meet the growing demands for support.

Service providers at the facilities in Town A reported concerns with the limited number of housing options in the community. Although many of the individuals who first moved from Riverview were able to move into more independent living situations, subsequent people who were transferred have not been able to move through the facility as quickly. Staff reported that this was because there are not enough supported housing options available for them. Second, care providers were concerned about the leap residents had to make from supported living to independent living. They felt that more "stepped options" or other intermediate housing solutions would make transitioning more successful for the residents.

> And that's where we're in this place now where we do have about 20 folks who are severe, persistently mentally ill who have kind of reached a functioning level that's at their peak, which is not community living, you know, which is not going to that next level of independence. It's really more of a group home type model. They're safe here, they're comfortable here, but really do we need to keep them in a rehab facility? No. We could move them on, but there's no place to move them on to.

In both communities there are a small number of services and organizations that are willing to accommodate persons who have moved from Riverview in their work, training, and social programming. Despite this, there are limits and challenges to these services. Community mental health staff indicated that the job opportunities for people with mental illness are limited both in quality and quantity.

> I'm hopeful, but it's almost as if there's this, you know, sure, volunteer, get a resume, do all the stuff, but there's a glass ceiling that's really low, like knee high. (Community Mental Health, Staff)

Some work opportunities are offered on-site at the large rehabilitation facility in Town A. But although positive for some residents, we heard from participants that this sometimes limited connections outside the facility. In Town B, meanwhile, one organization runs a thrift store, employs people with mental health issues to offer products and services to local businesses, has art and crafts programs, and offers job training.

In the development of the rehabilitation facility in Town A, there was an expectation that residents would access most services off-site to promote community connections. In reality, it has been a challenge for community organizations to meet the needs of additional people while continuing to serve their established clientele. The capacity of community organizations has been undermined by years of social service funding cuts (Morrow et al., 2009; Vogel, Rachlis, & Pollak, 2000). Moreover, these strapped community organizations were not created to meet the needs of formerly institutionalized individuals. Staff spoke to this issue.

> [One organization is] full and they have a waiting list.… We're unable to access any of their services because they have their own, you know, their own agenda, and we have problems there. With [name of organization] for instance, they want people to go through an interview process and get a membership, and our clients, most of the clients, not all of them, are not comfortable with that process, that sort of thing. (Facility Staff)

DISCUSSION

The downsizing of British Columbia's one large psychiatric institution has provided mental health care providers with a unique opportunity to develop new facilities and methods of working with people with serious and chronic mental health problems. Overall, our study found that the process was successful and beneficial for most of those transferred to the region we investigated. Most of the transfers were well planned and supported by staff at Riverview, and the new facilities increased opportunities for recovery-based goals. Indeed, some former Riverview residents have moved on to more autonomous living arrangements.

However, the shift from traditional custodial care models to PSR through the Riverview redevelopment process has proved challenging due to multiple factors: implementing a PSR model without full integration of recovery values; insufficient training and support for staff working with the new model of care; lack of buy-in from decision makers to fully acknowledge the cost of implementing a recovery model; the disjuncture between political and practice objectives resulting in inconsistent training; and a tenuous and uneven implementation of recovery at the community level in terms of housing, meaningful activities, and tailored programming for individuals emerging from a long-term institutionalized setting.

The limited resources afforded to community-based mental health supports, especially to housing and employment, and the ongoing priority placed on psychiatric interventions rather than on community-based care will continue to impede the implementation of recovery models. The practice of PSR, including building

relationships, providing continuity in care and resources, and being flexible in planning requires substantial time and resources in order to be realized.

Researchers, policy makers, and practitioners should be reminded that recovery and PSR are not tools for creating independence and self-managed individuals, but a means by which to embrace all members of our community including those who experience the world from a different perspective and with a unique set of challenges and strengths. This approach involves caring, providing the necessary tools and resources for living, and engaging with individuals as well as acknowledging and tackling stigma, discrimination, and other structural barriers.

NOTES

1. How best to describe and define mental states is debated in the literature (Lesage & Morissette, 2002; Mental Health "Recovery" Study Working Group, 2009). Choosing language that respects these debates while still acknowledging forms of mental distress experienced by people is tricky and in our case compounded by the fact that in our research setting, diagnoses of mental illness are used uncritically and were universally adopted by all our research participants. We have thus chosen to use terms like "mental illness," "mental health problems," and "mental distress" interchangeably.
2. Elsewhere we have written about the experiences of the residents (see Morrow & Jamer, 2008).
3. Riverview Hospital (formerly Essondale) has been BC's sole psychiatric hospital for nearly a century. Its population peaked in 1956 at over 4,000 patients (British Columbia Royal Commission on Health Care and Costs, 1991). Between 1956 and 1976, Riverview reduced its bed capacity by more than half. In 1987 the provincial government introduced another plan to replace Riverview with community-based resources and longer term inpatient units around the province (BC Ministry of Health Services, 1987). Downsizing under this plan began in 1992 but was suspended in 1996 because of pressure on psychiatric services in hospitals and a lack of community care resources (Auditor General of British Columbia, 1994; BC Provincial Mental Health Advisory Council, 1996).
4. Regionalization has been a major feature of health care reform in Canada over the last 20 years. British Columbia began planning these changes in the 1990s, and in 2002 the province amalgamated 52 regional health authorities into five geographical zones, in part to encourage local access to health services.
5. The full list is available from the PSR/RPS Ontario website: http://www.psrrpsontario.ca/principles.html
6. The names of the towns have been omitted for confidentiality.
7. We discuss the challenges and ethics of interviewing people with experiences of institutionalization in Morrow and Jamer (2008).
8. Staff chose which residents would be moved in consultation with the director of Riverview Hospital. Decisions about where a resident would go were based on where the person was originally admitted, whether they had family connections there, and whether the facilities in the region could meet their care needs.

RÉSUMÉ

Malgré l'intérêt croissant que l'on accorde au concept de rétablissement, les défis que pose l'application d'un modèle de rétablissement dans les lieux de soins de santé mentale sont encore peu documentés. Dans cet article, nous présentons les résultats d'une étude ethnographique féministe que nous avons réalisée en Colombie-Britannique. Pendant trois ans, nous avons suivi des hommes et des femmes qui, après la désinstitutionalisation, ont été pris en charge dans des lieux de soins psychiatriques tertiaires qui utilisent un modèle de réhabilitation psychosociale fondé sur les principes du rétablissement. Nous montrons que la formation du personnel est inadéquate et que les ressources de soutien dans la communauté sont surchargées, et que cela entraîne une application inégale du modèle qui ne maximise pas les occasions de rétablissement. De plus, l'organisation et la prestation des soins mettent l'accent sur les besoins individuels comme si ceux-ci s'opposaient aux besoins sociaux et collectifs liés à des facteurs comme le sexe, l'appartenance ethnique

et la culture. Notre étude indique que, si l'on veut réaliser pleinement la philosophie du rétablissement et offrir à tous des soins de santé mentale de façon équitable, une plus grande volonté politique est nécessaire, et que celle-ci doit se traduire par des engagements envers des services de santé mentale communautaires.

Mots clés : rétablissement, désinstitutionalisation, réadaptation psychosociale, soins psychiatriques tertiaires, déterminants de la santé mentale (structurels, sociaux et selon le sexe)

REFERENCES

Anderson, C., & Chiocchio, K. (1997). The interface of homelessness, addictions and mental illness in the lives of trauma survivors. In M. Harris & C. Landis (Eds.), *Sexual abuse in the lives of women diagnosed with serious mental illness*. Amsterdam: Harwood Academic Publishers.

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16*(4), 11. Retrieved from http://www.dhh.state.la.us/offices/publications/pubs-305/anthony1993c.pdf

Auditor General of British Columbia. (1994). *Value-for-money audits: The transfer of patients from Riverview Hospital to the community.* Ministry of Health.

Barker, P. (2003). The tidal model: Psychiatric colonization, recovery and the paradigm shift in mental health care. *International Journal of Mental Health Nursing, 12*(2), 96-102. doi:10.1046/j.1440-0979.2003.00275.x

BC Ministry of Health. (1998). *Revitalizing and rebalancing British Columbia's mental health system: The 1998 mental health plan.* Victoria: Ministry of Health and Minister Responsible for Seniors, Adult Mental Health Division.

BC Ministry of Health Services. (1987). *Mental health consultation report: A draft plan to replace Riverview Hospital.* Province of British Columbia.

BC Provincial Mental Health Advisory Council. (1996). *Working group to identify the regional resources necessary to resume the downsizing of Riverview Hospital: Report.* Victoria: The Working Groups. Retrieved from http://proquest.umi.com.proxy.lib.sfu.ca/pqdweb?did=1132364941&Fmt=7&clientId=65345&RQT=309&VName=PQD

Bedregal, L. E., O'Connell, M., & Davidson, L. (2006). The recovery knowledge inventory: Assessment of mental health staff knowledge and attitudes about recovery. *Psychiatric Rehabilitation Journal, 30*(2), 96-103. doi:10.2975/30.2006.96.103

Bertram, G., & Stickley, T. (2005). Mental health nurses, promoters of inclusion or perpetuators of exclusion? *Journal of Psychiatric and Mental Health Nursing, 12*(4), 387-395. doi:10.1111/j.1365-2850.2005.00849.x

Bonney, S., & Stickley, T. (2008). Recovery and mental health: A review of the British literature. *Journal of Psychiatric and Mental Health Nursing, 15*, 140-153.

British Columbia Royal Commission on Health Care and Costs. (1991). *Closer to home.* Province of British Columbia.

Burman, E. (2003). From difference to intersectionality: Challenges and resources. *European Journal of Psychotherapy, 6*(4), 293-308. doi:10.1080/3642530410001665904

Burman, E., & Chantler, K. (2003). Across and between: Reflections on researching "race," gender and mental health. *Feminism and Psychology, 13*(3), 302-309. doi:10.1177/0959353503013003004

Calsaferri, K., Treherne, J., & van der Leer, G. (2002). *BC's mental health reform best practices: Psychosocial rehabilitation and recovery.* Victoria, BC: BC Ministry of Health and Ministry Responsible for Seniors.

Cuadraz, G. H., & Uttal, L. (1999). Intersectionality and in-depth interviews: Methodological strategies for analyzing race, class, and gender. *Race, Class and Gender, 6*(3), 156-186.

Dip, R. C. (2008). Towards promoting recovery in Vancouver community mental health services. *International Journal of Psychosocial Rehabilitation, 12*(2).

Dobson, S. (2001). Introduction: Institutional ethnography as method. *Culture and Organization, 7*(2), 147-158. doi:10.1080/10245280108523556

Everett, B., Adams, B., Johnson, J., Kurzawa, G., Quigley, M., & Wright, M. (2003). *Recovery rediscovered: Implications for the Ontario mental health system.* Canadian Mental Health Association, Ontario Division.

Farkas, M., Gagne, C., Anthony, W., & Chamberlin, J. (2005). Implementing recovery oriented evidence based programs: Identifying the critical dimensions. *Community Mental Health Journal, 41*(2), 141-158. doi:10.1007/s10597-005-2649-6

Felton, B. J., Barr, A., Clark, G., & Tsemberis, S. J. (2006). ACT team members' responses to training in recovery-oriented practices. *Psychiatric Rehabilitation Journal, 30*(2), 112-119. Retrieved from http://www.pathwaystohousing.org/Articles/PTHPublications/ACT_Team_Members__Responses_to_TrainingPsychrehab2006.pdf

Goldner, E. (2005). Foundational elements for mental health reform in Canada. *Canadian Public Policy, 31*(Supplement), S36-S40.

Goldner, E., Lesage, A., & Groden, D. (2007). *Regionalized tertiary psychiatric residential facilities: Documenting an innovative model of community care for people with severe mental illness in British Columbia.* BC Mental Health and Addictions Services and University of Montreal.

Greaves, L., Amaratunga, C., Ballem, P., Chow, D., Koninck, M. D., Grant, K., . . . Vissandjee, B. (1999). *Gender and sex in the CIHR.* Centre of Excellence for Women's Health.

Hankivsky, O., & Cormier, R. (2009). *Intersectionality: Moving women's health research and policy forward.* Vancouver, BC: Women's Health Research Network.

Harris, M., & Landis, C. (Eds.). (1997). *Sexual abuse in the lives of women diagnosed with serious mental illness*. Amsterdam: Overseas Publishers Association.

Health Canada. (2003). *Exploring concepts in gender and health.* Ottawa: Health Canada.

Health Systems Research and Consulting Unit. (2007). *Riverview Hospital redevelopment: A clinical review*. Final report. Toronto, ON: Centre for Addiction and Mental Health.

Jablensky, A., Sartorius, N., Ernberg, G., Anker, M., Korten, A., Cooper, J. E., . . . Bertelsen, A. (1992). Schizophrenia: Manifestations, incidence and course in different cultures. A World Health Organization ten-country study. *Psychological Medicine Monograph Supplement, 22*(4), 1092-1097. doi:10.1017/S0264180100000904

Jacobson, N., & Farah, D. (2010). *Recovery through the lens of cultural diversity.* Toronto, ON: Community Resource Connections of Toronto; Centre for Addiction and Mental Health; Wellesley Institute.

Johnson, J., Greaves, L., & Repta, R. (2007). *Better science with sex and gender: A primer for health research.* Vancouver, BC: Women's Health Research Network.

Klein, S., & Long, A. (2003). *A bad time to be poor: An analysis of British Columbia's new welfare policies.* Vancouver: Canadian Centre for Policy Alternatives, and Social Planning and Research Council of British Columbia.

Kohn, L. P., & Hudson, K. M. (2002). Gender, ethnicity and depression: Intersectionality and context in mental health research with African American women. *African American Research Perspectives, 8*(1), 174-184.

Leff, J., & Warner, R. (2006). *Social inclusion of people with mental illness*. New York, NY: Cambridge University Press. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2006-10902-000&site=ehost-live

Lesage, A., & Morissette, R. (2002). Chronic my a**. *Canadian Journal of Psychiatry, 47*(7), 617-620. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=mnh&AN=12355672&site=ehost-live

Lesage, A. D., Groden, D., Ohana, P., & Goldner, E. (2006). *Seven Oaks and South Hills projects: Year 2 assessment report.* Vancouver and Montreal: Riverdale Hospital and Louis-H. Lafontaine Hospital.

Lesage, A., Groden, D., Goldner, E. M., Gelinas, D., & Arnold, L. M. (2008). Regionalised tertiary psychiatric residential facilities. *Epidemiologia e Psichiatria Sociale, 17*(1), 38-46.

McCallum, D. (1994). *Listening: A review of Riverview Hospital.* Victoria, BC: Office of the Ombudsman.

Mental Health Commission of Canada. (2009). *Toward recovery & well-being: A framework for a mental health strategy for Canada.* Calgary, AB: Mental Health Commission of Canada.

Mental Health Commission of Canada. (2010). *Roundtable on social inclusion June 10–22, 2010: Background paper summary.* Unpublished manuscript.

Mental Health "Recovery" Study Working Group. (2009). *Mental health "recovery": Users and refusers.* Toronto, ON: Wellesley Institute.

Morrow, M. (2004). Mental health reform, economic globalization and the practice of citizenship. *Canadian Journal of Community Mental Health, 23*(2), 39-50.

Morrow, M., Dagg, P. K. B., & Pederson, A. (2008). Is deinstitutionalization a "failed experiment"? The ethics of re-institutionalization. *Journal of Ethics in Mental Health, 3*(2), 1-7. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2009-04077-007&site=ehost-live

Morrow, M., & Jamer, B. (2008). Making meaning in a "post-institutional" age: Reflections on the experience of (de) institutionalization. *International Journal of Psychosocial Rehabilitation, 12*(1).

Morrow, M., Pederson, A., Smith, J., Josewski, V., Jamer, B., & Battersby, L. (2010). *Relocating mental health care in British Columbia: Riverview Hospital redevelopment, regionalization and gender in psychiatric and social care.* Research project final report. Vancouver: Centre for the Study of Gender, Social Inequities and Mental Health. Retrieved from http://www.socialinequities.ca/wordpress/wp-content/uploads/2010/05/Relocating_MHC_BC_web.pdf

Morrow, M., Wasik, A., Cohen, M., & Perry, K. M. (2009). Removing barriers to work: Building economic security for people with psychiatric disabilities. *Critical Social Policy, 29*(4), 655-676. doi:10.1177/0261018309341904

Nilsson, L. L., & Lögdberg, B. (2008). Dead and forgotten — post-mortem time before discovery as indicator of social isolation and inadequate mental healthcare in schizophrenia. *Schizophrenia Research, 102*(1-3), 337-339. doi:10.1016/j.schres.2008.03.011

PSR/RPS Ontario. (2010). *Core principles of psychosocial rehabilitation (PSR).* Retrieved from http://www.psrrpsontario.ca/principles.html

Ramon, S., Healy, B., & Renouf, N. (2007). Recovery from mental illness as an emergent concept and practice in Australia and the UK. *International Journal of Social Psychiatry, 53*(2), 108-122. doi:10.1177/0020764006075018

Rhodes, A. E., Goering, P. N., To, T., & Williams, J. I. (2002). Gender and outpatient mental health service use. *Social Science & Medicine, 54*(1), 1-10. doi:10.1016/S0277-9536(01)00002-8

Rossiter, K., & Morrow, M. (2011). Intersectional frameworks in mental health: Moving from theory to practice. In O. Hankivksy (Ed.), *Health and intersectionality inquiry in Canada* (p. 312). Vancouver, BC: UBC Press.

Salmon, A., Poole, N., Greaves, L., Ingram, R., & Pederson, A. (2006). *Integrating sex and gender in mental health and addictions policy: Considerations and recommendations for federal policy development.* Vancouver: BC Centre of Excellence for Women's Health.

Saraceno, B., & Barbui, C. (1997). Poverty and mental illness. *Canadian Journal of Psychiatry, 42*(3), 285-290.

Smith, D. E. (Ed.). (2006). *Institutional ethnography as practice* (1st ed.). Lanham, MA: Rowman & Littlefield.

Smye, V., & Browne, A. (2002). "Cultural safety" and the analysis of health policy affecting aboriginal people. *Nurse Researcher, 9*(3), 42-56.

Song, L. (2007). The attitudes towards and enactment of psychosocial rehabilitation principles: Discrepancies and correlates. *International Journal of Social Psychiatry, 53*(3), 232-246. doi:10.1177/0020764006074558

Spitzer, D. L. (2004). *What's sex and gender got to do with it? Integrating sex and gender into health research.* Canadian Institute of Health Research.

Townsend, E., Langille, L., & Ripley, D. (2003). Professional tensions in client-centered practice: Using institutional ethnography to generate understanding and transformation. *American Journal of Occupational Therapists, 57*(1), 17-28.

Trainor, J., Pomeroy, E., & Pape, B. (2004). *A framework for support* (3rd ed.). Toronto, ON: Canadian Mental Health Association.

Vogel, D., Rachlis, M., & Pollak, N. (2000). *Without foundation: How medicare is undermined by gaps and privatization in community and continuing care.* Public Interest Research Project. Vancouver, BC: Canadian Centre for Policy Alternatives.

Ware, N. C., Hopper, K., Tugenberg, T., Dickey, B., & Fisher, D. (2008). A theory of social integration as quality of life. *Psychiatric Services, 59*(1), 27-33. doi:10.1176/appi.ps.59.1.27

Weisser, J., Morrow, M., & Jamer, B. (2011). *A critical exploration of social inequities in the mental health recovery literature.* Vancouver, BC: Centre for the Study of Gender, Social Inequities and Mental Health.