Accessing and Utilizing One's City Space: The Role of Specialized Community Mental Health Teams in Brazil and Canada

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ABSTRACT

Community mental health programs have garnered significant attention during the last decade. In this paper we ask to what extent these programs impact the capacity of service users to move around in the city space. Drawing on case studies from ethnographic research conducted in Campinas (Brazil) and Montréal (Canada), which included semi-structured interviews with a total of 16 service users and 49 mental health professionals, we explore the significance of urban mobility as part of service users' mental health recovery and service providers' practice. Findings suggest that service providers play a key role in facilitating meaningful mobility in the city space.

Keywords: specialized community mental health, mobility, mental health practice, social determinants of health, recovery

RÉSUMÉ

Les programmes communautaires de santé mentale ont fait l'objet de beaucoup d'attention au cours de la dernière décennie. Dans cet article, nous nous demandons dans quelle mesure ces programmes influent sur la capacité des usagers à se déplacer dans l'espace urbain. En nous appuyant sur des études

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de cas ethnographiques menées à Campinas (Brésil) et à Montréal (Canada) comprenant des entrevues semi-structurées avec 16 utilisateurs de services et 49 professionnels de la santé, nous explorons l'importance de la mobilité urbaine pour le rétablissement et la pratique en santé mentale. Les résultats suggèrent que les intervenants jouent un rôle clé dans la facilitation d'une mobilité significative dans l'espace urbain.

Mots-clés : santé mentale communautaire spécialisée, mobilité, pratique en santé mentale, déterminants sociaux de la santé, rétablissement

The past two decades have been witness to a significant evolution in the way mental health problems and their corresponding treatments are conceptualized in both policy and in practice. The concept of mental health recovery is now the dominant organizing principle for public mental health services in many countries (Khoury & Rodriguez, 2015; Davidson & White, 2007; Jacobson, 2004). A thorough literature review on the recovery philosophy demonstrates empirical support for the postulate that although the recovery process is unique to each individual, and dependent on their specific context, eco-system, and strengths, professional intervention can facilitate this process (Anthony, 1993; Davidson, O'Connell, Tondora, Styron, & Kangas, 2006; Rodriguez, Corin, & Guay, 2000; Rodriguez, Bourgeois, Landry, Guay, & Picard, 2006). This professional intervention requires certain critical values anchored in egalitarian attitudes to care, hope, implication on the part of service providers, and a recognition of the importance of the relationship between service users and service providers (Rodriguez et al., 2006; Turcotte & Dallaire, 2018). This "stance" towards clinical intervention is in turn supported by a recovery-oriented system which can be achieved through training and managerial practices (Khoury & Rodriguez, 2015). The integration of mental health recovery as both an approach and a philosophy at the core of mental health policy at an international level underscores the importance of the concept; it is process-oriented, person-focused, and shapes governance structures toward social inclusion, quality of life, citizenship, and participation. Moreover, these underlying values and principles have resulted in discussions and research about the recognition of a social model in mental health (Beresford, 2002; Tew, 2004), human rights in mental health (Rodriguez del Barrio et al., 2014), citizen participation in both research and practice (Beresford, 2007; Rodriguez et al., 2006) and an impetus to identify core components of recovery. In addition, we have seen important changes in the strategic direction and in the practice guidelines of mental health delivery systems in response to the push to integrate the recovery concept in practice, policy, structure, and care. For example, recovery-oriented practice guidelines (MHCC, 2016) in Canada stipulate that recovery "occurs in the context of one's life" (p. 38) and points to the imperative need for mental health professionals to consider and act upon social determinants of health. The Québec government's synthesis of health determinants (MSSS, 2012) outlines four broad areas that can affect health including individual characteristics, living environment, systems, and the global context. Included in the areas of living environment and systems are the following categories: local community and neighbourhood and urban planning.

Reducing inequality and promoting integration are common threads in both the recovery discourse and in structural practice approaches that intervene on social determinants such as income, social support, early childhood development, education, employment, housing and gender. However, there is limited discussion or empirical research that specifically teases out the role of an individual's mobility in the city space as an

indicator of mental health recovery and as a social determinant of mental health. The concept of mobility in the city space is particularly pertinent to the role of community mental health services. These services are typically located in the community, that is to say, outside of the walls of the hospital, and are often "store front" spaces. As such, their influence on the local community and neighbourhood is not negligible, yet often overlooked in the literature.

This article offers a detailed discussion of mobility as it relates to community mental health programs that aim to be recovery-oriented, and is supported by a thorough literature review and by secondary findings from the authors' empirical research on community mental health services in Campinas, Brazil and Montréal, Canada.

BACKGROUND

Urban Mobility

In this paper, we understand mobility as the representation of urban mobility and travel within the city spaces and public spaces in one's community or beyond. More significantly, we understand mobility as having multiple representations of meaningful movement or activity, as it is understood and defined from the perspective of service users.

The dynamism of the city space is dependent on social factors such as transportation, housing, and access to public spaces. Detailed research in the field of applied anthropology and mental health geography delves into these social factors in urban planning and connects them with community and individual health and well-being (see Anderson & Baldwin, 2016; Baldwin & King, 2017; Baldwin, 2015; Curtis, 2016; McGeachan & Philo, 2017; Petit, 2019; Philo & Wolch, 2001; Twigg & Duncan, 2018; Wolch & Philo, 2000; Yanos, 2007). The comparative analysis of secondary data from two ethnographic studies demonstrated the connection between urban mobility, the aforementioned social factors, and the role of community mental health services in supporting or obscuring the mobility of service users in the city space. This comparative study between Global north (Montréal, Canada) and Global south (Campinas, Brazil) cities are used to illustrate how mobility perspectives can be used to interpret the complex interrelationships between community-based care setting and the material, social, and symbolic attributes of specific "safe travels" within the city space that contribute to that well-being (Curtis, 2016).

A report by Baldwin and King (2017) on the impact of urban development on social cohesion and connection suggests that feeling safe and secure in a community to which one feels connected is vital for good health, well-being, and quality of life. Specifically focused on mental health, Whitley and Prince (2005, 2006) discuss the social factors that impact well-being and quality of life, and how these are affected by urban mobility. Their qualitative study determined mobility as a key element that can aggravate social inequalities experienced by people living with severe and persistent mental health problems. They suggest that barriers to accessing certain public spaces at specific times increased isolation and diminished community contact. This, in turn, negatively impacted community members' mental health. They refer to time-space inequalities to suggest that the capacity to move around one's community space is a core component to social connection and mental health. Work by applied anthropologists in urban planning suggests that factors such as public transit policies and systems, inclusive urban design, and designing for social networks

and cohesion contribute to increased access to public and shared spaces. They refer to this exclusion as a time-space inequality (Baldwin, 2015, Baldwin & King, 2017). Community-based studies, such as second wave mental health geography research (McGeachan & Philo, 2017; Philo & Wolch, 2001; Wolch & Philo, 2000), recorded citizens' use of their urban environment and its subsequent role as a source of well-being. Community mental health delivery systems are being rapidly reshaped due to globalization, radical welfare reform, and urban restructuring. In that context, these authors explicate the grounded, local experiences of difference and socio-spatial exclusion. Yet, they also suggest the need for further research on global mental health that considers socio-spatial exclusion, particularly with reference to the lack of attention currently given to places, spaces, and voices in the Global south (McGeachan & Philo, 2017).

Corin's (2002a) research indicates that attending to difference and to reducing socio-spatial exclusion can support people living with mental health problems remain autonomous in their community. She explains that this type of support includes creating the possibility for mental health service users to construct their own "care space" in the community, at their own pace. This personal construction of space, at differing rhythms, sometimes results in a chosen urban mobility which is at once set back from the world but close enough for the individual to reconnect when he or she wants. The author calls this phenomenon "within and without." It integrates the possibility for different, marginal types of autonomy and mobility within the city space including the right to a "positive retreat" (Corin, 2002b) and to living "within society and without society" (Corin, 2002a*)*.

However, there is currently a gap in the literature that specifically addresses the intersection of urban mobility, available resources and facilitating factors to accessing public spaces, and an individual's personal recovery journey.

Community Mental Health Programs: A Comparative Perspective

Specialized community mental health services have seen a rapid development internationally, particularly in Brazil and Canada (Onocko Campos et al., 2012; MSSS, 2012; 2015; Rodriguez, 2011). In both countries, community mental health treatment is a cornerstone in the continuum of mental health reforms. Community mental health services offer the possibility to avoid potentially stigmatizing and traumatizing in-patient psychiatric care by placing the person and their living environment at the centre of care services. Brazil and Canada are at the forefront of the development of community mental health programs and of integrating experiential evidence into practice. In 2006, Canada's Standing Senate Committee on Social Affairs, Science and Technology published a report which encouraged "implementation of collaborative care initiatives in the development of an integrated, community-based continuum of care" (p. 124). Following the release of this report, the Mental Health Commission of Canada was formed as a catalyst for change (Kirby, 2008). In Brazil, an ambitious reform in the late 1990s led to the establishment of Psychosocial Attention Centers (CAPS) and the renewal of psychosocial and management practices, with the objective of supporting the autonomy of users in the community. In both countries, policy has been influenced by the voice of service users, considered to be experts of experience. In Québec, Canada, recent policies have focused on empowerment, participation, and recovery, largely due to the input of service user-led community organizations, whilst in Brazil the anti-asylum movement is largely driven by professionals as well as service users and their families.

The Assertive Community Treatment (ACT) program in Canada and the CAPS in Brazil have a similar mission and are both specialized mental health care and pharmacological treatment programs providing services to individuals with complex mental health problems. However, they are distinct in a few organizational ways. The Psychosocial Attention Center offers a one-stop-shop program model wherein service users receive treatments and interventions, but also access to workshops, music, art, and the opportunity to socialize with others. In the Canadian model, the ACT team offers referrals to non-profit community organizations or alternative mental health resources that are not part of the public healthcare system in order to respond to service user's goals, interests, and needs that fall outside of the program's central mandate. This mandate includes supporting service users to avoid hospitalizations by maintaining independent living and ensuring pharmacological treatment adherence.

We conducted research on these community-based mental health programs in Campinas and Montréal. We focus on the particular cities in which the programs were implemented rather than to their country since the particularities of the specific city space or territory will influence the nature of urban mobility.[1] Both cities of Campinas (Sao Paulo state, Brazil) and Montréal (Québec, Canada) have invested in specialized mental health care that is community located with the goal of increasing the personal autonomy of the person in his or her community. They are cities with different sociocultural, sociopolitical, and socioeconomic backdrops; as such, this shapes the social inequalities faced by citizens in these cities. Thus, several factors identified by Baldwin and King (2017) regarding social cohesion, health, and well-being (e.g., public transit and infrastructure) differ vastly in these two cities. These differences are crucial to the development of a better understanding of the complex relationship service users have with their urban mobility. This paper offers an exploration of mental health practice from the point of view of the people who are travelling to and from their homes to access the services and/or resources identified in their intervention plans. In reviewing data, we were attentive to what service users said about their urban mobility. We observed the facilitators and barriers to their desired mobility. This allowed the authors to identify the conditions that help or hinder their experience of community life.

In a secondary analysis of both ethnographic studies, the authors each paid attention to the experiences of community mental health care by outlining the situated actions, interactions, and activities that lead to access and utilization of community resources. The authors then compared the resulting data. This international and intercultural comparison between Campinas (Brazil) and Montréal (Canada) offers a fresh look at what is happening in each city in order to grasp and understand the subjective meaning of urban mobility.[2] The authors also address the spatial inequalities in both local realities and how this might relate to an individual's personal recovery process. This psychosocial emphasis is less prominent in the contemporary literature on moving around in the city space (Curtis, 2016; Whitley & Prince, 2005, 2006; Thomas et al., 2007; Philo & Wolch, 2001).

1. The particularities of specific city spaces and territories have also been shown to affect the operationalization of mental health programs (MSSS, 2012).

2. An ongoing dialogue between Campinas (São Paolo) and Montréal (Québec) began in 2009 with the International CURA in mental health and citizenship (Rodriguez & Onocko Campos, 2015).

METHODS

This paper is the fruit of critical reflections based on graduate work[3] carried out by the authors (Khoury, 2019; Ruelland, 2018, 2019). In the current paper, the authors return to their datasets, enriched by not only their initial ethnographic data, but also by a renewed analysis of their observations. Using a comparative approach, the authors reconsider the role of urban mobility on the mental health recovery process. The results of this secondary analysis are presented through a detailing of the trajectories of two individuals who participated in our initial doctoral research studies. The comparison of their narratives as experts of experience facilitates a subjective exploration of the concept of urban mobility. Through intensive ethnographic observation the authors were able to extrapolate and analyze the complexity and the significance of mobility, thus triangulating empirical observations with the stories heard by the individuals concerned. The two participants discussed in this paper are also individuals who the authors were privileged to shadow frequently, and spontaneously. As such, they are the participants encountered most frequently in the research process. This might be because the participant from Montréal was particularly interested in the research process and the participant from Brazil was involved in many activities at the mental health centre.

Our research was supported by the International Community University Research Alliance (CURA) for Mental Health and Citizenship (Rodriguez & Onocko Campos, 2015) which was engaged in an international effort to renew practices and initiate social transformation so that people living with severe mental health issues could have the space and place to exercise their rights and live a life of quality in their community of choice. This is important for any discussion or research in this field because people living with mental health problems are particularly affected by structural and symbolic inequalities (Poirel et al., 2015; Ruelland, 2015). These inequalities often result in, and maintain, their situation of marginalization and social exclusion. Thus, a legitimate question would be: which conditions lead to improved access and use of community resources and inclusion in public spaces?

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3. The research in Campinas (Brazil) aimed to contribute to understandings of the transformation of social relations of power experienced by the mental health service users and service providers. Using ethnographic data collected during a 10-month period from across the Campinas mental health network, we observed that the transformation of the social relations of power experienced by the participants was actualized in specific collective configurations commonly known as "rodas." Rodas is the Portuguese word for circle. The term rodas refers to small groups of people who meet to reflect, debate, and decide on actions to be taken regarding mental health practices in the city, similar to talking circles. These collective configurations allow citizens to give form and create meaning to local attempts at democratizing mental health care. The analysis of rodas' group dynamics opens up new avenues for understanding the potential of collective power in an organizational context. Through the sharing of time in a plurality of open spaces, through sharing affect as well as through collective problem-solving of critical events impacting daily life, the rodas act to reduce organizational hierarchy. Results indicate that this collective effort of constantly renewed democratization does not, however, make it possible to overcome most of the inequalities of power perpetuated in the current organization of services and in Brazilian society. As a form of citizen participatory practice, rodas nevertheless provide collective levers that denounce contradictions and social injustices within and outside the organization.

The research in Montréal (Canada) aimed to contribute to understandings of recovery-oriented care in an ACT team by explicating social, clinical, and discursive processes amongst service users, service providers, community resources and intersectoral partners. Using ethnographic "mobile" research methods (Ferguson, 2016) the author shadowed service providers and service users and met with them in semi-structured interviews. Results indicate that mental health recovery is not a salient term for service users and rarely used by service providers. However, recovery is part of agency documentation and professional practice guidelines. As such, service providers did discuss recovery when asked, and understand it from an individualizing perspective. They relate it to socio-professional functioning and individual responsibility. However, the situated actions and interactions uncovered through ethnographic research indicate that the intensive nature of ACT leads to relationship development with service users that can become a substitute social network.

Using the narratives of two service users as particular cases in Montréal and Campinas,[4] respectively, these two qualitative case studies support the examination of two community mental health models as both mental health policies at the macro level and organizational systems at the meso level that play a major role in facilitating or impeding urban mobility. Both research studies used a critical ethnographic approach, which allowed for an intimate explication of the inner workings of the respective community mental health teams. The ethnographic approach, as a way to develop knowledge through detailed exploration of data sets, is a methodology that allows for reasoning through detailed in-depth data of a particular site, individual or phenomenon (O'Reilly, 2012; Ybema, Yanow, Wels, & Kamsteeg, 2009; George & Bennet, 2005).

In addition to participant observation at both sites, individual semi-structured interviews lasting 30 minutes to 2 hours were conducted with a total of 16 service users and 49 professionals. The semi-structured interview guides were developed independently but both authors included questions about participants' perspectives regarding their experiences with the community mental health team in their neighbourhood, their social network, their satisfaction with their community contacts and their ability to access and utilize community resources.

Ethnographic analysis is never linear and is tangled up with every stage of the research process (O'Reilly, 2012). For both studies, coding followed a highly inductive approach that began with an open coding phase. Connections between these codes were ascertained (e.g., social network, medication supervision, community contacts) and led to the emergence of key, broad categories. To enhance rigour, analysis of interview findings and participant observation data was triangulated with documentary evidence from different sources.[5]

For this paper, the authors subsequently re-examined the data from the 16 service user interviews through the lens of urban mobility, access to public spaces, resource utilization, and well-being. Following this secondary analysis and the selection of one representative narrative from each site, two common themes emerged. These themes can be grouped into two broad categories of interpretation, including (1) social and institutional influences on urban mobility; and (2) influence of meaningful access and utilization of community resources on the recovery process. The information contained within these two themes alludes to an underlying but powerful sense that urban mobility and spatial equality can contribute greatly to one's "barometer of well-being" that bears a great deal of significance to a service user's mental health and sense of belonging. Even though "recovery," "equality," or "inclusion" were rarely directly discussed, participants mentioned many links between well-being and moving around the community and in the city space.

The authors found a high level of concurrence in the results and key categories that emerged from the two research studies. A comparative approach allowed for an encounter between the two sites which highlighted the tensions and paradoxes in attempts to develop recovery-oriented, community-based mental health practice.

The citations from participant interviews integrated into this article were carefully selected. Although the number of citations is limited, each one is meaningful in that it represents the most significant elements

4. Both projects were supported and partially financed by the Community-University Research Alliance – mental health and citizenship-CRDI and CRSH. The research in Montréal took place from January to September 2014 and in Campinas October 2011 to December 2012.

5. Those sources included the Ministry of Health and Social services in Québec and the municipal health secretary in Brazil, and the parent institutions of the participating programs.

of a theme as articulated by a majority of study participants. While the perspectives of services users were wide-ranging in our studies, the following narratives explicate several themes that emerged related to place, mobility, boundaries, and well-being. We briefly summarize the broad results from the two studies, and predominantly focus on what was heard in the interviews regarding accessing and using community resources and networks because of the close alignment of these findings between the two studies. We then discuss lessons learned and reflect on practice implications.

ETHICS

Both studies obtained ethics approval from the Université de Montréal as well as from the participating institutional research ethics boards. All of the participants signed consent forms and kept a copy of the signed agreement. The informed and free consent of participants was assured. Each participant was given a letter outlining the nature of the study and their rights and obligations. Participation was voluntary. Participants were assured that their information would be kept confidential.

FINDINGS

Two main themes emerged from the secondary analysis and comparison of the two studies: The concept of accessing and utilizing resources with a socio-spatial equality perspective and the specific role of specialized community mental healthcare programs. Two illustrative narratives are used to organize the presentation of the respective empirical findings and ensuing posterior discussion of secondary findings.

The Service User Narrative: A Dialogue

The two initial studies provided the authors with a plethora of experiences, which explicate the city space mobility as problematic. The data also points to the understanding of mobility as problematic as it relates to individuals' rapport with space and time. The experiences of two individuals has been carefully chosen to understand their respective journeys through the mental health system, their ability to access resources within and without the system as well as their relationship with mental health professionals.

Julio's Mobility in Campinas, Sao Paulo, Brazil

Julio is a man in his early forties who lives with his mother and brother. According to him, his first mental health crisis occurred following two traumatic events. While working as a ticket vendor at a bus station he was the victim of two armed robberies. When meeting with him, he often reminisced about this job stating he enjoyed work and missed the steady employment he once had. Following the first mental health crisis, he was hospitalized for 40 days and then transferred to the Psychosocial Attention Center that had recently opened in his neighbourhood. Julio was pleased to have this community-based service available, which he preferred over going to a hospital:

> And, if there was not CAPS? Oh my God! The minibus comes to get us at home and brings us back. There is a lunch, snacks, and supper for those that stay here a long time; there are free medications, people have an allocation and everything. The CAPS is a paradise for us. There is everything! You take your medication, and you don't pay. You leave, and they give you a bus ticket. They give everything! Imagine if I didn't

> have the CAPS? There, at the psychiatric hospital I didn't receive anything, there wasn't all this, all I did was eat and drink there, but they don't give you a ticket to go outside. We couldn't leave there. We could stay for weeks and weeks and only receive visitors.[6]

Julio had a weekly follow-up appointment with Manon, his assigned service provider. Since he lives close to the Center, he rarely took public transportation, preferring to use his bicycle as his principal vehicle.

> When I come by bike, I feel like I won't fall back [in crisis] and that I won't be unwell again because I can get here, and once I am here, I participate in many activities. Just coming here every day is an activity. I don't want to be imprisoned in a hospital or at home. I must do things. Now, I wash my clothes; I do things. I wash the toilets and I take care of our little bird. These are activities that help me to not think about things. If you stop moving your head is vulnerable to the thoughts of the devil.[7]

For Julio, the ability to travel on his bike is a factor in helping him feel well. It is the mode of transport that he has chosen and with which he is completely autonomous.

Julio participates in various athletic and artistic workshops offered by the Center. To participate he must first get himself to the Center. Due to the poor state of roads and the lack of public transit, he is taken by car, driven by a service provider, from the Center to the workshops. Although his participation in the workshops expands his geographic radius of mobility, the Center mediates his mobility and exposure to other neighbourhoods. The Center does not mediate this solely on the basis of Julio's mental health status, but also as a function of his socioeconomic status.

Like most urban centres in Brazil, Campinas has always faced the complex difficulties associated with urban migration, the expansion of shanty towns called *favelas*, urban crime, and poverty. These socio-economic factors contribute to growing social inequalities. The lack of infrastructure in Campinas is particularly evident in the favelas such as the one surrounding the Center. Julio lives in that favela as do the majority of the Center's service users. The unpaved roads in these neighbourhoods are often impractical to navigate, especially during rain, and particularly when riding a bike.

Jacques's Mobility in Montréal, Québec

Jacques is a man in his forties who lives independently in an unsupervised apartment close to the city centre. His apartment is located in the same building as a metro (subway) station and there is a main line bus stop outside of his building. He is able to purchase a bus pass every month with the disability insurance that he receives.[8] He has been with the ACT program for two years, but prior to that he had a series of 14-year follow-up appointments in an external psychiatric clinic. Two years ago, he was hospitalized and his treatment team at the external clinic referred him to the ACT team, which he described as a "hospital without walls" and as "vital" to his well-being.

> [The weekly visit] is very important because I wait with impatience for their arrival at my home. It's a way for me to deliver on something. [On what?] On a subject that preoccupies me and which I would like to discuss at length during an appointment at my home.

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6. Author's translation from Brazilian Portuguese.
7. Author's translation from Brazilian Portuguese.
8. This is not a typical situation. Most service users at this Montréal ACT program rely on a monthly social assistance stipend to cover rent, food and other expenses such as transportation.

Jacques has a very close relationship with his mother who lives in a seniors' residence and he visits her at least once a day by public transportation.

> My mother, we are very, very close and so I have followed her everywhere in her journey; at her apartment, at her hospital, at her evaluation centre and finally at the residence where she is now… I like to go see her in the evenings and after lunch.

However, he sometimes takes a break from these visits in order to volunteer in his neighbourhood and beyond his immediate neighbourhood.

Jacques also likes to take time for himself. Recreational daily activities are accessible to him not only because of his geographical location and residential environment but also because of his socio-economic situation and his level of social integration: "In the afternoon I try to see a movie if possible… I like to go to restaurants."

He currently teaches French to adults on a volunteer basis at a local community organization and also volunteers in a community kitchen. He is able to access these organizations by bus and metro and is also able to walk to the many cafés or corner stores that surround his centrally located downtown apartment. He was connected to many of these volunteer activities by his ACT service provider. Jacques's many social contacts through volunteer work, with his mother, with a spiritual therapist at another hospital, at the movies, in a restaurant, or even in the elevator of his apartment building are very important to him and he describes them as central to his recovery process: "You don't live in a bubble; you can't hide in an apartment."

He currently considers his mental healthcare workers from the ACT team and the therapist he sees at another hospital (grief therapy following the loss of his father, referred to by ACT) as points of socialization. He looks forward to their visits, as he rarely goes to the clinic himself. When discussing his future with the ACT team he says: "I'd like them to accompany me until I die."

Jacques's principal worker is Chris. Faroud and Amal make up the mini-team and Dr. G. is his psychiatrist. Jacques is seen every two weeks via a home visit. Sometimes the meeting takes place in his apartment and sometimes they will go to a coffee shop or breakfast restaurant to talk.

The public transport system in Montréal is well developed. Most ACT service users benefit from a monthly bus pass, either through a social assistance program, through a budget process established with their case worker, or in Jacques's case, paying for the pass using income or revenue otherwise accrued. The public transport system is relatively dependable, and some service users have a habitual "route" that they take through the Montréal underground system.

For example, Fred, whose monthly bus pass is paid using his social assistance payments, takes the metro for about 2 hours every morning. Every once in a while, he exits. He explains, "I walk around the metro station" before hopping back onto a train. Not only is this part of his daily routine but it is also, according to Fred, an activity that he considers a hallmark of his integration, recalling the conclusions of Corin (2002a) in discussing concerned individuals living simultaneously "within and without" the symbolic limits of society. For Fred, he is well when he is able to do his tour of the underground city. And this tour implies leaving the immediate local neighbourhood. Fred's urban mobility, but also the meaning he prescribed to his capacity to travel and move around in the city space, are significant for his personal mental health recovery process.

Most community services, such as the ACT, are strategically located near a metro or bus line. If individuals who are followed by the ACT team have a medical appointment or another appointment that is not easily accessible by public transportation, a member of the ACT team will typically drive them and accompany them in one of the team's vehicles designated for this purpose.[9]

DISCUSSION

These brief narratives support a common perspective of well-being (MHCC, 2009; Yanos, 2007) in which the subjective meaning attributed to the role of mobility is tied to structural factors that facilitate or obscure one's ability to circulate as one would like. Thus, it is plausible to consider barriers to mobility in the city space as a social injustice that influences mental health recovery and social inclusion. These themes are summarized below, using examples from the narratives presented above to demonstrate barriers and facilitators in Julio's and Jacques's interactions with specialized community mental healthcare service providers, with others inside and outside of their community, and with the city.

Institutional Influence on Mobility: An Implicit Control

Although the impact of mental health reforms is nuanced by local, culturally specific political and social situations (MSSS, 2012), the literature indicates that countries with a strong primary care health and mental health system result in a healthy population (Starfield, 1998 in Fleury, 2008). At the same time that emphasis is placed on strengthening primary care services, specialized community mental healthcare services have seen significant investment.

Our findings indicate that many of the service users of these specialized community mental healthcare teams experience mobility through the city space in a pre-defined and controlled manner. Although mental health structures have changed and evolved toward a community-based service offer, clinicians and workers remain largely in control of a service users' mobility. This introduced the vital, yet often diminished, role of structurally informed practice (e.g., intervening on social determinants of health) and advocacy. In addition, it has implications for the ways in which service users living with serious mental health problems negotiate their mobility within the city space. As we have seen, CAPS and ACT programs have differing service offers and thus enter into a relationship with service users in different ways. At the CAPS, almost all therapeutic, psychosocial, and leisure activities are offered in the physical space that it occupies in the community. When this is not possible, service providers will shuttle service users to their designated or desired workshops. However, the ACT program reflects a socio-political decision to maintain service users in the community and out of the clinic by offering very little by way of services or activities in its physical space. Although several service users go to the clinic daily for money, medication, medical tests, or psychiatric appointments, the vast majority of people are visited by the team in their home or at a coffee shop (or other community-based location).

Julio's narrative demonstrates that his capacity to circulate from one service to the next is determined by what is offered to him by his service provider. In both the Campinas and Montréal contexts, the specialized

9. These are not personal cars but rather owned and managed by the hospital.

community mental healthcare team determines the "track" upon which the service user can circulate. As with Julio in Campinas, Jacques and other ACT service users in Montréal can circulate the geographical borders of their neighbourhood and their service provider's territory. They are nevertheless guided by what groups, activities, and opportunities are offered to them. Also, they are subject to the approval from their service providers who often manage the money, activity choices, bus pass, or bus ticket dispersal. In short, socio-spatial dynamics inherent in a person's mobility in the city space are mitigated by both the service user and the service provider. However, it is the service provider that maintains an implicit control over this capacity to move around the city space.

Mobility and Integration: A Question of Spatial Inequalities

Community mental health delivery systems are being rapidly reshaped under conditions of globalization, radical welfare reform, and urban restructuring. This comparative ethnography between the Global south and the Global north can contribute to an understanding of what is occurring. The socioeconomic and ecological context of Brazil, a country that is facing rising rates of extreme poverty is expanding the numbers of service-dependent populations. Following Brazil's deinstitutionalization movement a few decades ago, it became harder to agree that "(…) mental health services could be understood as the outcome of a rational planning process undertaken by all-knowing service providers" (Philo & Wolch, 2001, p. 232). Rather, this research suggests that it requires the situated responses of the service users and their community to both socio-spatial inequality and mobility and public transportation in their respective neighborhoods.

The notion of spatial inequality is typically employed in economic and developmental discussions (Grant, 2010; Kilroy, 2009) to demonstrate inequality in economic and social indicators of well-being across a geographical unit. It is referred to as a "poverty trap" by Grant (2010) and discussed as "self-perpetuating, embodying serious economic and social problems" (Kilroy, 2009). These spatial inequalities are rarely directly discussed in the literature on social determinants of health. However, participants commented regularly on their ability, or inability, to access resources based on the specific geographic territory they lived in.

It seems that it is not so much, or at least not only, interventions or sophisticated treatments that support or hinder a service user's recovery journey or sense of empowerment as much as structural aspects such as access to transportation. This access seems to be related to the personal economic status, the personal network, the urban infrastructure and finally the interactions with a mental health professional.

The policy and practice emphasis on specialized community mental healthcare teams has created the possibility for mobility within the city space. Service users that were once relegated to the confines of a hospital room are now living in community housing or independent apartments and by virtue of their visits to the clinics or other appointments are more present in the public space than they would have been 10 years ago. Concurrently, their capacity to circulate and the opportunities to circulate and actively engage in the public space, especially beyond their immediate local surroundings, are mitigated by the ACT and CAPS programs. Returning to our previous discussion on mobility (Anderson & Baldwin, 2016; Baldwin & King, 2017; Baldwin, 2015) and time-space inequalities (Whitley & Prince, 2005, 2006) we believe that our case studies support their suggestion that access to transportation and changes in urban design can significantly impact social determinants of health.

There is also a variation in the ability to access different spaces within the immediate and wider environment in the two case studies. In Montréal, where public transportation is well developed and accessible, there is an increased use of public spaces and more varied mobility through the city. However, the infrastructure in Campinas is less developed. As such, Julio does not have access to public transport, but uses his bicycle. His capacity to use his bicycle autonomously is significant for him; however, he is limited by the complete lack of bicycle paths in the favela he lives in.

However, the availability and relative accessibility to public transportation and thus to a variety of community activities and services in Montréal does not necessarily reduce feelings of isolation. Jacques and other participants consistently evoked the lack of a strong social network outside of the ACT team (Khoury, 2019). In fact, many stated that the ACT service providers were their only social network. Jacques referred to the treatment team as his "friends" and another participant, Axel, referred to them as his "family." These two studies suggest that restrictions in how, when, where, and why an individual circulates may play a role in the maintenance of hospital-centric models that are not fully community oriented and that retain the status quo of historical social and economic inequalities.

CONCLUSION: EXPERIMENTING MEANINGFUL MOBILITY AS A CORE COMPONENT OF PERSONAL MENTAL HEALTH RECOVERY

An explication of mental health service users' mobility within the city space of two cultural contexts points to a phenomenon of the institution as not simply an influence on a service users' mobility, but also as a determining factor. On the one hand, the ability to move around in the city space depends on the service provider or treatment team to provide money for bus passes, to make referrals to community organizations or to provide car services. However, the ability to circulate also goes beyond the role of the treatment team; how, when, where, and why an individual accesses the city space is dependent on their personal preferences and interests and on structural facilitators and barriers such as proximity to public transportation, accessibility to public transportation and services or activities that are available in the community. It is at this juncture that the paradoxes inherent in the specialized community mental health treatment model are evidenced.

To deal with this paradox this paper invites service providers, decision makers, and researchers to reflect upon questions about the subjective meaning of mobility with service users: Where and why do you want to go? Can you get there? If yes, how? If not, why and how can we act together to facilitate your access to that space?

The participants' experiences presented in this paper may be considered as positive and optimistic. However, we retain a critical stance regarding the need for continued and progressive evolution of mental healthcare systems. The subjective experience of mobility and the singular meanings prescribed to it by the service users do not seem to be a central preoccupation for service providers. Interventions are inextricably tied to economic forces and austerity measures that favour uniformization and expert control (e.g., a diagnosis is required to receive bus tickets) rather than being constructed on the basis of the right to meaningful autonomy, mobility, and integration. Returning to our previous statement on the importance of system-level theories to guide practice, this secondary analysis of two ethnographic studies indicates the need to explore the role of community mental health teams and service providers as not just clinical actors, but also as political

and social actors, capable of implementing political interventions (Pelletier, Davidson, & Roelandt, 2009). This means that they could act upon mobility and improve the capacity for urban mobility by working with service users to create changes in their communities, such as supporting the creation of a bike path for Julio. As the discourse in community mental health research and practice continues to evolve, we observe that the importance to study the intersection of mental health practice and disrupting social inequalities as praxis becomes essential. More widely, our study addresses the question of social justice in the city space. It offers a renewed emphasis on social and environmental justice to inform mental health program development and deployment and for policy to be more aware of mobility issues.

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