

Relocating

Mental Health Care in British Columbia



Riverview Hospital Redevelopment,
Regionalization and Gender in
Psychiatric and Social Care

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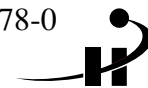
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Executive Summary

The Riverview Redevelopment Project is the name for a historic process that has seen hundreds of residents from British Columbia's aging psychiatric hospital moved into a variety of facilities in regional centres. While we, the authors of this study, understand that the greatest impact of this change has been on the lives of former residents, this report aims to capture the bigger picture of this dramatic shift in the organization and delivery of mental health care. We have sought to understand, in particular, to what extent redevelopment was embraced by planners as an opportunity to incorporate understandings of the social and structural determinants of mental health, including gender, into mental health care. We listened to and interacted with care recipients, families, staff, managers, and community-based organizations in two communities, Vernon and Kamloops, over a three-year period to understand the myriad ways in which the Riverview Redevelopment process was experienced. We have concluded that while the opportunity for addressing social and structural determinants of mental health was not lost, there is still room to develop the regionalized mental health care system to more accurately reflect the ideals of a recovery model of care, through more staff training on how gender affects mental health, and through greater resource allocation towards the non-medical aspects of mental health, especially housing and employment.

Introduction

Over the past decade there have been numerous developments in mental health care in BC. Consistent with what has occurred elsewhere, the mental health care system has been reformed in BC through two simultaneous processes: a shift in the understanding and treatment of mental illness, and a reorganization of mental health care services and delivery (Morrow, 2004). The first process has led to changes in the philosophy of care and in the involvement in care of families and mental health service recipients. The second process has consisted of the downsizing of the province's main psychiatric hospital and regionalization of mental health services throughout BC. Both processes have had powerful effects on the way people with mental illnesses are treated. This report details the results of a three-year study conducted to better understand the complex dimensions of these processes, with particular attention to the different experiences of men and women who lived through them, and to the extent to which regionalization was seen as an opportunity to make mental health care more responsive to both the medical and social needs of people.

In 2000 the BC Ministry of Health announced the Riverview Hospital Redevelopment Project. This project was to involve the transfer of patients out of BC's one large psychiatric institution, Riverview Hospital, in Coquitlam, and into smaller, home-like settings in communities throughout the province (BC Mental Health and Addiction Services, 2010; Interior Health Authority, 2006b). But the transfer process included more than the physical movement of individuals from Riverview Hospital. It also comprised a reassignment of funding away from Riverview, which is governed by the Provincial Health Services Authority (PHSA), and towards regional health authorities, in order to build new facilities, renovate existing facilities and develop and staff new services (BC Mental Health and Addiction Services, 2010). Reform therefore resulted in changes to both the physical location of care and its organization and delivery. Our study examined both: the transfer process and the development of tertiary² mental health services in one region of the province, Interior Health. In particular, the study sought to assess attention paid within the reform process to the differing needs of women and men.

Jointly undertaken by researchers at Simon Fraser University and the BC Centre of Excellence for Women's Health (BCCEWH), with the support and input of colleagues at Riverview Hospital and the Université de Montréal, the study began by examining the transfer process because this was the first impact of reform in Interior Health. Thus, our researchers began collecting data just two years after the first cohort of people were transferred, in 2003. Between 2005 and 2007 we conducted extensive interviews and focus groups with mental health directors and managers, front-line mental health staff, family members and people who

were transferred from Riverview to two communities, Vernon and Kamloops, as well as with community organizations serving individuals with mental illnesses in those communities. To be clear, the aim was not to evaluate the outcomes of the transfer process itself, but rather to describe its various dimensions, to locate it historically, and to analyze it in the context of what is known about how institutional processes and practices differently affect women and men.

Specifically, we approached the study with four, inter-related goals in mind. First, we wanted to explore the experiences of diverse stakeholders who lived through the Riverview transfer process. Second, we wanted to understand the different mental health care needs of women and men transferred from Riverview and whether these were adequately addressed. Third, we wanted to document the development of tertiary psychiatric care in the context of the regionalization process. And finally, we wanted to explore community responses to the novel situation of providing services to an influx of people with mental illness from outside the region.

Ultimately, our research revealed tensions between the goal of reorganizing care into a regionalized health system and providing better care to people with mental illnesses.

Based on our findings we have come to view the initial development of tertiary mental health services in Interior Health as challenging but largely successful. Consistent with the results of early clinical tracking studies (Lesage, Groden, Ohana, & Goldner, 2006) our research confirmed that the residents of the new or renovated facilities in Interior Health, who had been transferred from the Lower Mainland, were generally managing well in their new communities. The challenges related to the imposition of a new model of care after the patients arrived and to delivery of services in a system that, we discovered, paid little attention to the gendered aspects of mental health.

In the shift of services from Riverview Hospital to facilities managed by Interior Health, the model of care had also shifted, from a primarily custodial model to a psychosocial rehabilitation (PSR) model, that is, care framed by the principles of recovery, in which people with mental illness are assisted in achieving maximum autonomy. Our study identified issues of concern in fully implementing PSR, particularly in the context of limited resources and an inflexibly medicalized model of mental illness. Meanwhile, mental health managers and directors had little knowledge of the gendered nature of mental illnesses, and mental health services continue to be largely concerned with medical issues such as compliance with medication, while struggling to attend to other social and structural determinants of mental health like poverty, culture, ethnicity and sexual orientation.

Ultimately, our research revealed tensions between the goal of reorganizing care into a regionalized health system and providing better care to people with mental illnesses,

including maximum autonomy and community integration. These tensions are illustrated most clearly in the fact that more resources continue to be provided to the psychiatric care of people with mental illness than to their social care.

Our findings will be useful for decision-makers who shaped the Riverview Redevelopment process in BC, as well as for stakeholders, including recipients of care who experienced the transfer process. The results should also inform future practices, especially planning and implementation for the remaining transfers of individuals from Riverview into regional settings. More generally, we hope our research will contribute to contemporary public policy discussions such as those surrounding the development of the ten-year plan to address mental health and substance use in BC (BC Ministry of Health Services, 2009), as well as within the Mental Health Commission of Canada, by providing evidence on the impact of the downsizing of Riverview Hospital on its patients, their family members and the wider mental health care system. Further, this study contributes to an understanding of the challenges and possibilities of providing psychiatric tertiary care in a regionalized mental health care system. Finally, we hope that our work provides an impetus for further research and policy development that considers ways to provide gender-informed mental health care in Canada.

Rationale

The 1998 Mental Health Plan for BC, which set the stage for the Riverview Redevelopment Project, demonstrated that there was concern among policy planners in the provincial government for the gendered aspects of mental health. The Plan argued, among other things, that while “both women and men with mental illness share common experiences related to their illness, mental health programs need to acknowledge the fundamental differences in women’s and men’s experiences” (BC Ministry of Health, 1998, pg. 27). Indeed, the report went so far as to include the following observation by the advocacy group Mental Patients’ Association³: “Lack of gender sensitive services cause the majority of mentally ill women to stay either isolated or to accept services which do not address their needs” (p. 27).

This insight, that women and men have shared, yet distinct experiences of living with mental illnesses, and the idea that mental health services should reflect their differences were also the impetus for a program of research on women and mental health at the BC Centre of Excellence for Women’s Health (BCCEWH), undertaken around the same time the Mental Health Plan was being developed. The BCCEWH program, supported in part through funding from the BC Ministry of Health, produced several studies designed to better understand

women's experiences of the mental health care system in BC⁴ (Morrow & Chappell, 1999; Morrow, 2002; Morrow, 2003a; Morrow, 2003b).

As the launch of the Mental Health Plan made clear that Riverview was going to be downsized, the BCCEWH decided to include mental health care reform as part of its ongoing research program. Given the historical significance of deinstitutionalization as a key mental health reform, and given the signals sent by the Plan that gender would be taken into account in reform, we recognized that the changes taking place at Riverview Hospital and throughout BC provided a unique opportunity to study the process in action and to extend our research on gender and mental health. Although research has been done on mental health reforms and deinstitutionalization in other settings (Barbato, 1998; Hazelton, 2005; Henderson & Thornicroft, 1997; Rosen, 2006; Ryu et al., 2006) only a small portion of this work is specifically relevant to the Canadian mental health care context (Lesage, Groden, Ohana, & Goldner, 2006; Rose, 1979; Shera, Aviram, Healy, & Ramon, 2002; Skull, 1984). Other research has investigated clinical outcomes for patients transferred from Riverview (Lesage, Groden, Ohana, & Goldner, 2006). Our study was unique, however, because we were interested in the *process* of transferring people from Riverview, and in how this process was experienced by a range of participants and stakeholders. Because one's location within the mental health care system—as a provider, manager, recipient of care, family member or worker in the community—shapes the experience of the process, documenting these different perspectives is critical for a full understanding of the actual implementation of mental health reforms. Thus, careful studies of deinstitutionalization in Canada, like ours, are critical for learning how to address both the psychiatric and social needs of people with mental illnesses, including their needs for housing, income security, access to meaningful activity, employment opportunities and freedom from discrimination. As well, our attention to gender and the needs of men and women with mental illnesses adds to a growing body of evidence that shows that gender, in its intersections with other social and structural determinants of mental health, is central for developing care and responses to people with mental illnesses (Burman & Chantler, 2003; Kohn & Hudson, 2002; Rossiter & Morrow, in press).

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Background

Sex, Gender, Intersectionality and Mental Health

Evidence suggests that the mental health needs of women are significantly different from those of men and that an application of gender and sex-based analyses are therefore essential to research in mental health (Gold, 1998; Harris & Landis, 1997; Rhodes, Goering, To, & Williams, 2002). For example, women are more likely than men to be diagnosed with depression, anxiety and eating disorders and are more likely to attempt suicide (Howell, Brawman-Mintzer, Monnier, & Yonkers, 2001; Kessler et al., 1994; Kornstein & Clayton, 2002; Prior, 1999). Men complete more suicides and are more often diagnosed with anti-social personality disorders (Kessler et al., 1994). Men and women signal and cope with distress differently and access different kinds of services and supports (Rhodes et al., 2002). At the same time, increasingly, researchers are seeing that gender cannot be understood in isolation of other social and structural determinants of health (Hankivsky, 2007; Hankivsky & Cormier, 2009; Read & Gorman, 2006). For example, social inequality, poverty and violence have been shown both to exacerbate existing mental health problems and engender new ones in both women and men (Anderson & Chiochio, 1997; Harris & Landis, 1997; Saraceno & Barbui, 1997).

Social inequality, poverty and violence have been shown both to exacerbate existing mental health problems and engender new ones in both women and men.

The mental health of different groups in Canadian society is thus influenced by multiple intersecting factors including gender and sex, but also many others, like historical and contemporary social circumstances.

Intersectionality is therefore a key concept in a fuller picture of how mental health develops—or fails to. For example, legacies of colonialism and racism have resulted in high rates of suicide, addictions and mental health problems for First Nations people (Health Canada, 2000; Kirmayer, Brass, & Tait, 2001). Racialized immigrant groups experience specific challenges related to the stresses of acculturation (Boyer, Ku, & Shakir, 1997; Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988). Gay and lesbian youth are more likely than other young people to attempt suicide (Badgley & Tremblay, 2000; D'Augelli, Hershberger, & Pilkington, 2001), and transgendered people experience multiple forms of abuse and violence, which effects their safety and mental well-being (Courvant & Cook-Daniels, 1998; Eyler & Witten, 1999). Further, the research literature demonstrates that marginalized groups have particular difficulty in accessing appropriate mental health care and experience the stigma of mental illness and the accompanying discrimination differently than non-marginalized

groups (Alvidrez & Azocar, 1999; Collins, 1993; Gary, 2005; Mill, Austin, Chaw-Kant, Dumont-Smith, & Edwards, 2007; Ship & Norton, 2001).

Despite massive deinstitutionalization over the past 60 years, little is known about its differing effects on men and women, or what kinds of unique needs arise for the sexes during the adjustment to new surroundings, care models or communities. Even less is known about

Gaps remain with respect to the understanding of the role of gender in mental health, particularly among providers and policy makers.

the relevance to these processes of other intersecting factors such as race, ethnicity, sexual orientation, age and culture. Traditionally, women have been said to fare better following deinstitutionalization because they experience, on average, higher functioning when they are in early stages of illness; fewer stays in all types of psychiatric settings; and better social support (Angermeyer, Kuhn, & Goldstein, 1990; Bennett, Handel, & Pearsall, 1988; Test, Burke, & Wallisch, 1990). However, although initially women with mentally illness often do better than men in independent living situations, research has emerged that suggests these benefits are not necessarily sustained over time (Cook, 1994). And although women tend to more frequently access outpatient mental health care services (Rhodes et al.,

2002), access is not synonymous with appropriate care. To truly understand the diverse experiences and long-term implications for women and men of deinstitutionalization requires going beyond the data traditionally measured in studies. Determining the reduction in clinical symptoms or the adjustment rates to semi-independent living situations, for example, isn't enough. It would require an assessment of the accessibility and appropriateness of services. This kind of research would be beneficial in managing important transitions in care.

The case for gender-informed mental health care has been made in Canada and in other international jurisdictions (e.g., Ad Hoc Working group on Women, Mental Health, Mental Illness and Addictions, 2006; Morrow & Chappell, 1999; Morrow, 2003b; Department of Health, 2002, 2003a, 2003b). And yet, gaps remain with respect to the understanding of the role of gender in mental health, particularly among providers and policy makers. The current study recognizes this gap and builds on the national and international work that has been done on gender. It contributes specifically to discussions about how gender and other intersecting factors are relevant to the care and support of women and men who have experienced long-term psychiatric institutionalization.

Mental Health Reform

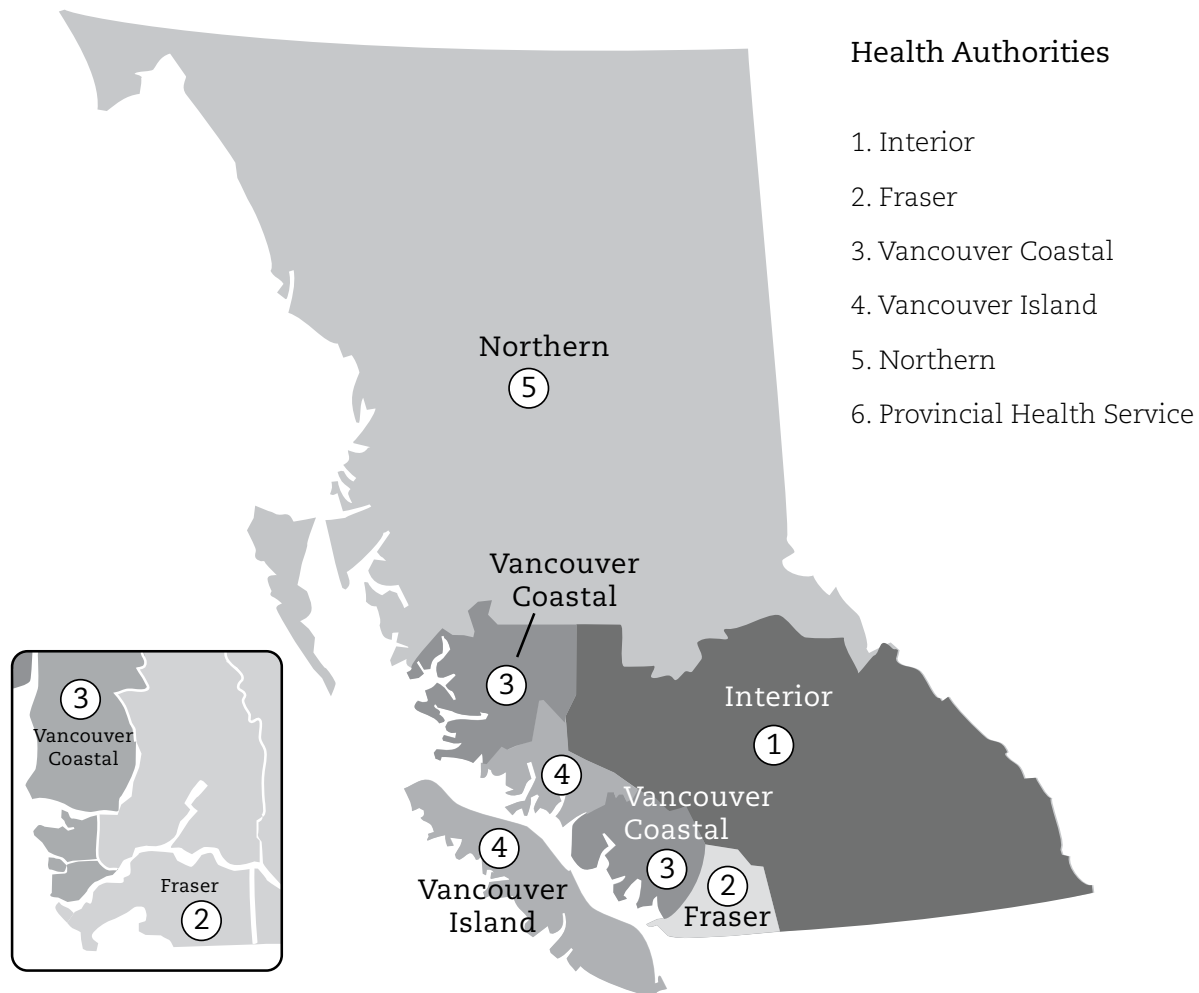
The impetus for past and current reform processes in mental health comes from a number of interconnected factors. These include scientific advancements in psychiatric drugs and criticism of the negative impact of institutional care, coupled with the push for a new philosophy of care concerned with the quality of life and civil rights of people with mental illnesses (BC office of the Auditor General, 1994; Lesage, Morissette, Fortier, Reinharz, & Contandriopoulos, 2000). Together these changes have contributed to the belief that community-based mental health care is not only possible but desirable (Chambers, 1993; Wasylenki et al., 2000), and they have engendered a move to create mechanisms for the participation of mental health care recipients and, where possible, their families in health care decision-making (BC Ministry of Health, 1998; Morrow, 2004).

Health Services Regionalization in British Columbia

The downsizing of Riverview Hospital must be understood within the larger context of health care regionalization in BC. The establishment of regional health authorities has been a major feature of health reform in Canada during the past decade. Although the specifics of the structures have varied, all provinces have established some form of a regionalized health system as a means to coordinate services, planning and administration. In BC, regionalization of the health care system was recommended by the Royal Commission on Health Care and Costs in its 1991 report *Closer to Home* (BC Royal Commission on Health Care and Costs, 1991). Although this report led to much discussion, regionalization was not implemented until several years later, in the mid-1990s. This took place in stages, and its successive iterations resulted in considerable restructuring and massive reorganization of health service delivery and administration (Weaver, 2006).

The current arrangement, which began in 2002, and resulted from the amalgamation of 52 regional health authorities, has the province organized into five geographical zones (Fraser Health Authority, Interior Health Authority, Northern Health Authority, Vancouver Coastal Health Authority and Vancouver Island Health Authority) and one provincial health authority, with the First Nations Nisga'a Health Council remaining an independent health authority. Figure 1 shows the geographical division of BC into the five regional authorities, with Interior Health in dark grey.

Figure 1. British Columbia's regional health authorities.



Regionalization was also touted as encouraging local responsiveness of and access to health services by providing services “closer to home”.

The geographic health authorities are responsible for managing and delivering most publicly funded health services. The Provincial Health Services Authority (PHSA) is responsible for managing and coordinating provincially delivered services, including Riverview Hospital. As such, the PHSA has assumed a leadership role in the Riverview Redevelopment process and has been a collaborative partner on the Riverview Hospital Redevelopment Project Steering Committee, which includes representatives from the Ministry of Health Services and the five geographic health authorities (BC Mental Health and Addiction Services, 2010). Meanwhile, building on the traditional role assigned to the provinces in Canada, the BC provincial government defines itself as the steward of the health care system, responsible for its financing and overall direction, but not for direct management and local policy making (BC Ministry of Health, 2008).

When it was initially conceptualized in the Royal Commission on Health Care and Costs, support for regionalization came from across the political spectrum. Advocates of regionalization saw it as a progressive strategy because regionalization was seen as a tool to increase involvement in the care process by recipients of care and families through the fostering of local accountability (Davidson, 1999; Weaver, 2006). In mental health, supporters believed regionalization would promote quality of care and quality of life for individuals with mental illness through the change in the model of care that would accompany relocation of mental health care from large institutions to community settings (BC Ministry of Health and Ministry Responsible for Seniors, 1987). Regionalization was also touted as encouraging local responsiveness of and access to health services by providing services “closer to home” (BC Royal Commission on Health Care and Costs, 1991; Weaver, 2006).

These hopes led to tremendous energy being devoted to working out the details of regionalization of mental health care, culminating in the 1998 BC Mental Health Plan. However, even as bureaucrats, health managers, patients and communities prepared for the shift, other changes were afoot. Implementation did not take place in a vacuum; it was accompanied by a dramatic shift in the provincial political climate, sharp policy shifts, and cutbacks to the social welfare system (Cohen et al., 2008; Cohen, Tate, & Baumbusch, 2008; Klein et al., 2008; Morrow, 2006b). Some studies have suggested that these changes have had a deleterious impact on community-based supports for people with mental illnesses (see Morrow, 2006a; Morrow, Wasik, Cohen, & Perry, 2009). Thus, any assessment of regionalization must take this wider policy context into account.

And the changes continue. Since we conducted our study there has been further reorganization within the Ministry of Health, including a name change, to Ministry of Health Services, and the creation in June 2009 of a separate Ministry of Healthy Living and Sport. In September 2009 the government released a new budget that entailed cutbacks to health services (see, for example, McLellan, 2009; CBC, 2009; Hunter, 2009), and, at the time of writing, further organizational changes, including the release of the March 2010 budget (BC Ministry of Finance, 2010) were underway. The fact that restructuring of health care is a constant feature means that policies, which can only really work when implemented over the longer term, are also often shifting to respond to new organizational forms. While our study occurred under the former administrative arrangements, our recommendations are made at a sufficiently general level that this new structure does not affect their usefulness.

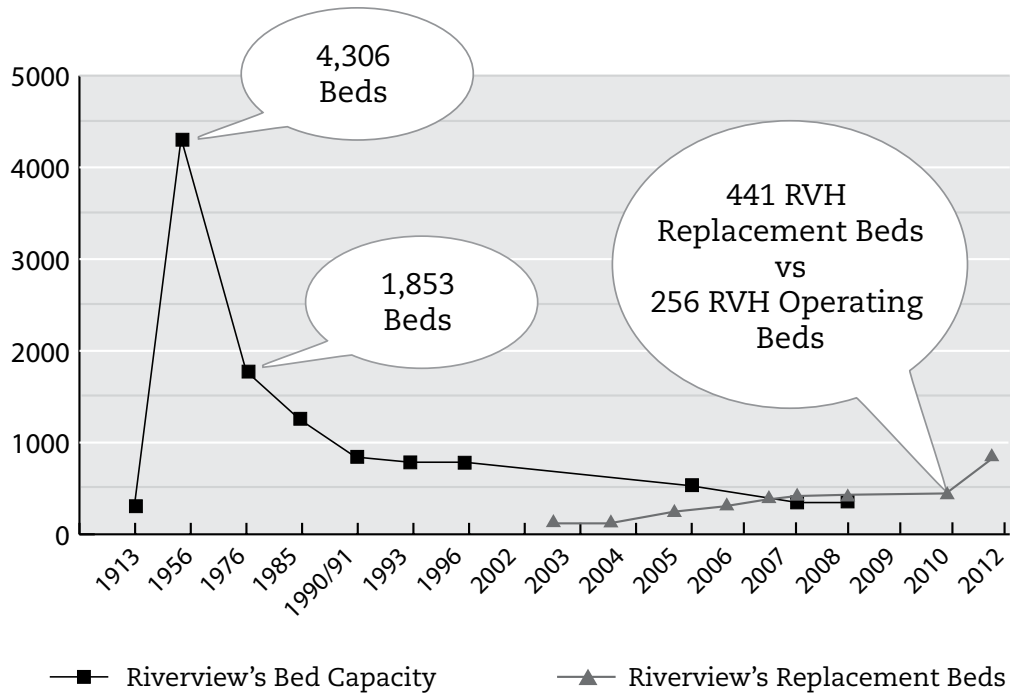
Deinstitutionalization of People with Mental Illness in British Columbia

Although deinstitutionalization in BC began well before regionalization, regionalization has provided new ways of organizing mental health care as people are transferred out of Riverview. Historically, people with mental illnesses began to be systematically deinstitutionalized from large psychiatric hospitals into communities throughout Canada in the early 1960s, a shift that has been accompanied by an overall reduction in the number of available long-term psychiatric beds (Lesage et al., 2000; Reinhartz, Lesage, & Contandriopoulos, 2000). In BC, Riverview Hospital, formerly known as Essondale, has been the province's sole major psychiatric facility for nearly a century. It reached its peak population in 1956 with more than 4000 patients (BC Royal Commission on Health Care and Costs, 1991) and has since undergone consecutive, although interrupted, efforts to reduce its size. The most dramatic decline in patient population occurred between 1956 and 1976 when 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, 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 (BC Office of the Auditor General, 1994; BC Provincial Mental Health Advisory Council, 1996).

The release of the 1998 BC Mental Health Plan led to the most recent iteration of downsizing—and the subject of this study—known as the Riverview Redevelopment Project, which entailed the systematic movement of patients beginning in 2002. Figure 2 uses two proxy measures—Riverview's bed capacity, and the provision of replacement beds outside the hospital—to depict the process of psychiatric deinstitutionalization since the hospital's

opening in 1913. Further down, in Table 1, we detail some landmark events in the recent deinstitutionalization process out of Riverview.

Figure 2. Deinstitutionalization in BC as measured by its bed capacity and establishment of replacement beds elsewhere in the province.



Sources:

British Columbia Ministry of Health Services; Vancouver Coastal Health & Fraser Health (February 11, 2010). *Riverview redevelopment continues to move ahead*. News Release. Retrieved from http://www2.news.gov.bc.ca/news_releases_2009-2013/2010HSERV0007-000142.htm

British Columbia Ombudsman (1994). *Listening: A review of Riverview Hospital*. Public Report No. 33. Victoria, BC: Office of the Ombudsman, Province of British Columbia.

British Columbia Royal Commission on Health Care and Costs (1991). *Closer to home: The report of the British Columbia Royal Commission on Health Care and Costs (v.2)*. Victoria, BC: Crown Publications.

In the past, care in large, long-term facilities like Riverview was characterized by a custodial model in which patients were subject to institutional routines such as set meal and bath times, minimal personal autonomy and limited involvement with the outside community. Although care models at Riverview changed over time to incorporate some principles of recovery, such as more active involvement in personal care planning and greater interaction with the community, the design of the buildings themselves, the geographically isolated location of the facility and staff training were not conducive to fully actualizing care based on recovery. The Riverview Redevelopment process included a commitment not only to moving individuals from Riverview to more ‘home like’ settings, but to shifting the philosophy of care from a custodial model to one that was governed by recovery principles. For example, in a description of the Riverview Redevelopment Project posted to BC’s Mental Health and Addiction Services website, the new facilities emerging from deinstitutionalization are said to provide patients with a “more ‘normalized’ lifestyle.” The website description goes on to suggest that the new settings “are more conducive to patients’ goals of independence and community re-integration” (BC Mental Health and Addiction Services, 2010).

Table 1. Landmarks in the history of Riverview Hospital Redevelopment.

1987	BC government draft plan to replace Riverview with community-based resources and longer-term in-patient units across the province (Ministry of Health, 1987).
1991	Royal Commission on Health Care and Costs releases report <i>Closer to Home</i> (BC Royal Commission on Health Care and Costs, 1991).
1992-96	Downsizing begins at Riverview; later suspended due to concerns about pressure on acute psychiatric services in Vancouver and over lack of community care resources throughout BC (BC office of the Auditor General, 1994; BC Provincial Mental Health Advisory Council, 1996).
1994	Auditor General’s Report on Riverview detailing numerous issues with Riverview’s services including patient abuse. Riverview deemed lacking in adequate mechanisms to respond. Ombudsman recommends Riverview adopt a Patient Charter of Rights and support a patient-run advocacy body (Yearwood-Lee, 2008).
1998	BC Mental Health Plan includes goal of replacing Riverview with beds in smaller facilities over a seven-year period (BC Ministry of Health, 1998).
2002	Riverview Redevelopment Project announced and patient transfers begin.
2012	Expected date to complete transfers from Riverview.

Our research focused on the development of new facilities and services in the region operated by Interior Health, which was among the first of the five geographic health authorities to achieve self-sufficiency under regionalization by developing its own psychiatric tertiary care services. It was also among the first to receive patient transfers from Riverview, beginning in 2003. Specifically, we chose to study the transfer of patients to the communities of Kamloops and Vernon. As the site of a new psychiatric tertiary care facility called South Hills, to which people were initially transferred from Riverview, Kamloops made a strong study community. Vernon, meanwhile, had received provincial funding to renovate one of its existing facilities, Aberdeen House, where some former Riverview residents were to be accommodated after leaving South Hills.

Interior Health

Like the other regions, Interior Health, the second-largest geographically designated region of the province, received new mental health beds after 2002 for both tertiary residential and rehabilitation care. In Table 2, we break these down by the various facilities in the five Health Services Areas encompassed by Interior Health (Personal communication, July 2009).

Table 2. Establishment of tertiary residential and rehabilitation beds in Interior Health

Health Service Area	Date	Facility	Beds
East Kootenay (Cranbrook)	May, 2004	FW Green	2
	July, 2005	Tamarack Cottage	7
West Kootenay (Trail)	March, 2004	Harbour House	9
	March, 2004	Harbour House	6
	June, 2005	Harbour House	3
South Okanagan (Penticton/ Osoyoos)	June, 2004	Country Squire	8
	Sept, 2005	Braemore Lodge	4
North Okanagan (Vernon)	June, 2004	Aberdeen House	7
	March, 2005	Polson Place	5
Thompson Cariboo Shuswap (Kamloops)	April, 2003	South Hills	40
	April, 2006	Hillside	44
	May, 2007	Hillside	3*
	Jan, 2006	Hilltop House	6
	Jan, 2008	Apple Lane	6

* established to serve Northern Health Authority

Interior Health also provides other specialized residential services for people with mental health and addictions problems. Overall, as of July 2008, there were 1034 mental health and addictions beds in the region.⁵

Table 3 details the number of direct transfers from Riverview that occurred in Interior Health until September 2006. In total 119 people were transferred to the region from Riverview. Most of these individuals went to South Hills and were subsequently sent on to other tertiary residential or rehabilitation programs (Personal communication, July 2009).

Table 3. Patient transfers from Riverview Hospital to Interior Health

Year	Facility (Location)	Transfers
2003	South Hills (Kamloops)	39
2004	South Hills (Kamloops) FW Green (Cranbrook)	20 2
2005	South Hills (Kamloops) Polson Special Care Centre (Vernon)	14 5
2006	South Hills (Kamloops) Hillside (Kamloops)	6 29

In addition, 4 people transferred directly to the region from Riverview without going through South Hills. One of these individuals went to live independently in Trail; one went to a facility called Country Squire, in Osoyoos; one went to Tamarack Cottage, in Cranbrook; and one moved to Aberdeen House in Vernon (Personal communication, July 2009). With the exception of these four, all individuals transferred from Riverview to Interior Health went through the South Hills facility. Of these, 15 participated in interviews for our study in 2006. Table 4 summarizes the information they provided at that time on where they had gone since arriving at South Hills from Riverview.

Table 4. Transfers as of 2006 after arriving at South Hills from Riverview Hospital (excluding initial transfer from Riverview), as reported by study participants

Individual	Transfers	Destination
Sylvester	0	no change
Lucas	0	no change
William	0	no change
Beth	0	no change
Mary	0	no change
Maude	0	no change
Karen	0	no change
Lewis	0	no change
Steven	1	Aberdeen
Terry	1	Aberdeen
Robert	1	Garden Manor
Martha	1	Independent Living
Tyler	2	Aberdeen; Canadian Mental Health Association House
Janice	2	Down's; Aberdeen
Susan	2	Garden Manor; Stepping Stone

Research Methods

Methodology

The starting point for our study design was feminist ethnography. Feminist ethnographic studies typically employ several methods and are sensitive to the ways that gender structures social relationships (Naples, 2003; Reinharz, 1992). Because we were interested in the transfer of individuals out of a hospital setting we embarked on a specific kind of feminist ethnography, called institutional ethnography, which starts by documenting people's lived experiences with the aim of understanding these experiences in the context of larger social and institutional processes

(Smith, 1987; Smith, 2006). This approach has been used to study a wide range of issues in the health field (Mykhalovskiy & McCoy, 2002; Rankin & Campbell, 2006; Rankin & Campbell, 2009) including mental health (Townsend, 1998).

We recognize that one's position in the mental health care system affects both the experience of changes in policy and practice and the way one describes this experience.

Institutional ethnographers rely on people's knowledge of how policy and institutional relationships affect their practice and their lives. We adopted institutional ethnography as the analytic lens through which to better understand how the everyday experiences of people involved in mental health care—as recipients of care, providers of care or decision makers about care—are organized through social relations and institutional structures (Smith, 1987; Smith, 2006).

We recognize that one's position in the mental health care system affects both the experience of changes in policy and practice and the way one describes this experience. To this end, we committed to including a range of participants in

our study (see Dobson, 2001; Smith, 2006; E. Townsend, Langille, & Ripley, 2003), including mental health managers, staff, care recipients, family members and community-based organizations. Our specific ethnographic methods included interviews, focus groups, and site visits with these individuals. We also conducted a review of relevant literature and policy documents in order to understand this original ethnographic data in the context of larger, ongoing debates about mental health care and gender.

Review of Literature and Policy-Relevant Materials

Specifically, we analyzed international and national literature related to the topics of mental health reform and psychiatric deinstitutionalization, with particular attention to Canadian studies and analyses (e.g. BC Ministry of Health Services, 2002b; Lesage, Groden, Ohana, &

Goldner, 2006; Moran, 2000; Moran & Wright, 2006; Morrow, 2003b; Morrow, 2007; Wasylenki et al., 2000) and to literature on gender and mental health and other social and structural determinants of mental health. We reviewed all this material for what it might tell us about the diverse experiences of people with mental illnesses and the range of supports they need (e.g., Ad Hoc Working group on Women, Mental Health, Mental Illness and Addictions, 2006; Boyer, Ku, & Shakir, 1997; Ellery, 1998; Harris & Landis, 1997; Kirmayer, Brass, & Tait, 2001; Kirmayer, Simpson, & Cargo, 2003; Kirmayer, Tait, & Simpson, 2009; Kornstein & Clayton, 2002; Waldram, Herring, & Young, 2006). We also examined policy documents pertaining to the Riverview Redevelopment process, beginning with the 1998 BC Mental Health Plan (BC Ministry of Health, 1998), the first official articulation of the plan to downsize Riverview Hospital, and including documents that explored reform issues in the mental health care system more generally (BC Ministry of Health Services, 2002a; Calsaferrri, Treherne, & van der Leer, 2002; Canadian Alliance on Mental Health and Mental Illness, 2000; Federal/Provincial/Territorial Working Group on Women's Health, 1990; Hall, 2001; Interior Health Authority, 2002; Kirby, 2006; Kirmayer, Simpson, & Cargo, 2003; Koji, 2003; McCallum, 1994; McNaughton, 1992; National Health and Welfare Canada, 1989; Nelson, Lord, & Ochoka, 2001; Reist et al., 2004). All the policy-related materials reviewed were publicly available at the time of research and included, for example, website information about the Riverview Redevelopment process, published transfer plans by Interior Health and historical reports documenting plans for downsizing Riverview.

Finally, because this research builds on previous policy-related research on gender and mental health in BC by members of the current research team and others, this material was also utilized in our literature and document review (Ad Hoc Working group on Women, Mental Health, Mental Illness and Addictions, 2006; BC Women's Hospital & Health Centre and BC Centre of Excellence for Women's Health, 2004; Morrow & Chappell, 1999; Morrow, 2002; Morrow, 2003a; Morrow, 2003b).

Site Visits

Interior Health serves a geographic area covering nearly 215,000 square kilometers that includes cities (Kelowna, Kamloops, Cranbrook, Penticton and Vernon) as well as many rural and remote communities. As mentioned earlier, Kamloops and Vernon were chosen as our research sites in part because most of the people transferred from Riverview to Interior Health went to Kamloops first, and some subsequently moved to Vernon. But the cities were also chosen because they represent two geographically and politically distinct towns with different sets of mental health resources, such as community-based services, community hospitals, educational institutions and employment base. Thus, the goal was not to be explicitly

comparative, but to use two sites that captured a number of different dimensions of the transfer process as it played out.

Kamloops is the site of South Hills, a 46-bed psychiatric tertiary care facility that was built with provincial Riverview Redevelopment funds. South Hills is focused on treatment and rehabilitation with the goal of preparing individuals for community reintegration. Located in a residential area of Kamloops with access to amenities and a short bus ride's distance to the downtown core, its design incorporates small pods of single rooms surrounding communal kitchens and living areas. It has few reminders of traditional mental health institutions, with neither a seclusion room nor a detached nursing station.⁶

Vernon received funding from the Riverview Redevelopment Project to renovate the existing facility called Aberdeen House in order to accommodate Riverview transfers. Aberdeen House is a 14-bed licensed adult psychiatric residential facility run by the Canadian Mental Health Association under contract by Interior Health. Aberdeen looks more like a regular house than South Hills and is situated in a residential area where it is mostly indistinguishable from the surrounding homes. Seven of the beds are tertiary specialized residential. The program components include life skills, rehabilitation and preparation for return to the community. Aberdeen provides private rooms for individual residents and a shared kitchen and living space.⁷

Beginning in February 2006, we conducted four data-gathering site visits. The initial visit was intended to build relationships with various stakeholders of the study. Individual interviews and focus groups took place during the next three visits in June, 2006, July 2006, and March 2007. These sessions were conducted in a range of locations, including psychiatric acute, rehabilitation and tertiary care facilities and at community-based organizations. In the project's third year, we undertook two additional visits (in November 2007 and April 2008) to coordinate knowledge exchange activities, including presentations to mental health managers and facility staff, and, in a separate forum, to community mental health organizations and people with experience of mental illnesses and institutional care (see Appendix 1). The purpose of these presentations was to share our initial study findings and seek feedback from key study participants.

Our researchers did not arrive unannounced. Two community-based researchers previously affiliated with our team and well connected in these communities were employed beforehand to assist with building community relationships, especially with local community-based mental health organizations. As well, our team had invested energy in connecting with mental health care providers.

A timeline of our site visit activities can be found in Table 5. Sampling and details of the interviews and focus groups are summarized in Table 6.

Table 5. Study site visit activities by year, 2006-2008

Year	Activity
2006	<ul style="list-style-type: none"> • Meetings with Interior Health managers and community-based organizations • Facilities Tours • Community tours • Individual interviews with former Riverview residents and mental health managers and directors
2007	<ul style="list-style-type: none"> • Further individual interviews with former Riverview residents and mental health managers and directors • Group interviews with family members • Focus Groups with mental health facility staff and family members • Knowledge exchange with Interior Health Mental Health and Addictions Directors
2008	<ul style="list-style-type: none"> • Knowledge exchange activities

Interviews, Group Interviews and Focus Groups

Individual interviews, group interviews and focus groups were conducted with research participants. The number and types of participants are detailed in Tables 6 and 7. Individual interviews ranged from one half-hour to two hours in length. Group interviews included more than one participant, but were smaller than focus groups. For example, in several instances, two staff members were interviewed together, and, in the case of families, we sometimes met with more than one member at a time. All individual and group interviews were conducted using semi-structured interview guides for each type of participant (see Appendix 2).

Focus groups were intended to supplement interviews by opening a forum in which participants would build on each other's responses, rather than just interacting with the interviewer(s). They involved bringing together between 6 to 11 people for concentrated discussions beginning from a set of semi-structured focus group questions (see Appendix 2). We conducted two focus groups with tertiary mental health care workers (15 participants total) and one with community mental health care providers (11 participants). Family members of individuals who had been transferred from Riverview were difficult to connect with, in

part because many individuals from Riverview had lost contact with their families. With this in mind, one focus group (7 participants) was conducted with family members supporting relatives with serious mental illnesses in Interior Health who had not been involved in the Riverview transfer process.

Sampling for Interviews and Focus Groups

Consistent with our understanding that people differently located in the mental health care system would experience the transfers from Riverview Hospital differently, and that policy and institutional practices shape people's work practices and lives (Smith, 2006; Townsend, Langille, & Ripley, 2003), our sample was designed to draw from a number of categories of research participants. This included the following categories of interviews:

- 1) Mental Health Directors and Managers in Interior Health⁸
- 2) Tertiary Mental Health Care Providers
- 3) Mental Health Care Recipients who were former residents of Riverview⁹
- 4) Family Members
- 5) Managers and Staff of Community-Based Organizations¹⁰

We employed a purposive sampling method (Denzin & Lincoln, 2008) in order to ensure that we had suitable numbers in each category of participant.¹¹ For example, we wanted to make sure we spoke to managers and directors in Interior Health who had been involved in decision-making with respect to the transfers, and to front-line staff who had contact with individuals who had come from Riverview. This included managers of facilities and staff who had been involved in the initial planning process with support from Riverview, as well as staff who had subsequently worked day to day with transferred individuals.

Table 6. Individual interviews by category, number and interviewees

Category	Number	Interviewees
Mental Health Directors and Managers	18	<ul style="list-style-type: none"> • Interior Health officials overseeing psychiatric tertiary care development • Provincial Health Services Authority officials overseeing Riverview Redevelopment
Tertiary Mental Health Care Providers	15	<ul style="list-style-type: none"> • occupational therapists • registered nurses • life skills workers • transitional care aides • other allied health care workers
Mental Health Care Recipients who were former residents at Riverview	17	<ul style="list-style-type: none"> • 9 male residents • 8 female residents
Family Members of Mental Health Care Recipients	7	<ul style="list-style-type: none"> • 1 mother/2 brothers (daughter/sister) • 1 mother (daughter) • 1 mother and father (daughter) • 1 husband (female partner)
Managers and Staff of Community-Based Organizations	11	<ul style="list-style-type: none"> • community mental health providers • social service providers • women’s centres and shelters • vocational support organizations
TOTAL	68	

Table 7. Focus groups by category, number, and location

Category	Number	Location
Mental Health Staff	3	2 in Kamloops 1 in Vernon
Family	1	1 in Vernon

Field Notes

Field notes are an important component of reflexive research practice (Denzin & Lincoln, 2008). In keeping with this, the researchers on the team collectively generated field notes at the end of each site visit. These notes served the dual purpose of tracking individual researchers' thoughts and reflections on the process (e.g., their reactions to individual stories of the research participants) and also served as a form of collective analysis of the themes emerging from the data. This allowed the researchers to engage in an iterative process whereby new issues/themes that emerged could be followed up in subsequent interviews.

Data Analysis

An initial coding framework was developed using the thematic areas that had been developed to guide the interviews. The data were first organized and coded according to emergent themes for each individual interview or focus group. Data from each type of study participant (i.e., director, staff, mental health care recipient, family member, community-based organization) was then examined to look at themes that were cross-cutting across participant type. Inter-rater reliability was established by more than one researcher coding the same data and through data analysis meetings where codes and themes were discussed for accuracy (Denzin & Lincoln, 2008). Data were collected until no new themes were being generated (data saturation), with one exception. In the case of interviews with family members, the sample size was too small to reach saturation, so caution must be used in generalizing the results from this sample. Interview and focus group data were organized using NVivo 7, a qualitative software package. Field notes that were generated after each field visit were also reviewed and analyzed using the same processes.

Gender-based and intersectional frameworks were also applied to the data. 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., 2007; Health Canada, 2003; Johnson, Greaves, & Repta, 2007; Salmon, Poole, Greaves, Ingram, & Pederson, 2006; Spitzer, 2004). Intersectional analyses take into account the intersections of social locations like gender, race, ethnicity, culture, sexual orientation and physical ability. As discussed earlier, researchers have increasingly proposed that an analysis of these factors is necessary for understanding the complex interactions of mental health determinants (Burman & Chantler, 2003; Burman, 2003; Kohn & Hudson, 2002; Smye & Browne, 2002). Both forms of analysis have been increasingly adopted in health research (Hankivsky & Cormier, 2009; Johnson, Greaves & Repta, 2007; Clow, Pederson, Haworth-Brockman, Bernier, 2009).

Limitations of the Study

There was a considerable time gap of two years between the start of the Riverview Redevelopment Project transfer process to Interior Health, in 2003, and our data collection, which began in 2006. Some of our interviewees had therefore been living in their new, non-institutional facilities for a year or more when we spoke with them. As our data were derived from interviews and focus groups, we had to rely on people's self-reported experiences of processes, and the time gap could have impacted some participants' memories. Although in all instances we attempted to triangulate our findings to ensure their reliability and validity (Creswell, 2006), there may be some errors of fact related to recall that we could not verify. However, recalling that our research was not designed to evaluate the Riverview Redevelopment process using set measures and/or outcomes, this possibility has limited potential to damage results. Our study captures multiple stakeholders' experiences of the Riverview transfer process in a particular moment in time.

Our study captures multiple stakeholders' experiences of the Riverview transfer process in a particular moment in time.

Activities to develop regional capacity for psychiatric tertiary and community-based mental health care continue province-wide to this day, including within Interior Health. We knew going into the study that this would occur, and we designed a study that was not predicated on such fluctuations. Moreover, having shared our findings as part of the research process, our results have already been heard by many members of the mental health community in Kamloops and Vernon, as well as in Kelowna, where Interior Health has its head office. The point is not that the data we have collected are the only version of events, nor that further changes have not occurred, but rather that we have described an ongoing process that has features and patterns that are recognizable to those who experienced the process. As this is not a longitudinal study, the changes since our data collection are outside the scope of our study and thus our findings. Further, while it might be possible to generalize from some of our findings to consider other cases within the region studied, these are not intended to be generalized to other regions and health authorities, but rather to raise questions about whether a close examination of the processes in those jurisdictions would elicit similar findings.

Caution must also be applied with respect to generalizing about the experiences of family members from our findings. Recruiting family members of the people transferred to Interior Health from Riverview Hospital proved difficult. In the end, we were only able to interview seven such individuals. This may relate to a feature of the lives of some former Riverview Hospital patients. In our interviews with staff at the facilities in Kamloops and Vernon we gathered that many of these patients had limited contact with family. Results from our supplementary

focus group with family members of recipients of mental health care who had not been part of the transfer process cannot be assumed to capture the experiences of family members of those who did.

Finally, we recognize that our study is limited in its ability to examine and report on the impact of mental health care reforms on the province's Aboriginal¹² populations and other ethnic groups. Although it was clear that Interior Health had embarked on a number of initiatives in recent years to specifically address the mental health concerns of Aboriginal clients (Interior Health Authority, 2003; Interior Health Authority, 2006a), little of this work had translated into concrete programs or changes in care models in the facilities in which we did our research. There was some compelling anecdotal evidence in the stories of staff working at the facilities that for some Aboriginal and Asian clients, reconnection to their home communities resulting from the transfers had improved their well-being. However, these examples spoke more to how ethnicity (like gender) was dealt with at the level of the individual by the care system (as opposed to on the structural level) than they did to a general good result from regionalization for these groups.

FINDINGS 1

Moving From Riverview

In this section we report results that capture the experience of the transfer process from multiple vantage points, including the challenges and opportunities that have resulted from mental health care regionalization in Interior Health. We follow these results with a discussion about capacity-building among community-based mental health organizations that provide programming, housing, shelter or other related services to people with serious mental illness under the new, de-institutionalized arrangement. As we will show, an emerging theme in this area is the sharp divide that exists between psychiatric (medical) care and social care, as exemplified in the disparity in resource allocation for medical care as opposed to community-based mental health services.

The findings here reflect the phase in which individuals were transferred from Riverview Hospital to the South Hills facility and, in some instances, to other facilities in either Kamloops or Vernon.¹³ Typically, individuals were transferred to South Hills prior to placement elsewhere in the region. This initial transfer was intended to permit individuals to stabilize and to be assessed before a decision was made about whether they were suitable for community care or supported independent living.

Directors, Managers and Tertiary Mental Health Care Providers

Following the announcement of the Riverview Redevelopment Project there was a long lead-up to the first set of transfers from Riverview Hospital to South Hills in 2003, during which pre-transfer preparations, support and cross-site visits of staff (and some patients) between Riverview and South Hills were carried out. Although management and staff from South Hills were involved in these preparations, the schedule and timeline were primarily determined by Riverview and the Provincial Health Services Authority. In contrast, the actual physical moves of the first cohort of patients happened very quickly, over a period of a month.¹⁴ This proved difficult for Interior Health staff as they had to cope with many people arriving quite suddenly. Interview participants reported that residents were received very rapidly at the beginning of the transfer process, sometimes as many as 10 in a week. One explanation study participants proposed for the rapid pace was that since transfers of individuals also meant transfers of resources from the Provincial Health Services Authority to Interior Health, the short timeline was established in part to accommodate the fiscal year end and to meet planned targets. Nonetheless, some staff members were pleased with the way transfers were coordinated and how patients were “turned over” from Riverview. Here are the views of one mental health nurse about the transfer process:

Basically we would get, you know, told or informed that we were going to get a patient. We would get basic information, usually the patient history and a little bit of a turnover from Riverview. And sometimes the staff in Riverview would actually come with the patient. That was really good because then they could, you know there's a lot of things that are not necessarily on the charts, but tips and what the patient likes, and a lot of, like their family history and their medical history and their psychiatric history is on the charts, but oftentimes what's not on the chart is “Oh he likes orange juice with his meds”. You know, just different quirks that people have, and so that's kind of nice. I thought that was really nice, when we got that much of a thorough turnover. (MENTAL HEALTH NURSE)

However, Interior Health staff reported that despite this kind of attention and preparation, they did not always feel they had accurate information about the level of illness of the patient being transferred or the opportunity to contribute to an assessment of these individuals. This led to some concerns about whether the transfer facility was appropriate in all cases. There did not appear to be any discussion or awareness that people might regress or decompensate because of the move, nor acknowledgement that this was something that could have been taken into consideration in patient care planning. A mental health social worker described the transfer of one individual who was not suitable to their facility.

Because from a psychosocial perspective she was not suitable to come to [name of facility]. But because she was psychiatrically, she fit the facility that she came anyway. And it was only through her family advocating strongly to have her returned back to Riverview grounds – she didn't actually go back to Riverview, she went back to [name of facility], that that happened. So, from my perspective we didn't have a lot of input into who came. (MENTAL HEALTH SOCIAL WORKER)

South Hills had been designed as a rehabilitation facility in which residents would work towards a move to a more independent living arrangement. And, in fact, study participants reported that a significant number of individuals in the first transfer group from Riverview were able to move fairly quickly through South Hills to other forms of supported housing, and, in one or two instances, into independent living. This suggests that even after long-term institutionalization some individuals adjust quickly to more independent forms of housing and can rapidly reintegrate into communities.

However, the paucity of mental health housing in Kamloops meant that as subsequent transfers were carried out, individuals were less likely to be able to leave South Hills for more independent living situations—even if they were well enough to do so. Mental health staff consistently reported the lack of supportive community housing in the city. This was not simply a practical problem; it had an impact on the patients themselves. Staff reported occasions in which, as a consequence of the delay in a move, residents who'd been ready for more independence tended to regress. Staff expressed concerns that they could not challenge people to strive for more independent living if there were no housing facilities for them to move to. Further, they indicated that once patients left South Hills, their spot would be filled by other incoming patients from the local community, making it a lengthy wait to get back in should the person be unsuccessful in independent living. An occupational therapist indicated:

And what I find actually happens is people crescendo and reach a level of independence, and if you don't move them onto another challenge fairly soon, they regress and go back down and just start soaking up more and more services here. That the window for when they [can be] discharge[d] is actually fairly small before they start going back down. (OCCUPATIONAL THERAPIST)

Offering a Spectrum of Housing/Care Options

It became clear across all of our interviews with front-line staff in tertiary and community-based mental health care settings that a greater spectrum of housing options is needed for people with serious and persistent mental health and addictions problems. This included suggestions for specialized forms of housing for women with children and for people with concurrent mental health and substance use issues, as well as for more supported housing and family care homes. Respondents also identified the range of supports they felt should be available within existing housing models so that people's changing needs could be met without having to move to new facilities. This would prevent people from having to move from their homes when they experienced either symptom reduction or exacerbation. This kind of housing model would need varying levels of staffing according to resident needs over time. A mental health director summed up the housing shortage this way:

The other is housing, supported housing, you know what else is new (laughter). We've heard that over and over again. And also housing with sufficient mental health support, so that people can monitor symptoms, understand symptoms and help that individual get the support they need. (MENTAL HEALTH DIRECTOR)

Former Residents of Riverview¹⁵

In contributions to our study, the individuals who had been transferred from Riverview primarily reflected on their experience of the move, their new surroundings and the people and things they missed at Riverview. They also spoke about their future goals and aspirations. The reflections below include those from individuals primarily housed at South Hills (Kamloops) and Aberdeen (Vernon), but also come from several people who had moved from these facilities to others in Interior Health (see Table 4).

Most of the research participants (three quarters) reported that they liked the physical environment of the new facilities better, particularly the privacy afforded by having individual bedrooms (in most cases). Some people reported enjoying the increased mobility and interaction with the local community, which resulted from the integration of facilities into regular neighbourhoods. However, about one third commented on difficulties they had with their new accommodations, and, in particular, with the continued curtailment of their freedoms.¹⁶ For example, Beth¹⁷ described how, despite the move to a new facility with more privacy and ostensibly more opportunities to make autonomous decisions, having a mental illness nevertheless limited her independence and made her vigilant:

So, based on privileges I think, like it's a privilege for me to be able to sit out here on this bench right now, because if I did something too wrong, I could be hauled back inside, transported away from here, you know, and put locked up in a little cell. And you know, no possessions, no nothing, you know. And it's crazy to think that that's possible, but anything's possible... (BETH)

Some participants spoke about the people, including staff they had become close to, and even institutional routines at Riverview Hospital that they missed. Many individuals that we spoke to were experiencing the opportunity to make decisions and carry out day-to-day routine tasks on their own for the first time in many years. One man's comments hinted at the complexity of how he experienced the change. He described missing the familiar routine of Riverview and knowing how the system worked there, while at the same time acknowledging that, given a choice, he would prefer to grow beyond his current level of functioning:

I don't know if I noticed how they're treated at [name of facility] ...versus Riverview, but I know for my own self, when I first got here I kind of missed Riverview in a way, because I was that close to becoming institutionalized, you know, like being totally dependent on the system, eh. I really didn't want to end up that way.
(WILLIAM)

Housing versus Home

Many of the mental health care recipients we interviewed voiced similar goals for themselves. These included a desire to live independently or to have a consistent home, suggesting that they did not necessarily regard where they were living as their home. In part, this was because they were often in facilities where they would not likely remain in the long term, since the new model of care could see them graduating into other settings appropriate to greater levels of independence. This contrasted markedly with residents' experiences of living at Riverview, where many had lived for years without an expectation that they would ever move.

We documented that just under half of the people we interviewed had lived in more than one residence since they left Riverview, with two women and one man moving at least twice (see Table 4). According to some of our sources, this was inevitable, as care after regionalization had been organized around appropriate facilities, rather than individuals. While this is understandable from one perspective, as it permits facilities to have specific mandates and manage staffing, residents sometimes experienced frequent moves as highly stressful. Those who came from Riverview were not always aware that they might have to move again, which added to feelings of stress and instability.

Thus, in reflecting on their new living situations it was clear that individuals were looking forward to a time when they were able to have a ‘real’ home, one that allowed them to live outside of the confines of a controlled care facility but where they could still get the supports they need. This was particularly significant for study participants who had been isolated from their cultural communities for long periods of time. Mary, an Aboriginal woman, had this wish for her future:

I: What about, and if you were to think from five years from now, what would you like to be doing?

M: Going home.

I: Going home. Going back to [name of Aboriginal community].

M: Going home.

I: Yeah. Do you have family there still?

M: Yeah, my brother, my mum’s brother is the Chief. (MARY)

Passages like this take on a particular poignancy in view of the fact that despite the goal of graduating people through facilities towards independence, the reality is that there are limited housing options for people with mental illnesses in their home communities, and some will remain in more institutional forms of care even after they are capable of greater autonomy. Ultimately, the new care model and aesthetically pleasing facilities resulting from regionalization may have a less important impact on individuals than the degree to which they experience control over their lives and their choices.

Family Members

Although our findings are limited with respect to the number of families we were able to interview who had relatives directly transferred from Riverview, the data we did gather suggest that the move from Riverview was experienced as positive. The families in our study reported that their relative was doing better in the new facility than they had been in Riverview. In the following account, Tricia, a family member whose daughter was originally a resident at Riverview, shares her perspective on the hospital and how leaving it affected her daughter’s well-being:

What I'm referring to is we always hoped that she would benefit from a move. We were very unhappy with what, where her life had gone, in the direction of her life. And we knew that the circumstances, the environment [at Riverview] was absolutely horrible. ... You know, I'm always mum and she always wants to look after mum, and love mum. And this is the type of person she is. And in Riverview she just pretty well gave up. She just didn't care anymore; it was just survival, really. She was scared, she was smoking. And she didn't want to be smoking but she had to smoke because everybody else smoked. So it was survival, and she has never smoked since she hit [name of town]. That's the end of smoking. She's so proud of herself, "I don't smoke anymore" ... Now it's all changed. She – it doesn't matter if she phones me once a week or not. If she phones she wants to know how everybody is, but there's no crying anymore. ... And in Riverview of course she wasn't eating properly, so she was, she was just poorly dressed, poorly clothed, poorly cared for. She didn't really care anymore. So today she's just like a different person. She cares about herself and cares about where she lives. She emphasizes she's loving it there. (TRICIA, MOTHER)

Similarly, other family members described the effects of the move on their relative as resulting in improvements on the cognitive level (e.g., they observed a higher level of functioning), on the emotional level (e.g., their family member appeared to feel safer and more secure), and on the behavioural level (e.g., they observed that their family member was engaged in more constructive activities and had better hygiene). In addition, family members described their own experience of the environment of the new tertiary care facilities as positive, deeming it friendlier and more welcoming than Riverview.

Stability for Patients and Their Families

Given these encouraging impressions by family, it is unsurprising that in some instances families were anxious that the new psychiatric tertiary care facility was not necessarily intended to be a permanent home for their relative. For example, some family members were not clear about the plans for their relative's future care. Consequently, they were concerned about whether their family member would move, where they would go and what that would mean for the patient and for the family. The following participant, Kyle, the father of a woman who moved from Riverview to a smaller tertiary care facility, conveyed the anxiety he felt when he learned about the plan by the local mental health team to move his daughter to another living situation as her recovery progressed.

The only thing that I was ticked off with is we were told that the facility was being built, and she was accepted, and we were very happy. And then after she's in there for a while, they tell us that this place is just going to be short-term, because they're teaching her how to live on her own, and she would be moved on, you know. And it made me angry because they never mentioned anything like that from Riverview. Of course I don't think they really knew. They're going to this place and they can only be there for a certain duration, and then they would be moved to some other facility, which could be anywhere in British Columbia.

(KYLE, FATHER)

To fully understand the families' concerns, we must keep in mind that a side benefit of having had their relative in a more traditional institutional setting like Riverview was that they weren't responsible for daily care. Given the sometimes difficult and challenging behaviours of people with serious mental illness, family members are often relieved when their relative is safe and,

in their minds, secure and not considered a threat to themselves or others. This finding also speaks more generally to the lack of supports for families in caring for mentally ill relatives. Thus, families wanted assurances that their relatives would have a permanent place to stay and feared becoming overwhelmed and under-supported if multiple moves occurred.

Families wanted assurances that their relatives would have a permanent place to stay and feared becoming overwhelmed and under-supported if multiple moves occurred.

Staff and Managers of Community-Based Organizations

Although the bulk of our research was focused on the transfer process as it pertained to destination psychiatric tertiary care facilities, we were also interested in better understanding the role and capacity of community-based organizations. That's because now that Interior Health is mandated to provide care to people with chronic mental illnesses, these organizations will likely have increased contact with that population. Indeed, in the development of South Hills there was an expectation that residents would access most services off-site to promote community connections.

Community-based mental health services are most often run by non-profit organizations, typically through contracts from the regional health authority. These organizations provide a range of services to people with mental illnesses including supported housing and employment, access to recreational activities, social opportunities and rehabilitation activities. The data in this section illustrate that the Riverview redevelopment process was carried out largely

without the consultation or involvement of the community-based service sector, and that resources from Riverview were generally not used to support or enhance community-based services. Thus, the move towards regional self-sufficiency in providing care to people with mental illness has not included a comprehensive plan backed by resources to support and develop social care for people.

It is important to note that the physical scale of the two communities we studied differed and that they had different political histories and levels of community resources, as well as different communication mechanisms between community mental health and psychiatric tertiary care. During our research we mapped the types of services available to people with mental illnesses, and it was through this mapping, in conjunction with interviews, that some differences emerged.

In both communities there was a serious gap with respect to rehabilitation services, education and work opportunities for people with mental illnesses.

Vernon, for example, is renowned for the highly developed and well-connected network of mental health services in the community and for effective communication mechanisms between the community sector and Interior Health. Although Kamloops also has a range of community-based services, there were serious gaps in services for people with concurrent mental health and substance use problems and in housing for people with mental illnesses. Respondents in Kamloops also reported feeling less connected to Interior Health, and there did not appear to be any consistent communication mechanisms between community-based organizations and Interior Health. In both communities there was a serious gap with respect to rehabilitation services, education and work opportunities for people with mental illnesses. Thus, individuals have very limited choices for moving towards greater independence or opportunities to pursue meaningful activities. This reflects a critical conundrum for organizations like South Hills, whose purpose is to help people reach the fullest potential possible within the limits of their mental health concerns. Finally, both communities were severely lacking in women-specific services, creating particular difficulties for women with mental illness (see “Findings 3: Gender and Intersectionality” later in this report).

With these differences in mind, we were interested in the role that community-based organizations had been accorded by Riverview and Interior Health in the planning and preparation for the influx of new people. Prior to the transfers the Provincial Health Services Authority and Interior Health held a number of public forums in Kamloops to inform the general public about the construction of South Hills and the eventual arrival of its new residents. Similar public education was not deemed necessary in Vernon because people were being transferred or moved to an existing

facility. Still, community-based organizations were somewhat more aware of the upcoming transfer process in that community because of the aforementioned established, effective communication mechanisms between Interior Health and community organizations.

In Kamloops, officials extended their education campaign to meetings with representatives from the local school that South Hills would be built close to, with local business people and with police. The purpose of these meetings was to share information in order to reduce the stigma associated with people coming from Riverview. The officials hoped they could prepare business owners and police officers to respond appropriately to individuals with mental illness, including new South Hills' residents. This community education, however, did not appear to extend to community-based organizations in Kamloops. In the following excerpt the manager of a community-based organization in Kamloops describes their experience of learning about the transfers:

....We were aware of it [the transfers] coming, yeah. But I don't think any more aware than, no more information than was being given in the press.

(MANAGER, COMMUNITY-BASED ORGANIZATION)

The uneven landscape of who knew what among community-based organizations in Kamloops resulted in different levels of preparedness for the new residents in the community. Meanwhile, the transfers did substantially affect some of the community groups and their mandates. For example, a vocational gardening program that originally provided services to people in the community living with mental illness underwent a complete change in its goals, staff and clientele in order to respond to the different needs of the South Hill residents. This program now provides the main source of activities for many residents and no longer serves its former clientele, who were people at a different stage of wellness. In another instance, a community-based organization had to continue providing services to the community as well as accommodate new people with different needs from South Hills. It struggled to do so based on existing funding and had to find creative ways to respond. The manager of this organization talked about the limits of their organization's capacities.

Um, soon after South Hills opened up, we did have applications and, I think there was a bit of a learning curve for both South Hills employees that were making the referrals to the [name of organization], to get a handle on clients we could accept here and clients that we couldn't. And mainly it had to do with the level of functioning, if the person needed one-to-one care, then we just don't have the staff, and that's not really what we're set up to do here...

(MANAGER, COMMUNITY-BASED ORGANIZATION)

In fact, a general theme emerging from our interviews with community-based organizations in both Kamloops and Vernon was that they were often already at capacity providing services to people living in the community before the former Riverview residents arrived in town. Hence, the organizations scrambled to meet the added demands of the new residents. Not surprisingly, this presented an equal challenge to those, including staff members in psychiatric tertiary care, who were trying to link newly-arrived former Riverview patients with the community-based organizations and services.

[Name of organization], which offers services to the geriatric population, because they have, they're full and they have a waiting list that 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. So even with the Riverview clients that's what we found out. We mostly do like mostly in-house and we go to the [name of fitness facility], or you know, the [name of swimming pool], where you know, it's [the] least stressful as they can.

(REHABILITATION WORKER)

Community-based organizations consistently described challenges arising from funding limitations. These were not limited to meeting the needs of the former Riverview residents. They also related to mental health and addictions in the community in general and to adapting to the new context in which people with serious mental illness were no longer sent out of town to Riverview. Further, a round of cuts by the provincial government in 2001 had made it difficult for local organizations to continue providing the services they had been offering until then. Some study participants voiced concern that their ability to meet the need would be further troubled if people receiving psychiatric tertiary care in Kamloops did not eventually return to their smaller home communities.

The issue that we've run into in communities is that we haven't received extra staffing, so we have Hillside now and we have South Hills. You know, there's a fair number of clients that choose not to go back to their home communities even though they haven't been from Kamloops, and so we're increasing our population and we don't, we haven't really received an increase in staffing to handle the demand, so it's a challenge for sure for our Residential team to accommodate a growing population. (MENTAL HEALTH FACILITY MANAGER)

Investments in Medical versus Social Care

In summary, government resources allocated to carry out the transfer of patients from Riverview to Kamloops and Vernon were primarily directed toward the development and provision of tertiary psychiatric care, without obvious additional funding to other levels of care, leaving the community-based mental health service sector struggling to meet the growing demands in the community. This highlights the apparent divide between psychiatric (medical) care and social care of people with mental illness and suggests that the system is currently weighted in favour of psychiatric care, with few plans for actively supporting (through development and resources) the community-based mental health service sector.

FINDINGS 2

Mental Health Care Models

The structure of the mental health care system can enhance or inhibit the development and implementation of mental health care models. During a period of reform, the system shifts, and, as a result, more or less room is made for a given model of care, depending on how the system organizes and delivers services and on what care philosophy—or philosophies—end up dominating. This idea is illustrated by our findings, which detail the challenges experienced by staff in implementing a psycho-social rehabilitation (PSR) model of care using recovery principles despite the ostensible support for them under regionalization, in part because of the lack of community-related supports put into place to facilitate recovery in its fullest sense.

In the context of the Riverview Redevelopment Project there was consensus at the outset among mental health directors, managers and staff that mental health care was shifting away from the philosophy of custodial care to recovery through the use of psychosocial rehabilitation as a care model. So-called custodial philosophies of care emphasize the importance of institutional routines and place the mental health care worker in a paternalistic role in relation to patients, who are not encouraged to make decisions for themselves or to engage in many independent activities. In contrast, recovery models make explicit that the aim of care is to support individuals with mental illness to achieve the highest possible level of functioning and independence.

While a range of definitions and understandings of recovery exist, we can say that, in general, contemporary ideas about recovery are reflected in the work of the Mental Health Commission of Canada (2009) and in the following quote:

A person with mental illness can recover even though the illness is not 'cured'. Recovery is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. (Anthony, 1994, pg. 525)

Recovery is thus understood as both a process and an outcome (Deegan, 1988; Liberman & Kopelowicz, 2005). Ramon, Healy, & Renouf (2007) build on this in suggesting that,

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, systematic effort, which entails risk-taking. (p. 119)

Social models of recovery further emphasize regaining economic and residential independence (Jablensky et al., 1992; Trainor, Pomeroy, & Pape, 2004).

Psychosocial Rehabilitation (PSR), also based on the philosophy of recovery, was adopted as the main model of care for psychiatric tertiary services in Interior Health. Farkas, Gagne, Anthony, & Chamberlin (2005) suggest that to be considered a recovery-oriented mental health program, four Key Recovery Values should be exhibited. These include: (1) "person orientation," that is, a primary focus on the individual and recognition that they have other roles in life besides being a patient, case or disease; (2) "person involvement," that is, attention to people's right to full partnership in all aspects of their recovery; (3) "self-determination/choice," that is, the right by individuals to make personal decisions or choices about their recovery process and acknowledgement that these may not be consistent with treatment compliance; and (4) "growth potential," that is, a focus on the individual's inherent capacity to recover.

A limitation of these models is that they fail to explicitly recognize structural inequities, including those related to poverty, gender, race, culture, ethnicity and sexual orientation.

Directors, Managers and Tertiary Mental Health Care Providers

In this section we describe the experiences of mental health care managers and staff with respect to helping people transfer from Riverview Hospital, where a custodial model of care dominated, to facilities with a PSR/recovery-oriented model of care. Our findings focus on staff training and on the personal challenges staff experienced confronting their own values and beliefs about recovery. This section also explores the degree to which people receiving

care have been involved in decision-making in their care, and the ways in which gender and diversity are understood by staff in the context of care and recovery.

Conflicting Expectations

The South Hill facility in Kamloops was designed to facilitate the goals of PSR. This can be seen in its physical layout, in the balance of private to communal living space and in the staffing complement. For example, a salaried staff psychiatrist and fewer nurses were hired than are often associated with tertiary care, in favour of rehabilitation. South Hills was built without any seclusion rooms or detached nursing stations, both of which separate staff and patients and provide options for patient control. Front-line mental health staff persons in both Kamloops and Vernon were also trained in PSR methods through programs at the local university and college. They were thus prepared to work in the new facilities and to provide a different form of care to the people transferred from Riverview.

Study participants who had been involved in the initial planning and development of the facilities described how they had hoped and planned to implement a care model based on what they described as 'pure' PSR. They had hoped to adhere religiously to the principles of PSR, including allowing people maximum autonomy and decision-making in pursuing their day-to-day lives. However, they reported that their ability to do so was limited by a number of factors. One was the unanticipated level of need among people who had experienced long-term institutionalization, during which they had been subjected to routines to the detriment of skill development with respect to activities of daily living and decision-making. A mental health care worker described one such instance that stood out in their memory.

I mean I always relate this one example because we had a woman, she has since moved to another facility within Interior Health, closer to her family. But she had been institutionalized for many, many years. She was kind of late adolescence, the time that she had been institutionalized, so maybe 30, 35 years, something like that at Riverview and truly didn't now how to do a thing. And I can remember about 18 months into her stay here, her key worker, you know, coming to my office, just like practically in tears with excitement because that woman, that day had made her own tea and toast. (MENTAL HEALTH CARE WORKER)

At Riverview staff had made beds, prepared meals, managed money and organized leisure activities. At South Hills and Aberdeen, individuals were expected to learn how to carry out these activities for themselves. This new vision of care proved challenging for both residents and staff.

The literature suggests that changing a model of care is challenging in part because of the potential conflict between its underlying philosophy and existing personal values, and because of 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 this and suggest that training and ongoing mentoring are key to implementing a PSR model.

Staff at the tertiary care facilities in Interior Health reported struggling with allowing the residents of the facilities to make their own choices, and often used evaluative language to describe these choices as 'good' or 'bad.' In group interviews they discussed their feelings about residents' choices, including those that conflicted with staff members' moral beliefs. The quote below illustrates an awareness of this dilemma.

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. (MANAGER, MENTAL HEALTH FACILITY)

The concerns staff felt in implementing PSR and respecting client decision-making were particularly evident in a discussion about how to respond when residents wanted to exercise their sexuality. Staff members at one facility described one situation in which a woman resident had sex with many men when she was delusional, one of whom was known to be HIV positive. The woman wanted to get pregnant, and so it was suspected that she had not engaged in safe sex. In this instance it was unclear to staff what their roles and responsibilities were, and they chose to seek legal advice. "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). This and the previous quote illustrate how staff and management grappled with resident decision-making, especially where they might not approve or where the safety and well-being of a resident was at stake.

Another issue front-line staff confronted in trying to implement PSR was the complex presentation of clients transferring from Riverview, some of whom had multiple mental health and substance use issues.

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. We've got more forensic clients than we've ever had, we have more neuropsychiatric clients, we have a whole group, like probably one full pod if we put them all together of people who are mentally ill and mentally handicapped. So as our population has become more diverse, we have had to really modify that kind of more ideal PSR philosophy and practice. (MENTAL HEALTH WORKER)

At the same time, staff reported that the physical layout of facilities did impact their behaviour and methods of care in favour of PSR. The fact that South Hills had no seclusion room at the time we conducted our study, for example, created significant positive learning opportunities for staff when addressing difficult or escalating behaviours. Following the principles of PSR they contended with such behaviour through relationship building, communication skills and facilitating access to private rooms to which clients could retreat, rather than by resorting to physical or chemical restraints and isolation.

As discussed earlier, staff members in the new or redesigned facilities were initially required to have PSR training. Many staff members completed this training through a local university program broadly designed to produce mental health support workers for community, residential and semi-independent living settings. However, our review of the program curriculum revealed that it focused primarily on skill development and did not cover recovery values and concepts, potentially leaving staff without a solid foundation for understanding PSR. In our interviews, some staff members described occasions when they felt that PSR could not apply to certain patients because they were 'too ill,' demonstrating a lack of understanding of the PSR model. Given that they were attempting to implement a new care model without specific training for the setting and population they encountered, however, this is unsurprising.

As well, though admirable, initial emphasis on universal training in PSR was not supported with additional or follow-up training opportunities or with a mentoring process. Indeed, some staff reported that, over time, requirements for PSR training and certification had become more lenient, with staff being hired with 'equivalent' education and experience. Our study participants suggested that this had led to inconsistent understandings and practices of PSR.

Recovery models are premised on the belief that people experiencing mental illness should have maximum control over their treatment and care. Many provincial mental health plans include policy statements to this effect, and most jurisdictions have some mechanisms for involving service users in mental health planning (see BC Ministry of Health, 1998). The Riverview protocol for preparing residents to move to Interior Health required consultations with each individual and with any available family members or support people. And it

appears that this protocol was followed in practice.¹⁹ In some instances Riverview residents had the opportunity to visit the new facility prior to making a decision. However, we also heard in our research that resident ‘choice’ was constrained and/or overridden in the name of meeting the goals of the Riverview Redevelopment Project. That is, while residents were consulted, they did not, in any meaningful way, have the final say about where and when they would be moved.

In the late 1990s patient advocates at Riverview, in consultation with the residents, developed a Charter of Patient Rights (McCallum, 1994). The Charter alerted individuals living at Riverview that they could demand quality of care and quality of life and detailed their legal rights with regards to self-determination and privacy under the *Mental Health Act*. Although there were attempts in the transfer facilities to develop formal mechanisms to apprise residents of their rights, at the time of our study no similar charter of rights had been adopted. This is explainable, in part, as a result of funding cuts that effected programming encouraging resident involvement:

We had trouble getting people on committees. So, you know a lot of things we tried. 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. (PROJECT MANAGER, RESIDENTIAL FACILITY)

Ironically, it appeared that residents’ involvement in their own care was not always supported by some of the other organizations with which residents were affiliated. As reflected in the quote below, this occasionally led to criticism of the practices of the service providers who were following PSR practice:

And I know [name of tertiary facility] has taken, actually, flak from other areas because of the level of involvement of the clients in their own planning. So, you know, I know [the manager] has had situations where she’s had the client with her when they’ve called back to the referring nurse, or case manager, and they’re uncomfortable with the fact that the client’s there, so I think they’re quite progressive around their involvement of clients in their own care. (MANAGER, COMMUNITY MENTAL HEALTH)

Thus, our findings suggest that the implementation of PSR in tertiary care settings in Interior Health, while aided by the physical infrastructure of the new and renovated facilities and some early training, was impeded by the limits of that training and support for staff as well as by a lack of support from some mental health care workers, two factors that are essential to the full actualization of recovery models.

Former Residents of Riverview

In trying to better understand the impact of the PSR model on the individuals who were transferred from Riverview we asked people about their typical day and assessed what kinds of activities they were involved in or had access to. Our results demonstrate that the emphasis in the facilities where we interviewed individuals was on assisting people with basic activities of daily living such as cooking, cleaning, hygiene and money management. Most residents spent the better part of each day accomplishing these tasks. However, they also had access to volunteer and paid work in specialized settings and to a regular range of recreational activities and outings, including going to a local clubhouse, swimming, camping, volleyball, pub nights, social dinners, smoking, watching TV and bingo. In our interaction with respondents and in our observations we found that the degree to which individuals were engaged in such activities was in part dependent on their overall level of mental well-being. Thus, some individuals appeared very listless, confused and lethargic, while others seemed to be more highly engaged in activities and socializing.

Despite these distinctions, a theme running through the interviews was the desire to have meaningful activity and especially paid work opportunities. Robert indicated:

Oh, I've had all 'slavery' jobs and you know, when I was out in Coquitlam, and I've never really had like a full-time on the outside (job), because I've never had chances to have one, if you understand what I'm saying.

Those who did have paid work opportunities spoke positively about them. Sylvester had this to say:

S: A typical day is a workday on Monday, Wednesday and Friday. I love working with that.

I: Okay. Loves working. I am getting it on tape as well.

S: That's okay. Sylvester loves working as much as he can.

I: Oh that's great! And could you work at [name of workplace] more if you wanted to?

S: No, just Monday, Wednesday and Friday.

The desire for work in some cases was tied to concerns about having enough money and to the feeling of being limited or controlled in the use of their money. Lucas explains:

I: Why is Riverview better?

L: Well, I got a package of cigarettes every day and \$34 a week.

I: Right.

L: Here I get \$200 a month. That's not enough to smoke on.

I: Oh, I see. Do you get it all at the end of the month kind of thing?

L: I get \$25 on Tuesday and \$25 on Friday. I can't even buy the carton and get it cheaper.

Overall, most of our respondents reported that they liked the flexibility they had in their new facilities and enjoyed getting up when they wanted, eating when and what they wanted and being able to go to local businesses and shops. However, this was attenuated by stories that illustrated the lack of concrete opportunities for meaningful activity, especially paid work and the ability to attain higher levels of autonomy.

Family Members

Social connections are also understood to be an important part of recovery. To this end, during the Riverview Redevelopment process there had been an attempt to move people to facilities in regions from which they originated and where they might be closer to family. This practice had mixed outcomes from the perspective of both mental health care recipients and family members.

The stories of several residents we interviewed revealed a strengthening of connection with family and/or their ethnic communities as a result of the move. A community mental health worker remembers:

So, but the Aboriginal fellow that I took up to [name of small town], I've taken, I took him up there a couple of times to meet with his family. He basically did not speak at all, did not respond. The change, when he was there, he spoke in his native tongue, well it could have been that he'd had a beer with his family and that sort of loosened him up. But I, you couldn't get a yes or a no basically out of him, and he was just, you know, that was family. That was amazing. He was immersed like he had not left, like he, you know. (STAFF, COMMUNITY MENTAL HEALTH)

These stories, however, were the exception. The majority of the people in our study were estranged or had difficult relationships with family. Clearly, one of the goals of recovery is to help foster or restore relationships. Reaching this goal was hampered both by people's long-term institutionalization and by their ruptured relationships with family and friends.

Staff and Managers of Community-Based Organizations

A range of care models were in use in the community-based organizations we visited, depending, in part, on the type of service or support they offered. Most community-based mental health services described their services as following recovery-oriented principles with respect to fostering the involvement of people with mental illness in their organizational structures and the day-to-day running of their services. Many of these organizations were also actively working to decrease stigma and discrimination against people with mental illness by organizing events that connected them with the local community and/or job opportunities.

Organizations providing housing and addictions-related supports to a wider clientele spoke primarily about how their services were overwhelmed trying to meet the needs of all who came through their doors. This point speaks to the fact that a full application of a recovery model is limited if supports and services are not readily available to assist people in achieving maximum autonomy. It also underscores the divide between psychiatric care and social care, illustrating how structural barriers, such as the lack of community-based mental health resources and the ongoing dominance of the biomedical paradigm in mental health, help determine the limited traction gained by social models of recovery (Morrow, 2004; Teghtsoonian, 2008; Rossiter & Morrow, in press; Walker, 2006).

In both Vernon and Kamloops we encountered services and organizations willing to accommodate and facilitate work, training and social opportunities for persons that had been moved from Riverview. However they faced limits and challenges to how much they could do. Community mental health staff also confirmed that job opportunities for people with mental problems are limited both in quality and quantity. A social worker for a community mental health team stated:

Oh, it's pretty, you know what. But now the economy is getting better, so 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, you know what I mean.

She elaborated:

So the kind of jobs people get, like you know, we have some placements at [warehouse store], and things like that, so it can turn into a job, but maybe one or two a year, or even if that, you know, turn into actual work. So when people

get jobs, like it might be like a dishwasher or, you know, something like that. Ginseng farm, you know that kind of thing. (SOCIAL WORKER, COMMUNITY MENTAL HEALTH)

There are some successful job seekers among people with mental illness and innovative new community-based programs that support people with mental health problems to access work or gain work experience. Some of the programs are not targeted to the people that moved from Riverview to the tertiary facilities, but they are still a critical component of the services available. For example, one community-based manager described their organization's programs.

So we have a number of co-occurring disorders that are with us. Multiple barriered or persons with disabilities and addictions that stay with us for up to a year, that we employ for 16 to 25 hours a month. For both men and women, both, so everyone who's in our second-stage treatment has the opportunity for as much employment, actually, as they can handle. So we hire them all. I think we have 31 residents in a treatment program on the payroll working for us. So no one's ever done that before, so it's kind of fun. (MANAGER, COMMUNITY-BASED ORGANIZATION)

South Hills also had some on-site work opportunities on offer. Although positive for some residents, these tended to limit connections outside of the facility.

So, you know, one of the jobs is linen cart...At one time we had a client who was washing vegetables and fruit and putting them on a platter and making them available to the rest of the apartments, kind of as a teatime or a snack time. Cleaning up the grounds, somebody is cleaning up the grounds. Right now we have a recycle job because we've got lots of newspapers and bottles, so somebody, you know, goes around and picks up the newspapers and bottles and then goes with our rec therapist to, you know, take them to the recycle bin. (SOCIAL WORKER, RESIDENTIAL FACILITY)

The staff explained that residents at their facility were unlikely to hold competitive paying jobs because:

It would be odd, it would be unusual for them to be able to do that and not be transitioning out of [name of facility]. There's a couple of people that are able to do that, but for other reasons can't quite get out. (OCCUPATIONAL THERAPIST)

FINDINGS 3

Gender and Intersectionality

In our study we were interested in gender and how men and women might experience the transfer from Riverview differently. Besides gender, we were also attentive in our study to other intersecting factors, such as ethnicity and culture, that might influence individual experiences of the move from Riverview to Interior Health. Thus, our questions were designed to elicit responses that would clarify how mental health managers, directors and front-line workers understood gender, culture and ethnicity, and whether they were actively incorporating an understanding of the social and structural determinants of mental health into their planning and delivery of services.

Our analysis of the resulting data suggests that gender is understood solely as an individual attribute, not as a feature of social structure. Mental health care workers also seemed to believe that gender can be incorporated into care at an individual level with a 'person-centred' model of care. They lacked an understanding of gender as a relational concept, as a social and structural determinant of health, or as a factor requiring different models of care and systemic forms of change.

Overall, our research suggests that much work is needed to help planners and practitioners better understand the complex interactions of gender, culture, race, ethnicity, sexual orientation and other social and structural factors as they are relevant to experiences of mental illness and care provision. Specifically, these factors must be understood in the larger context and not just as individual attributes to be handled solely in individual care plans. In what follows we discuss several topics about gender that emerged from the data, including gender in relation to mental health care, gender and social support and gender and safety.

Directors, Managers and Tertiary Mental Health Care Providers

Management at Riverview and in Interior Health stated that differing needs based on gender and diversity were not part of the original or ongoing planning process with respect to the transfers from Riverview. Here is one facility manager responding on this subject.

I: Did you find that there was a discussion around differing needs for men and women?

R: No. A simple answer. No, there was no discussion, ever. I mean it never came up.

I: What about any other needs of specific populations, perhaps First Nations or any other specific?

R: I don't think any of the things that we were trying to take into account were of that scale. It was more of the micro-scale. You know, is this person vegetarian, do they have particular religious needs, do they go to, you know, like we don't have a synagogue, you know. What are they going to do about that? Have those issues been explored with them. You know, that kind of stuff. It was more at the micro-level than that larger issue, you know. (FACILITY MANAGER)

The interpretation of PSR among research participants, which emphasized 'person-centred' care, appeared to work against an understanding of the broader social and structural determinants of mental health such as gender, ethnicity and poverty. The following quote further illustrates this point:

We try to [address culture]. But we don't, kind of, well for me personally, I don't go as much by culture as much as, you know, what is the client's need. Because you can't assume that they're enmeshed in a certain culture because of, you know their background, you know what I mean? So it would just depend on, you know, so I'd meet with the clients to just find out where, what their needs were and what they wanted to do, and that kind of thing. (STAFF, COMMUNITY MENTAL HEALTH)

Despite this limited understanding of how gender and other aspects of social location and identity shape individuals' lives, experiences and mental health, the decision-makers and care providers we interviewed spoke of a genuine interest in knowing more about how gender and other social and structural determinants affect mental health and how this might shape the development and delivery of care. They described circumstances and issues that revealed how care needs did in fact differ based on the gender and ethnicity of clients, but felt limited in their ability to provide for these needs due to lack of training as well as by the organization of their roles and the services they provided.

For example, some staff reported to us that they experienced women's relational needs as a burden. In our interviews and focus groups, they often described working with women as more difficult than working with men because, they reported, women needed more of their time for emotional connection and interaction. The men were deemed easier to care for because they made more practical demands on the staff. Ironically, though providers did not

see emotional or psychological support as part of their jobs, the women clients often sought out these very staff members because of the relational security they experienced with them. Although the staff made an effort to remain respectful in their interactions with clients, they spoke of their frustration with having to spend more time with women and about how this prevented them from completing other job-related duties.

This stood in contrast with the descriptions we heard of men's needs, which were seen as more instrumental or practical in nature and therefore easier for staff to meet within their daily routine. While the key principles of healthy relationships may be applicable for both men and women (i.e., to have respectful and predictable relationships free from abuse of power), men and women may express this need differently, especially in a health care setting. A front-line worker described what happened when a residential facility that had previously been for men only became co-ed.

The men were very upset with the women coming in at first. And the women are needier, much needier. I can remember the staff at first going, "Man it was way easier when we had all men!" And I was only there for the first little bit of the women coming in, then I moved over to Community. But they were much more complicated, they were more emotional, you know, they needed more care with certain elements, they had more of a connection to their families, they definitely did. That's one thing I saw different is the women had more connections to their families, yeah. They stayed in touch with their siblings, and it was, I think, almost a healthier relationship. (STAFF, COMMUNITY MENTAL HEALTH WORKER)

These results demonstrate again that in the absence of specific training important gender and ethnicity issues affecting care can simply go undetected. The role of gender in particular emerged during our data gathering as a topic requiring more investigation. It appears that, in some instances, the gender of the staff may have mattered to clients, and that male clients in particular liked and preferred being taken care of by women.

Former Residents of Riverview

In our interviews with women and men who had been transferred from Riverview a number of gendered differences emerged. The women we interviewed were more likely to discuss their desire to stay connected to family and friends, whereas men were more likely to talk about their desire for physically intimate relationships. This might be because women were more likely to have children and to have maintained relationships with family and friends, or it may simply reflect socialized gender roles, where women see themselves as more responsible for

caregiving and relationship building than men. This would be consistent with the literature on mothering and mental illness, which has demonstrated the importance of women maintaining connections to their children as a component of recovery (Mowbray, Nicholson, & Bellamy, 2003; Commission on Social Determinants of Health, 2008). In our sample, more women than men had connections with family, particularly children, whereas men seemed to express more longing for physically intimate partner relationships.

Beth was an example of a woman who was struggling hard to maintain a relationship with her children. In the following passage she expresses her desire to be with her children and how this motivates her to get better:

Yeah, Yeah, I am not going to cling to anybody to get me through this life, you know. I want my kids, you know, be able to talk to me and not feel like something's wrong, I don't want them to feel like yeah, this person's just a chronic, you know, sad person. (BETH)

Two of the women and two of the men in our study seemed to have good friends, and yet only one man described comfort with the quality of his friendships. Instead, several of the men talked longingly about their desire for intimate female companionship. Terry's interview, for example, had numerous references to his interest in women but also his concerns about being sexually appropriate. In contrast Sylvester spoke mostly about missing his wife (whom he described himself as being estranged from). In the following excerpt the interviewer probes as to why Sylvester missed Riverview:

S: I loved it there.

I: You loved it at Riverview?

S: Yeah, because I got to see my wife at Riverview, she's out in [name of place].

I: Oh, and where is your wife now?

S: She's in [name of facility].

I: Okay

S: And I haven't seen her, I haven't seen [wife's name] here now in nearly four years.

In some instances men indicated that they enjoyed having female staff care for them because this fulfilled some of their need for female connection.

I: Okay. So who takes care of you the most here? Is it a man or a woman?

R: Well, I prefer a female rather than a male.

I: How come?

R: Because I've never been married in my life, and I've never had a chance to.

(ROBERT)

It was clear that for the individuals we interviewed relationships were often fraught because of long-term estrangement from family and friends and/or significant disruptions due to the experience of institutionalization. Sometimes the person's problematic behaviours in family interactions had led to the estrangement. Nevertheless, there was evidence among our interviews and focus groups that some individuals, especially the women we interviewed, were maintaining or rebuilding relationships with children and other family members as a result of their move to the Interior.

Family Members

Consistent with the literature on family caregiving, our findings suggest that, in general, women are significantly more likely to care for mentally ill family members than men are (Armstrong, 2007; Morrow, Smith, Pederson, & Battersby, 2006) and that the type of care provided differs depending on the gender of the family member providing care. Many of the women we spoke with perceived the responsibility to care as intimately tied to their roles as mothers, daughters and sisters. Descriptions by men of caregiving, on the other hand, were rare and typically not prompted by the father-child dyad, but restricted to husband-wife relationships, that is, the husband's involvement was to provide support to his wife in her role as the primary caregiver. This is highlighted in the following interview excerpts in which Nancy describes how her care for her son (who was not part of the cohort of Riverview transfers) compares to her husband's involvement in caregiving:

My job is my son's mom and to take care of him, because he cannot take care of himself. I'm to keep him safe and that means blocking phone calls so that the drug dealers don't get a hold of him, and I'm to keep him as healthy as possible – make sure he takes his meds. I make sure he's clean. I encourage him to shower. I'm there to motivate him, to get him off the couch, you know away from the cartoons for a while. I'm to eliminate as much stress as possible in his life, like taking care of his bills or anything that would bother him. I'm there to encourage him. I'm there to chauffeur him to anything that he would like to go to. I'm his entertainment, we play scrabble. I get him up the ski hill. He goes snowboarding and I ski. I'm there to teach him new things or for

him to relearn new things because, you know, living like this for a couple of years they forget how to live. I'm there to help him do routines. I'm there to tell him when to go to bed in a way, because he wouldn't really. I'm there to analyze how he's doing on the meds. I'm there to make sure he keeps his appointments. I'm there to . . . he has one person that comes over once a week, and takes him out for one hour.

In describing the role of her husband Nancy indicates:

My husband is very good, but because he has his own business, and he's, you know, the bread earner in the family, he has to do that. But I call on him to do things that I just can't do anymore, or I don't want to deal with, like you know, please phone the caseworker or where I might be too emotional. He's very good. He'll go play badminton, even though he's tired. He'll do all kind of things, you know. And he's really good for me to sound off, because he's very unemotional. So he does a different sort of role. And he's also there to offer my son work if he would like it. He's there to encourage or watch TV with him, just to spend some time with him.

Among the study participants with family members transferred from Riverview, only two male family members, both of whom were husbands, reported that they assumed primary caregiver roles. Our focus group with family members consisted solely of women, all of whom described themselves as having been the primary caregiver for a mentally ill family member at one point in time. These findings are consistent with literature on the gendered role of caregiving in Western society. Adelle described how she changed her job and sacrificed economic security to be with her daughter more consistently:

...That was why I used to work in a women's shelter, but I worked eight to ten hour shifts, but once she [her daughter] was in the hospital, I knew she was going to need me more, I came here. I went from a \$22 an hour job to a minimum wage job.

When asked about how she felt in changing her career, Adelle said,

... I was willing to do that because this is my baby, right. I would do anything. But like I said, the support, not having the support was tough.

Research has documented the high levels of historical and continued trauma and abuse experienced by both men and women in psychiatric care. The levels for women are estimated

to be particularly high (Goodman, Rosenberg, Mueser, & Drake, 1997; Harris & Landis, 1997; Hiday, Swartz, Swanson, Borum, & Wagner, 1999). In our study we felt that asking about experiences of trauma and abuse, although highly relevant to care, was too difficult in the context of the interviews we were conducting. We did not, therefore, ask women or men to talk about these experiences. However, there was evidence, in one or two of our interviews with family members that concerns about safety were heightened for women when living at Riverview, and that some of these concerns had been alleviated in the transfers to the new facilities. Daniel observed the following about his sister's safety at Riverview:

Daniel: And that's all she could focus on was her own safety.

I2: Wow.

Daniel: And now in this situation she's not afraid of anybody there.

I2: So her own sense of security is much stronger.

I: It makes you wonder what she went through there.

Daniel: Well, we're just glad she survived Riverview.

Staff and Managers of Community-Based Organizations

Directors and staff at community-based organizations expressed an overarching concern during interviews with the lack of women-specific services at the psychiatric tertiary care facilities in both Kamloops and Vernon. They noted the lack of women's addiction services, the lack of women-centred mental health services and specifically the need to address the link between violence and mental illnesses in women's treatment services.

Study participants reported that there were limited opportunities for training or employment above minimum wage jobs for women. Housing was also identified as being of particular importance for women, with study participants at community organizations in both Kamloops and Vernon reporting very limited housing options that are women specific. They noted that homeless women and men can also have differing needs with respect to shelter, employment and care. For example, it was suggested that women have more safety issues when homeless than men, and are more likely to need supports to help them with their children as well as, in some cases, with the transition out of the sex trade. The need for more independent housing and for emergency and transition housing for women was also a concern for both communities. Research suggests that a large percentage of the women in both psychiatric tertiary care and supported independent living facilities do have histories of sexual and/or physical abuse

at the hands of men, which make a mixed sex living arrangement potentially stressful and uncomfortable (Williams & Paul, 2008; Harris & Landis, 1997).

Many participants expressed frustration at being unable to address the social and structural determinants of mental health with the limited resources available in their communities. These findings are consistent with other studies in the province documenting the impact of health care restructuring, cutbacks and policy shifts over the last eight years (Cohen et al., 2008; Cohen, Tate, & Baumbush, 2008; Klein et al., 2008; Morrow, Frischmuth, & Johnson, 2005; Morrow, 2006b; Rossiter & Morrow, in press).

Discussion

Our data suggest that while the transfer of patients from Riverview Hospital to facilities in Interior Health managed the psychiatric needs of the people transferred, there are still challenges in the region in providing comprehensive services to those with serious and persistent mental illness. We observed little capacity to address issues of gender and other social and structural determinants as part of mental health care. Though staff members within the system were interested in the contributions that a gendered and intersectional perspective on care might produce, they were

nevertheless challenged to actually identify opportunities and mechanisms for doing so. In part this may reflect the limits of the model of mental health care that currently informs the organization and delivery of services.

Three themes link these topics across the diverse perspectives offered by our study participants. The first theme is the continued dominance of a medical approach to mental illness and the need to embrace and actively address the social dimensions of care. The second theme concerns the limits of the current person-centred model of psychosocial rehabilitation with respect to addressing social and structural determinants of mental health. In turn, these link to the third theme: the model of care and limited attention to the social and structural determinants of mental health and illness, which render issues related to gender and other intersecting dimensions of identity and social location invisible to all the study participants

This research study supports findings in the wider research literature that show the movement of people from large psychiatric hospitals to smaller, more home-like settings in the community is a positive development (Lesage, et al., 2000; Lesage, Groden, Ohana, & Goldner, 2006). Specifically, our research shows that Kamloops

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and Vernon have successfully established tertiary psychiatric care for people who have been transferred from Riverview Hospital to their communities. With the development of South Hills for tertiary rehabilitation and Hillside for neuropsychiatric care, Kamloops is emerging as a regional hub of care for people with serious and chronic forms of mental illness. Thus, the goal of establishing regional self-sufficiency in the provision of psychiatric tertiary care in Interior Health is largely being met.

One of the most important reasons for generating new psychiatric care models is the recognition that long-term institutionalization and the isolation of people from their communities and support systems has damaging effects and may limit the mental and physical health of residents. To this end, our research suggests that the move from Riverview to smaller facilities has mostly provided people with better living conditions and closer contact with the wider community.

In some instances it has also allowed individuals to reconnect with family and other support people in positive ways. The goal of treating people in their own communities, 'closer to home,' can now be more realistically realized.

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The transfer of psychiatric tertiary care to regional authorities has also presented a range of new opportunities. The process introduced new expertise and staffing, new human and financial resources and new facilities into the communities of Vernon and Kamloops. In turn, this has led to greater opportunities for professional development among staff, a trend which should contribute to the overall quality of care for people with mental illnesses in the region. In our research it was evident that although challenges exist with respect to working from recovery-oriented care models in tertiary care, there has been a concerted effort to transform care models from custodial to psychosocial rehabilitation. At least within the facilities in which we conducted our study, many staff members had received PSR training, and it was evident that Interior Health leaders and management supported the use of recovery-oriented models.

However, many barriers still exist with respect to fully actualizing a model that encompasses the principles of recovery, and especially models that attend to the social care needs of people with mental illness. For example, the first wave of people who were transferred from Riverview were generally able to move from South Hills to another facility when they reached a sufficient level of functioning. Yet, after this initial 'flow-through' of clients, people arriving thereafter were not necessarily able to find suitable housing despite the gains they had made in recovery. This was discouraging for both clients and staff involved in their care. It is also consistent with our observation that the number one challenge cited

by study participants regarding the provision of comprehensive mental health services in both communities was availability of an appropriate range of housing. In particular, study participants described the need for housing that could meet a range of needs so that people would not have to be moved frequently and could be supported in their recovery as their symptoms waxed and waned, or their physical health improved or deteriorated.

When people were able to transfer to housing in the community in either Vernon or Kamloops, they were typically in contact with secondary and community-based services that did not always have the adequate resources to meet their complex needs. It is evident that there is a need to further develop the capacity of community mental health care to support people who have come from Riverview as well as those who currently reside in and seek services in Kamloops and Vernon.

Community-based mental health care and the associated social services are not well resourced or supported.

Our research also shows that despite the role that social and structural factors like gender, race, ethnicity and poverty play in people's mental health and recovery, systematic attention to these issues in the development and provision of mental health care was absent in the Riverview transfer planning and in the subsequent development of psychiatric tertiary mental health care models in Interior Health. The prioritization of psychiatric care over social care has further exacerbated this inattention, with the result that community-based mental health care and the associated social services are not well resourced or supported.

As discussed, the case for gender-informed mental health care has been made in Canada and in other international jurisdictions. In Canada scholars working with women's health advocates, policy makers and providers have argued that women-centred care models will result in better mental health outcomes for women and that gender-based and intersectional analyses can usefully inform policy and practice (Ad Hoc Working group on Women, Mental Health, Mental Illness and Addictions, 2006; Morrow & Chappell, 1999; Morrow, 2003b; Morrow, Hankivsky, & Varcoe, 2007; Rossiter & Morrow, in press). The U.K. has produced a range of government-led reports and service innovations to this end (Department of Health, 2002; Department of Health, 2003a; Department of Health, 2003b). Most relevant to our study is a recently produced guide 'Informed Gender Practice' that outlines how best to work with women in mental health acute care (Williams & Paul, 2008). These contributions are relevant for understanding how, and in what ways, women's needs differ from men's and how this knowledge needs to inform the development of both psychiatric tertiary and community-based mental health supports and services. Largely absent from the literature, however, are contributions that help us to understand gender in its intersections with other social and structural factors.

Our study recognized and was designed to address these gaps and to contribute specifically to discussions about how gender and other intersecting factors are relevant to the care and support of women and men who have experienced long-term psychiatric institutionalization and have subsequently been transferred to new settings.

It was enlightening and heartening to note that, despite their limitations in implementing a care model that accomplished this, managers and staff members in Interior Health have a keen interest in learning more about how to make their programs and practice more relevant to the diverse needs of clients. Further, on an individual basis, it is clear that staff members work to address the particular needs of each of the individuals they work with. This individual approach is supported by literature on the implementation of recovery models; however, we would suggest that more systematic attention must be paid to the ways in which structural barriers and the social experiences of individuals contribute to particular vulnerabilities and needs.

Intersectional frameworks can be used to inform policy and practice in ways that bolster the development of supports.

As argued by Kohn & Hudson (2002), the mental health field needs to “move beyond standard models and methods of inquiry” (p. 178). To this end we argue that a social determinants lens and an intersectional approach, which, together, recognize the role of gender and other social inequities, are necessary in the development and provision of mental health care. Intersectionality permits an understanding of cumulative, interlocking, and historically embedded influences on the experiences, opportunities, and life chances of vulnerable populations (Hancock, 2007; Hankivsky & Cormier, 2009; Morris & Bunjun, 2006; Schultz & Mullings, 2006; Symington, 2004; Weber & Parra-Medina, 2003). In an intersectional approach gender is understood to interact with other social experiences such as culture, race, ethnicity, sexual orientation, gender identity and age in determining an individual’s experience of mental illness, their interactions with providers and their support needs. We suggest that intersectional frameworks can be used to inform policy and practice in ways that bolster the development of supports that move beyond symptom management in mental health to enhance the active citizenship of people with mentally ill health (Rossiter & Morrow, in press).

The tensions that exist between the goals of regionalization of the health care system and providing better care to people with mental illness can be measured in the ways in which the structure and funding of the mental health care system limit or enhance the ability to provide the best care and support possible to people with mental illnesses. In BC, the Riverview Redevelopment process is taking place in the context of constant changes to the organization of health care and continuing shortages of housing. These factors contribute to barriers for

individuals ready to move into the community and live more independently. Further, little has been done to augment services that support greater access to housing, income, employment opportunities and rehabilitation—all of which contribute to the full expression of citizenship (Morrow et al., 2006; Trainor, Pomeroy, & Pape, 2004). Our findings are consistent with other Canadian studies that have found that while medical needs are largely being met for people with mental illness, there is a dearth of vocational, social, recreational and educational services and supports (Koegl, Durbin, & Goering, 2004).

Residents' time continued to be organized by a medical and legal system that limits their autonomy and capacity for choice.

Finally, where you are located in the mental health care system—as a provider, manager, recipient of care, family member or worker in the community—affects your experience of changes to that system. We contend that attention to these differences is critical for a fulsome understanding of mental health reforms and in designing responses that will meet the range of needs of those directly involved. There is no single “story” of the development of tertiary mental health services in Interior Health, but rather a web of intersecting experiences that are framed by one’s positioning at a given point in time.

It is clear that the move from Riverview Hospital to facilities in Interior Health was an experience of both disruption and continuity for the residents who lived it. While the details of their everyday lives were altered and they had increased opportunities to engage with the basic tasks of daily life, their time continued to be organized by a medical and legal system that limits their autonomy and capacity for choice. This was compounded by the lack of meaningful options for people with respect to employment and other forms of activity. This speaks to the need for a comprehensive medical and social response to the needs of individuals with mental illness.

For families, though we only spoke with a small number, it seems that the move to Interior Health raised both promise and fear. The promise was that their family member would have a more home-like experience and would live in a more pleasant environment. At the same time, the model of care under which residents were meant to flow through South Hills and on to other facilities meant that the newest and nicest facility was not likely to be a permanent home. Rather, recipients of mental health services moved on to other facilities in a variety of neighbourhoods in both communities as administrators matched their care needs with available spaces. While Riverview may have raised the specter of abuse and fear among some family members, it also no doubt represented security in some cases. Transferring some former Riverview Hospital residents closer to home may have raised different fears that their family member was not necessarily in a secure place, or that their own lives might be disrupted anew by the

proximity of the formerly institutionalized family member. In some of our interviews, family members were candid about their concerns that they would be required to resume care for the person who had mental illness, and that the move to Interior Health signalled a weakening of support for themselves and their family member.

For administrators and staff operating mental health services in Interior Health, regionalization represented an important milestone in the development of their local health authority and its independence from BC's Lower Mainland hub of specialist services, tertiary facilities and programs. It meant more opportunities to work at a higher level of professional development and for growth in training programs and senior positions within their jurisdiction. Practically, this meant more positions for senior medical personnel (psychiatrists, advanced practice nurses) as well as more resources for the local health authority to manage. The same increase in positions may result for front-line workers in, for example, Vernon and Kamloops. This has implications for the economic base and social structure of both communities, as the number of well-paid professionals in town increases and they bring with them their values, priorities and expectations for the community.

This study was prompted in part by our desire to understand how a particular moment in the history of mental health care in the province would reshape the lives of people with mental illness and those who care for them. At the time the study was conceived, it looked as though this was the end of an era for what has been a somewhat notorious facility in the province. Over the duration of the study, however, the future of the Riverview site and indeed of Riverview Hospital has continued to evolve, and it remains unclear whether this was really the end of RVH. Regardless, a profound change has transpired throughout the province via regionalization. The communities overseen by the Interior Health Authority have undergone a shift in how and where services are provided for citizens with mental illnesses. The question now is not whether the services are in place, but how they will evolve from here on in and what effect the availability of mental health care "closer to home" will mean for the nature of care, the prospects for recovery, support for families and the communities themselves.

Endnotes

¹The British Columbia Centre of Excellence for Women's Health and its activities and products have been made possible through a financial contribution from Health Canada. The views expressed herein do not necessarily represent those of Health Canada.

²Tertiary psychiatric care typically involves specialized interventions delivered by highly trained staff to individuals with complex mental health problems. Psychiatric tertiary care is no longer tied to inpatient settings and can be provided through a number of different models including Assertive Community Treatment, or in facilities located in the community (Wasylenki et al., 2000).

³This group is now known as the Mental Health Empowerment Advocate's Program.

⁴Much of this research was made possible through the support of Victoria Schuckel, who worked with Adult Mental Health Services in the BC Ministry of Health, and through the work of the BC Centre of Excellence for Women's Health, Mental Health Discussion Group, comprised of people who had used mental health services; policy and program developers; front-line community based workers; and academics, and which acted in an advisory capacity on many of the projects.

⁵For more details, see www.interiorhealth.ca/information.aspx?id=566&terms=mental+health+beds.

⁶Kamloops is also the site of Hillside a 44-bed neuropsychiatric facility that serves the whole region, and Hill Top House, a 6-bed specialized residential facility. Individuals from Riverview were also transferred to these facilities. See Table 3.

⁷Vernon also has the Polson Extended Care Unit located at Vernon Jubilee Hospital; this program has 5 tertiary specialized residential beds for geriatric patients. See Table 3.

⁸Included here were managers of psychiatric tertiary care facilities.

⁹The former residents in our study had been institutionalized at Riverview anywhere from 3 to 30 years.

¹⁰This category included a diverse range of organizations providing mental health care and support, as well as organizations providing housing and addictions related services. Organizations providing care specifically to women (e.g. women's centres and shelters) were also included in this sample.

¹¹The Regional Director, Tertiary Mental Health, Thompson, Cariboo Shuswap Health Services Area facilitated contacts for mental health managers and directors in Interior Health and for facility managers. Additional contacts in Vernon were made through the Director, North Okanagan Mental Health Services. Managers at the mental health tertiary care facilities helped us to gain access to front-line workers, families and to individuals who had been transferred from Riverview. In order to interview transferred individuals we also worked with Riverview staff and contacts from a concurrent clinical tracking study (Lesage, Groden, Ohana, & Goldner, 2006). David Groden and Dr. Alain Lesage helped us access the cohort of individuals they were tracking, all of whom had been transferred to Interior Health. From this cohort we chose to interview seventeen individuals, with approximately equal numbers of men and women. Individuals were chosen based on their interest, their ability to give informed consent and their availability .

¹²One of the student researchers on the team, Viviane Josewski, did undertake an independent study for her Master's of Science thesis at Simon Fraser University looking at Aboriginal mental health initiatives in Interior Health. The thesis, entitled *Lost in Translation: A critical exploration of Aboriginal mental health reform in Interior Health*, was completed in August, 2009.

¹³During the time of the study a neuropsychiatric facility called Hillside Centre opened. Although we were able to do some interviews with staff and management there, we were unable to conduct interviews with clients or their families. Because of this, we lack a complete picture of the transfers to Hillside Centre and so have not reported those findings here.

¹⁴It was reported to us by research participants that later transfers occurred more gradually.

¹⁵For more about the experiences of people transferred from Riverview, see M. Morrow and B. Jamer, "Making meaning in a 'post-institutional' age: Reflections on the experience of deinstitutionalization," *International Journal of Psychosocial Rehabilitation* 12(1), available at www.psychosocial.com.

¹⁶It is important to note that most of the individuals we spoke with had been involuntarily committed and thus were on Community Treatment Orders.

¹⁷Pseudonyms were assigned to each care recipient who participated in interviews in order to protect their anonymity and confidentiality.

¹⁸Residents were chosen for the move by staff in consultation with the Director of Riverview. The decision about where the resident would end up (i.e., what region of the province) was based on where the person was originally admitted from, on whether they had family connections in the new region and on whether the facilities in the region could meet their care needs.

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Appendix 1

Knowledge Exchange Activities

Knowledge exchange activities began in 2006. Activities to date have included presentations in the Interior Health region and with the Provincial Health Services Authority, where the authors of this report shared study findings with key stakeholders and research participants. Presentations were also made at academic conferences and community events, and articles have been published in academic journals.

HEALTH AUTHORITY PRESENTATIONS

Authority: Interior Health

Date: April 2008

Co-authors: Marina Morrow and Ann Pederson

Title: ***Gender and Tertiary Mental Health Reform in Interior Health***

Location and attendees:

Kamloops (2 events): managers and staff; community organizations/families and care recipients

Vernon (2 events): same as above

Kelowna (1 event): Interior Health Mental Health Leadership Team

Authority: Provincial Health Services Authority

Date: January and June 2008

Co-authors: Marina Morrow and Ann Pederson

Title: ***Gender and Tertiary Mental Health Reform in Interior Health***

Location and attendees:

Riverview Hospital Grand Rounds, Coquitlam, BC

Leslie Arnold President, BC Mental Health and Addiction Services

Provincial Health Services Authority, Coquitlam, BC

COMMUNITY PRESENTATIONS

Date: July, 2008

Event: 2nd World Mad Pride Biennale

Co-authors: Marina Morrow, Ann Pederson, Vivian Josewski, Lupin Battersby, Brenda Jamer

Title: ***Reflections on the 'Redevelopment' of Riverview Psychiatric Hospital***

Location: Gallery Gachet, Vancouver

Date: September, 2008
Event: Columbian Centre Society AGM
Co-authors: Marina Morrow and Ann Pederson
Title: *Reflections on the Riverview Redevelopment Process*
Location: Nanaimo, BC

PRESENTATIONS AT ACADEMIC CONFERENCES

Date: November, 2006
Conference: Canadian Psychiatric Association Annual Conference, Toronto, Ontario
Title: *The Buck Stops Here? Reflections on Tertiary Mental Health Care Reform in BC*
Presenter(s): Marina Morrow

Date: November, 2008
Conference: Innovations in Community Health Care, Canadian Centre for Policy Alternatives (BC) and Faculty of Health Sciences, Simon Fraser University
Title: *Relocations, Dislocations and Innovations in Mental Health Reform: Examining the Examining the Interface between Tertiary and Community Based Mental Health Services.*
Presenter(s): Marina Morrow

Date: June 12-15, 2008
Conference: Madness and Citizenship Conference, Simon Fraser University
Title: *Reflections on the 'Redevelopment' of Riverview Psychiatric Hospital*
Presenter(s): Marina Morrow, Ann Pederson, Viviane Josewski, Lupin Battersby, Brenda Jamer

Date: September 17-19, 2008
Conference: PSR/RPS National Conference: Breaking through the Barriers to Recovery, Winnipeg, Manitoba
Title: *Shifting the Paradigm: Psychiatric Deinstitutionalization and the Challenges of Psychosocial Rehabilitation*
Presenter(s): Brenda Jamer & Lupin Battersby

POSTERS PRESENTED AT CONFERENCES

Date: April 16-18, 2008
Conference: Moving "Beyond Beds" in the Provision of Tertiary Mental Health Care for Adults and Older Adults in British Columbia, Vancouver Island Health Authority, Victoria
Title: *Reflections on Gender and Psychiatric Tertiary Mental Health Reform in Interior Health*
Presenter(s): Lupin Battersby

Date: March, 2008

Conference: Third International Congress on Women and Mental Health, Melbourne, Australia

Title: *Reflections on Gender and Psychiatric Tertiary Mental Health Reform*

Presenter(s): Marina Morrow

ACADEMIC JOURNALS PUBLICATIONS

Is Deinstitutionalization a 'Failed Experiment'? The Ethics of Re-institutionalization, by Marina Morrow, Paul Dagg, and Ann Pederson. *Journal of Mental Health Ethics* 3(2), pp 1-7; 2008. Available online at <http://65.39.131.180/ContentPage.aspx?name=Journal%20of%20Ethics%20and%20Mental%20Health>

Making Meaning in a 'Post-Institutional' Age: Reflections on the Experience of Deinstitutionalization by Marina Morrow and Brenda Jamer. *International Journal of Psychosocial Rehabilitation* 12(1); 2008. Available online at www.psychosocial.com

Appendix 2

INTERVIEW SCHEDULES

A. INTERVIEW SCHEDULE – Mental Health Care Recipients

Introductory Question

1. For me to understand what it is like for you here it would be helpful if you told me about your day:
 - a. Can you describe your morning? Afternoon? A typical day for you?

Transition Experiences

2. Did you have a choice about where and when you moved from RVH?
 - a. What happened?
3. What has it been like since you have been here?
 - a. How do you feel you are doing in comparison to when you first moved?
 - b. What are your goals and expectations for your care? Or, what would you like for your care?
4. How is living here different from RVH?
 - a. Is there anything you miss from/at RVH?

- b. What differences have you noticed in the way yourself or others are treated here as compared to RVH?
- c. What about in situations of conflict or where a person may be behaving in ways that are scary or dangerous?
- d. What about in terms of rules for behavioral conduct ?
- e. Do the rules about visitors work for you?
- f. How do you feel about visitors?
- g. Are you ever concerned with safety or privacy? How so?
- h. Are you comfortable living in a house with men and women?
- i. Is your current home the place you want to be? Why or why not? If not, where would you prefer to be?

Sense of control

- 5. Do you feel you have more control or less control over your life since relocating? Has it been different each place you have moved to?
- 6. At RVH there was a patient’s charter of rights – were you aware of this? Was it useful? Is there a charter of rights in your new facility?
- 7. Do you have any jobs at the house? Probe for laundry, food preparation (is this gendered?)

Mental Health Services

- 8. What is your understanding of your mental health status?
 - a. If they report a diagnosis then probe with: what does that mean to you?
- 9. What kind of treatment and services do you get here at the house? Who is providing those services?
 - a. Probes: Activities? Treatments? Complimentary therapies? Life skills training (what are you learning)?
 - b. How do you feel about the medications you are taking? Any side effects or concerns?

For Clients in Supported Independent Living

- c. Do you have a case manager, what has your experience been like with your case manager? (structure vs. flexibility)
- d. Are you in the assisted medication program? What has your experience been like with that program?

- e. What are other services that you might need specific to being a women/man?
- f. Have you ever noticed that men and women residents are treated differently by staff? How so? What about by other care providers? How so?

10. Do you have a preference to be cared for by a man or women? If so, who and why?

11. What are the things that make you feel comfortable/happy? What are the things that make you feel stressed? Are there things that you do differently to deal with stress?

Education/Work/Income

12. Are you involved in community activities such as going to church, playing sports, attending peer group activities or any other community based activities?

13. Do you do any work/volunteer? Have you done any training activities?

14. What do you spend your money on? Things you would like to buy but cannot afford to purchase?

Inclusion/belonging

15. Do you have any family? Do you see them?

16. Who else do you spend time with?

17. Is there someone you can count on to listen to you when you need to talk?

18. Neighbourhood – what have your experiences been like when you are out in the community?

Identity/Confidence

19. How would you describe yourself? What key words would you use?

20. How do you define yourself – consumer, patient, psycho-survivor etc.,?

Hope/Resilience

21. Where do you see yourself five years from now?

B. INTERVIEW SCHEDULE – Mental Health Care Providers

1. What are the responsibilities and tasks that you carry out as _____?

- Who do you report to? Who reports to you?
- Can you describe how clients are admitted, how long the stay and how they are discharged.
- Who, generally, is the population that you are serving? Have you had any contact with RVH patients since the redevelopment process began?

2. We are trying to get an overview of the historical process of the Riverview Redevelopment project:

- If and when did you become involved? (date and stage)

- Were there any tasks you were responsible for, and if so, how was this decided (directives, meetings, committees, documents)?
- Who were the people that you needed to engage/interact with as part of that? (IH, RVH, PHSA Management, Care Providers, Community, Families, Clients etc).
What did that look like?
- Did you continue to interact with these people throughout?
- As this process was unfolding and decisions were being made, were there any discussions or considerations made for different needs re: men and women?
- What about the needs of other populations? (LGBTQ, Aboriginal, etc)
- Are you still able to refer people to RVH? If not, where are you referring people with acute symptoms for stabilization? And then what happens?
- What access do you have for referring people to tertiary rehabilitation services?
- Does your hospital in-patient unit have a 'return to sender' policy? How does this play out upon an individual's release?

3. What is currently happening with regard to the RVH Redevelopment Project?

- Has your position changed in relation to the RVH redevelopment process?
- Did you use or need to know the RVH transfer plan? General or individual clients?
Do you refer to or update the transfer plans now?
- Are there any ongoing challenges that you are currently addressing?

4. Tell me about the values and philosophy that underscore your provision of services?

- If a reference is made to Psycho-social Rehabilitation (PSR), ask what is meant by that?
Examples?
- How has this philosophy evolved? How does it differ from the past?
- What had to happen to implement PSR? Was this a change in philosophy?
- Are there ongoing activities or actions happening to implement those changes?
- What are some of the challenges you faced in making that shift and what challenges are you currently facing?
- How would you describe the strengths and the weaknesses of the PSR model?

5. Given all the changes in Mental Health Care, we would like to get a sense of the impact on community services and the users of those services:

- Within this health authority, what are the mechanisms for communication between the tertiary care level and the community based mental health organizations?
- How would you describe the range of services in this community? Do they reflect current Best Practices (Community services, Employment, PSR, Housing, Crisis Response)?
- Are you aware of any initiatives or services to address concurrent disorders in the community? Please describe.
- What else is needed to facilitate and support recovery for people with serious mental illness? What about addressing needs based on gender and diversity, for example?

- Do you anticipate that more community based services will be utilized and/or needed in the future?
- What are some of the future challenges you can foresee for mental health service provision?
- What, if any, changes have been made to hospitals in this region? Are the hospitals in these areas now serving additional communities due to the restructuring and closure of RVH?
- Is it your sense that families are involved with mental health care recipients here? Who is typically involved in terms of family members (GENDER, siblings, parents, kids, spouses...)? Are you aware of any specific challenges for these family members?

C. INTERVIEW SCHEDULE – Health Authority Directors

We are trying to get an overview of the historical process of the Riverview Redevelopment project:

1. What are the responsibilities and tasks that you carry out as directors of Mental Health Services? Who do you report to? Who reports to you?
 - a. When did you become involved? (date and stage)
 - b. What were you responsible for? How was this decided (directives, meetings, committees, documents)?
2. How were decisions made about where to locate the new tertiary care facility and how to redistribute resources?
3. How were decisions made to change existing mental health care centres and how was the decision-making process communicated?
4. What is the path of transfer payments and spending?
5. How were decisions made about the financing of the new facilities in this health authority and what kind of flexibility did you have to decide where resources went?
6. What happens to the tertiary funding when the client moves into the community?
7. What evaluation plans are there regarding this process besides the Provincial Health Services Authority (PHSA) funded outcomes study?
8. Are there any ongoing challenges that you are currently addressing?
9. How would you describe the shift in the philosophy of care from RVH to this Health Authority?

In addition to the changes at the tertiary care level, we are also interested in exploring changes at the community level:

10. What community based organizations are currently providing services to consumers that have transferred from RVH? What are some of the key issues that have arisen?

11. How would you describe the range of services in this community? Do they reflect current Best Practices?

12. What else is needed to facilitate and support recovery for people with mental illness? What about addressing needs based on gender and diversity, for example?

13. Do you anticipate that more community based services will be utilized and/or needed in the future? Within this health authority, what are the mechanisms for communication between tertiary care and community based mental health organizations?

14. What are some of the future challenges you can foresee for mental health service provision?

D. INTERVIEW SCHEDULE – Family Members

We are researchers from FHS, SFU who have for the last year and a half been conducting research on the transfers from RVH that have occurred in your community. In our research we are interested in better understanding the experiences of family members who have relatives who have been transferred from RVH. In our discussion today, we will be asking you questions about your experiences with your relative, the challenges faced and resources needed.

Before we begin we would like to go through the consent form and get your permission to tape our discussion.

We would like to ask you to state your name every time before you speak, as this will help with the interview transcription.

Introduction:

1. Briefly, can you give us your name, relationship with your relative, and how long she/he was in RVH, and when she/he transferred to this facility?

Support Role:

2. Who in your family has taken the primary responsibility for supporting your relative? How was this decision made? Are other family members involved and to what extent?

3. Can you describe what you do in support of your family member? What do others in your family do?

RVH Transfer Process:

4. Tell us about your experience of your relative being transferred from RVH?

5. To what extent were you and your relative involved in the decision to move? What did that process look like?

6. Can you describe how your role/relationship changed after the transfer? How did the relationship with other family members change?

7. How did the care of your relative change after transferring to SH?

8. Are there any specific things your family member might need as a woman in the context of her care at SH (support as a mother, safety, social needs)?

9. Can you describe your interactions with the mental health care system in the process of supporting your family member?

Challenges:

10. What would you say are the most significant challenges you and your family have faced in supporting your family member with a mental illness (psychiatrists, concurrent disorders, Mental Health Act, respite care)?

11. How do you balance your support role with your other family and work responsibilities and social life?

12. Can you describe some of the positive things that have come out of supporting a family member with a mental illness?

Resources:

13. What kinds of resources have been available to you? Which of these have been the most useful?

14. What are the gaps in resources and what could you and your family use to make your support role easier?

15. What does your community need to supplement existing services for people with mental illness and their families?

E. Focus Group Interview Schedule – Mental Health Care Providers

1. What kind of mental health care supports has this community had historically?

2. Can you tell me about the events leading up to the Riverview Redevelopment process for your community?

3. As workers in the mental health care system were you involved in the decision making process?

4. What kinds of support as workers were you given during the relocation process?
5. What has your experience been like since the relocation?
6. What kinds of supports are needed in your community for women and men leaving RVH?
7. What kind of stresses has the relocation put on the mental health care system in your community?
8. What kinds of services/resources has your community gained as a result of the relocation process?
9. What are your expectations for the RVH transfer clients in terms of their capacity for recovery and self care?
10. What opportunities were provided for integration among current residents and community members?
11. What are the roles of GP's, e.g. at a walk-in clinic that functions as a primary care centre, in provision of care and, accessibility for former RVH clients?
12. What was the staff experience of the change in model of care?
13. How do mental health care recipients respond differently with women and men staff? How does staff gender effect patients? What are the differences in services in your community for men versus women mental health care recipients?

F. FOCUS GROUP INTERVIEW SCHEDULE - Family Members

We are researchers from FHS, SFU who have for the last year and a half been conducting research on the transfers from RVH that have occurred in your community. In our research we are interested in better understanding the experiences of family members who either have relatives who have been transferred from RVH or have been supporting someone with a serious mental illness. In our discussion today, we will be asking you questions about your experiences with your relative, the challenges faced and resources needed.

Before we begin we would like to go through the consent form and get your permission to tape our discussion. We would also like to take this opportunity to remind you to allow everyone to speak, be mindful of confidentiality, and the emotional nature of this discussion. Feel free to take breaks as needed.

We would like to ask you to state your name every time before you speak as this will help with the interview transcription.

Introduction:

1. Briefly, can you give us your name, relationship with your relative, and if your relative transferred from RVH and when they transferred?

Support Role:

2. Who in your family has taken the primary responsibility for supporting your relative? How was this decision made? Are other family members involved and to what extent?

3. Can you describe what you do in support of your family member? What do others in your family do?

4. If your relative was one of the people transferred from RVH, can you describe the process and how you were involved (were you consulted prior to the transfer, how were you and your relative prepared for the transfer)?

5. How did the care of your relative change as a result of the transfer?

6. How has your role/relationship changed since the transfer? How did the relationship with other family members change?

Challenges:

7. What would you say are the most significant challenges you and your family have faced in supporting a family member with a mental illness (psychiatrists, concurrent disorders, Mental Health Act, respite care)?

8. Can you describe your interactions with the mental health care system in the process of supporting your family member?

9. What are some of the barriers to accessing support for family members?

10. How do you balance your support role with your other family and work responsibilities and social life?

11. Can you describe some of the positive things that have come out of supporting a family member with a mental illness?

Resources:

12. What kinds of resources have been available to you? Which of these have been the most useful?

13. What are the gaps in resources (i.e., supports for men, respite care, supports for youth) and what could you and your family use to make your support role easier?

14. What does your community need to supplement existing services for people with mental illness and their families?

Appendix 3

ABOUT THE AUTHORS

MARINA MORROW is an Associate Professor in the Faculty of Health Sciences and Director of the Centre for the Study of Gender, Social Inequities and Mental Health at Simon Fraser University. In her work Marina has been interested in better understanding the social, political and institutional processes through which health and mental health policies and practices are developed and how social and health inequities are sustained or attenuated for different populations. Marina strongly supports public scholarship and collaborative research partnerships with community-based organizations, health care practitioners, advocates and policy decision makers. Marina's research has been published in a wide range of academic journals and policy reports, her most recent publication (with Kate Rossiter) is *Intersectional frameworks in mental health: Moving from theory to practice*. In O.Hankivsky (Ed) (in press) *Health and Intersectionality Inquiry in Canada*. Vancouver: UBC Press.

ANN PEDERSON is Director, British Columbia Centre of Excellence for Women's Health, an independent non-profit women's health research centre. In her work with the BCCEWH over the past 13 years, she has been involved in research on women and health care reform, health promotion and sex- and gender-based analysis. Ann has been particularly interested in the impact of regionalization on women's health programs and services as well as how policy shapes the lives of women and men receiving health services. Ann's training is in community health from the University of Toronto and she is currently enrolled in doctoral studies at the University of British Columbia.

JULES SMITH works as a clinical counsellor and educator for British Columbia Mental Health and Addictions Services at BC Children and Women's Hospital in Vancouver. She is currently applying the principles of institutional ethnography as a therapeutic intervention to assist her clients in addressing the social inequities that influence their mental health and well being. She has also participated in several research projects and is an investigator with the Reproductive Mental Health Team for the Center for the Study of Gender, Social Inequities and Mental Health. Her latest publication is a book chapter, *Mothers, madness and the labour of feminist practice: Responding to women in the perinatal period*, co-authored with Dr. Morrow in *Moms Gone Mad: Motherhood and Madness, Oppression and Resistance* to be published by Demeter Press, 2011. Jules also has a counselling and consulting practice, www.jules-smith-counsellingsite.com

VIVIANE JOSEWSKI is a PhD candidate and a student trainee with the Centre for the Study of Gender, Social Inequities and Mental Health. As a former nurse with a BA in psychology and MSc in Population and Public Health, Viviane has a strong interdisciplinary background. Her research focus is on critical health policy with foci on 1) health and social inequities; 2) Aboriginal health, gender and mental health, and; 3) mental health care reform.

BRENDA JAMER has an MSc in Counselling Psychology and is Manager, Research and Administration at the Centre for the Study of Gender, Social Inequities and Mental Health. She was recently involved in the development of a national peer research network at the Mental Health Commission of Canada (MHCC). She has over 20 years of experience in women's health addressing structural barriers to service access. Related publications include: 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(2).

LUPIN BATTERSBY is Manager, Information and Communications at the Centre for the Study of Gender, Social Inequities and Mental Health and a PhD student in the Faculty of Health Sciences at Simon Fraser University. Lupin has ten years of counselling and research consulting experience related to mental health policy reform, primarily contracting with the BC Centre of Excellence for Women's Health (BCCEWH) and Ministry of Public Safety and Solicitor General. Currently, her research focus is creating accessible mechanisms for the communication of qualitative research across sectors and disciplines.



Centre for the Study of Gender, Social Inequities and Mental Health (CGSM)

The Centre for the Study of Gender, Social Inequities and Mental Health (CGSM) based in the Faculty of Health Sciences at Simon Fraser University and funded by the CIHR's Institute of Gender and Health, supports collaborative, interdisciplinary, and multi-sectoral teams of researchers and research users from Canada, the United States, Australia, and the United Kingdom. CGSM investigators will address gender and social inequities in mental health through the development of innovative research, knowledge exchange and training initiatives.

For more information about the Centre, please visit our website at www.socialinequities.ca

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