RECOVERY CONCEPTUALIZATIONS IN YOUTH WITH MENTAL HEALTH CONCERNS UNDERGOING COMMUNITY REINTEGRATION FOLLOWING HOSPITALIZATION

by

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Dedication

I would like to acknowledge my thesis supervisor, Dr. Lynne Robinson, whose support and guidance was invaluable. You were so helpful in problem solving during these past two years as this thesis posed its share of roadblocks. I would also like to acknowledge the greater supervisory committee, Drs Jeff Karabanow and Michael Ungar whose insight helped shape this study into what it has become. Thank you all. I would also like to thank Dr. Catrina Brown for serving as my external examiner.

This thesis is dedicated to the youth in this study, and outside it, who show such courage in the face of adversity within the mental health system. May you continue to subvert the system and find your own versions of recovery.

The thesis is also dedicated to my mother who provided a shoulder to cry on when I thought this thesis would never be finished, was my greatest cheerleader and who rescued me from the depths of Research Ethics purgatory with several brilliant ideas.
Love you double.

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Abstract

Introduction: Recovery conceptualizations, or how one approaches recovery, have important implications for treatment and recovery trajectories after a person develops a mental health concern. If psychiatric hospitalization has occurred, an important step in the recovery process is community reintegration, but it is unknown how this process is connected to recovery conceptualizations during mental health recovery. This study examined this connection through the perspectives of youth, a demographic too often ignored within mental health research.

Methods: An exploratory qualitative methodology was used, framed by Merriam's (1998) process case study work. The process was bounded by the concept of recovery in youth, and occurring within the context of community reintegration.

Conclusions: Youth pursued recovery in a variety of ways but utilized the recovery paradigm as an overarching guide for the process. The recovery paradigm impacted which services they pursued and how they sought to be functioning over symptom-free through their service access.

Keywords: Mental Health, Recovery, Community Reintegration, Community-Based Mental Health Centers, Youth

Chapter One: Introduction

Problem

Canadian Mental Health System

In recent years, the Canadian mental health system has shifted towards a concentration on outpatient and community-based services (Ramon, Shera, Healy, Lachman & Renouf, 2009), this does not mean that the traditional hospital system is no longer being used. Youth who access the hospital system in Canada for a psychiatric concern are most typically diagnosed with a mood disorder (Rhodes, Bethell, Carlisle, Rosychuk, Lu & Newton, 2013). There is also hospitalization due to suicide attempts or suicide ideation, and this rate has not decreased since 2006 (Rhodes et al., 2013).

Recovery

There is a distinct trepidation felt by those operating (both patients and healthcare workers) within the Canadian mental health system in recent years in regards to how effective the system really is. Much of this concern is related to how people accessing the system are recovering (Ramon et al., 2009). It is difficult to operationalize the recovery process as there is no agreed upon definition and thus is a contested concept within the literature (Bonney & Stickley, 2008). Part of the issue in operationalizing recovery is that it can be conceptualized several ways. The two major conceptualizations for framing recovery within the literature are the technological paradigm and the recovery paradigm.

The technological paradigm is essentially the medical model and is the guiding conceptualization for the traditional health system (Gagne, White & Anthony, 2007). Within this, mental illness is considered an acute pathology (Gagne, White & Anthony, 2007) and thus a recovered state is an absence of all symptoms related to the pathology

(Bonney & Stickley, 2008). This follows the assumption that all people are healthy, well, and rational and anything other is a deviation that must be treated (Edley, Stickley, Wright & Repper, 2012). Interventions, within this model, are typically a series of separate treatments aimed at specific symptoms (Bracken et al., 2012), frequently through medication (Bonney & Stickley, 2008). This high usage of medication demonstrates the strong relationship of this paradigm with the powerful pharmaceutical industry (Bonney & Stickley, 2008) and pushes relationships, society and culture behind the medicalized treatment in recovery importance (Bracken et al., 2012). This paradigm is often in direct opposition to the recovery paradigm.

Recently, the literature has often noted the importance of the non-technical aspects of treating someone with a mental health condition (Bracken et al., 2012) and thus, the recovery paradigm has been gaining popularity. This paradigm puts emphasis on hope and self-responsibility in relation to the management of chronic symptoms (Edgley et al., 2012), rather than curing them through medication (Bonney & Stickley, 2008). The focus of this paradigm is on the person's strength and ability for growth and points to the values of a service rather than the treatments offered by them (Gagne et al., 2007). Due to this focus, it frequently involves the person searching out programming in the community, rather than through the traditional system.

Community Reintegration

Community reintegration is the process of returning to a community (be it a geographical space or a relational one) after a period of being away. A major step in the recovery process is the process of community reintegration, especially when hospitalization has been involved. For youth, leaving a psychiatric hospital can be

worrying (Braehler & Schwannauer, 2012). There is the risk of losing the progress made within the hospital upon reintegration and thus returning to the ward, the potential for which is increased if there is a lack of proper planning, tailored to the specific needs of the youth, before release (Yampolskaya, Mowery & Dollard, 2013). Considering the need for suitable services in all stages of community reintegration to increase success, it is problematic that youth are often dissatisfied with the traditional services selected for them within and by the inpatient unit (Mirza, Gossett, Chan, Burford & Hammel, 2008). This feeling is frequently a result of youths feeling as if their lived experience has been disrespected or misunderstood by the professionals (Mirza et al., 2008). Youths feel that they have no choice in the treatments selected for them due to staff perceptions of the cognitive ability of mentally ill youth (LeFrançois, 2008). Service providers believe that this method of treatment selection is in the best interest of youth, something which can be true (LeFrançois, 2008). Unfortunately, though, by not allowing youth to exercise their agency in treatment selection, they are further isolating youth from their community and from their own sense of power (LeFrançois, 2008). This can, therefore, make community reintegration far more difficult after discharge (Edwards et al., 2015).

Before, as well as during the process of community reintegration, youth can feel a distinct separation from life outside the hospital (Edwards et al., 2015), which may be understandable due to the isolation from greater society often felt within a psychiatric hospital (LeFrançois, 2008). Bridging this separation can be difficult for youth (Edwards et al., 2015) due to potential barriers that include stigma and related pressures, relations with parents upon returning to their care, the attitudes of their cohort and accessing treatment that is suitable to them (Savina, Simon & Lester, 2014). Suitable treatment

access is very important as the service timing is highly related to psychiatric ward readmission, far more than the number of services accessed (Yampolskaya et al., 2013). Finding services catering toward youth, especially ones which allow group work or socialization that utilize the protective feature of commonality of experience and acceptance among peers, increase the chances for successful community reintegration, yet can be difficult to access (Edwards et al., 2015). Also important is the ability of the youth to build, or rebuild, their identity to something beyond the sick role that is often accepted (or impressed upon them) during psychiatric hospitalization (Killackey et al., 2016) and the recovery conceptualization one utilizes can aid in driving that.

There is very little literature on the recovery conceptualizations of youth, the majority of research concentrates on adults due to the belief that youth developing mental health concerns at a young age renders them less capable as a knowledge holder than adults developing the same condition (LeFrançois, 2008). The majority of the literature on youth community reintegration concentrates on youth undergoing the process after criminal incarceration, rather than psychiatric hospitalization, or examines a very specific pathway for community reintegration such as school (Savina et al., 2014). There is very little known about how community reintegration is facilitated through more abstract ideas such as recovery conceptualizations.

Significance of the Study

While some of the roots of the recovery paradigm originated from Creer's work on children's and youth recovery (Sterling et al., 2010), youth have been largely ignored in research on recovery conceptualizations (Windell, Normab & Malla, 2012). This gap is especially large when considering the lack of authentic youth voices in youth mental

health research. The act of diagnosing children and youth (typically under 18/other age of majority) with a mental disorder removes their ability to exert agency in regard to treatment due to preconceived beliefs of capability amongst the mentally ill (LeFrançois, 2008). Practitioners report taking agency from youth due to safety, best interest, and lack of maturity of the youth regarding the ability to handle treatment decisions (LeFrancois, 2008). In reality, youth often desire to be included in these decisions (LeFrançois, 2008). This seems to relate to research as well, a problematic trend considering the growing body of evidence reporting that health service models which are unique and informed by youth needs are more effective and accessible for youth (Anderson & Lowen, 2010). The present study recognizes youth as being experts in their own lives. It is long past time that youth voices, and personal narratives, are widely appreciated within the mental health research sphere. Recently, there have been initiatives, such as Mind Your Mind Canada, that have sought to return epistemic justice to youth knowledge holders and this study will follow suit to fill this gap. This study will conclude with implications for mental health policy from the youth perspective.

Much work has been done on conceptualizing recovery from the point of view of the service user, but little research on implementing recovery in practice (Piat & Lal, 2012). The current study will determine how these conceptualizations of recovery can impact community reintegration, through the lens of youth in the process of accessing community-based services. While much of the guiding literature of the recovery paradigm utilized by Canadian services is from the United States, there are differences in what aspects of the paradigm is emphasized as important (Ramon et al., 2009). In practice, the American version has taken a more systems-based approach, whereas within

Canada the paradigm has become much more community-based (Ramon et al., 2009). In this, in Canada, recovery conceptualizations have been integrated more in community-based organizations than in the traditional medical services which are still utilizing the technical paradigm (Ramon et al., 2009). As previously stated as well, the majority of this literature is also from the perspective of adults. It is important to consider the perspectives of all stakeholders involved in the recovery process before recovery-oriented programming is implemented (Piat & Lal, 2012) and therefore filling the literature gap of the recovery conceptualizations of youth, directly from their perspectives, is vital for creating an effective mental health system. The current study's involvement of community-based services fits well with the Canadian recovery paradigm and can therefore lend support, or not, to the benefits of the paradigm for youth with mental illnesses.

There are very few studies examining any perspectives of community reintegration among a mentally ill youth population, the first one occurring in 2008 (Jivanjee, Kruzich & Gordon, 2008). The current study aims to expand this small area of research by moving on from more specific examinations of how community reintegration occurs through relationships, housing, work (Jivanjee et al., 2008) and school (Savina et al., 2014), to examine the more abstract idea of how recovery conceptualizations can affect the process of community reintegration.

Key Terms

Prior to any definitions being given, it is very important to note where the terms are being derived from. The literature surrounding mental health research and recovery is long established and worked on by many fields, which means that there are a variety of

terms which refer to the same phenomenon. The terms utilized within this thesis originate from writing in the fields of psychology and psychiatry. Health Promotion is a multidisciplinary field, so this terminology usage is not out of line for this thesis and thus psychology terms were chosen in reflection of the researcher's past training within psychology. This does not make any terms on the subject used in other fields less valid. The researcher does not mean to slight other fields, but instead wishes to control the size of the thesis.

Recovery conceptualization is an inclusive term for the variety of paradigms surrounding (or approaches to) recovery from a mental health concern (Piat, Sabetti & Couture, 2009). Within the context of this study, youth may adopt and identify with a recovery conceptualization that is aligned with the technical or recovery paradigm or a combination of both. Youth may choose to identify their recovery as the *technical paradigm* (Grant, 2015; Thomas, 2014) (known as the biomedical approach in some fields) and therefore seek the total absence of symptoms (Bonney & Stickley, 2008), as the *recovery paradigm* in which maintenance and functioning are more important (Gagne et al., 2007), or as a combination in which elements of both are integrated to serve the youth's individual needs. While for ease of organization within this study, the background information on these two paradigms is presented as a dichotomy within the literature review, they are not necessarily a dichotomy in practice and individuals may employ elements of both the technical and recovery paradigms throughout their recovery process. It is also recognized that youth may not have the knowledge to directly verbalize their recovery conceptualization so the researcher will look for key terms or sayings (such as "having no symptoms anymore" for the technical paradigm or "finding my own path"

for the recovery paradigm). Also, as a key value of this study is to return the voice of the youth and allow them the power to define their own mental health, a more abstract or sweeping definition of *recovery* will not be defined before the data analysis is completed. At this point, recovery is loosely defined as reaching a point in which the youth is satisfied with, and accepting of, their mental health. Youth will individually decide their personal stage of recovery and the related trajectory.

Within this study *community reintegration* refers to the process of returning to the community (geographically, socially and intra-personally) following psychiatric hospitalization. This process involves discharge and the related planning (Yampolskaya et al., 2013), reforming identity beyond the psychiatric hospital (Killackey et al., 2016), and re-entering previously accessed places (Savina et al., 2014) while also accessing new ones related to mental health treatment and the added identity of the sick role (Mechanic, 1968; Yampolskaya et al., 2013). Again, like recovery, the definition of this process will be left broad in appreciation of the potential for varying ways this is approached. This, therefore, suggests that there are a variety of ways community reintegration will be approached by the participants. However, all approaches within the context of this study will be done, at least in part, within the context of a *community-based mental health centre*, defined in this study as a centre situated outside the traditional mental health system and thus is voluntary and often involves a more holistic approach to mental health treatments and recovery (i.e. offering services in the range of medication to counselling to art therapy for example). *Holistic*, in the context of the present study, refers to the treatments which address whole being, such as breathing techniques or involvement of nature in treatment (Myers, Sweeny & Witmer, 2000). Other disciplines may refer to this

as complementary or alternative medicine (Coulter & Willis, 2004). Holistic was chosen as this language was more in line with what the participants of the current study used, especially Em. It can, however, be considered as encompassing the same wide focus of health treatments that alternative treatments include (Coulter & Willis, 2004).

Definitions of other concepts to be explored within the present study are:

a) *Sick Role* refers to an identity of deviance because one's illness prevents one from being productive to the level society dictates (Parsons, 1951; Mechanic, 1968). This is not an identity necessarily passively or voluntarily assumed as it often comes with negative responses such as stigma and frustration as there is an obligation that they get well and this may not be possible for some individuals (Parsons, 1951; Mechanic, 1968).

b) *Neoliberalism* is an economic policy which strives for limited government interference and a free market (Dumenil & Levy, 2004; Springer, Birch & McLeavy, 2016). It also supports the reduction of social welfare programming as it values self-autonomy and productivity for creating economic stability (Dumenil & Levy, 2004). The present study will not be a critique of neoliberalism, but instead recognizes the concept as being interwoven into Canadian society and thus must be addressed it is reported in the lives of the participants, mostly through pressures to obtain work and be productive to the level society demands (not necessarily deemed a bad thing by participants).

c) *Social determinants of health* are important tenets of the field of Health Promotion that outline the aspects of life that one is required to have to reach a true state of health (World Health Organization, 1986; Raphael, 2004). These

are not just physiological, but rather include all elements of life. The original determinants laid out by the Ottawa Charter are: access to adequate shelter, food and safety (noted as peace, social justice and equity) as expected, but also education, food, financial stability at a living wage and a healthy and sustainable environment (World Health Organization, 1986). Mikkonen and Raphael (2010) have broken this down further for the Canadian context and thus the Canadian social determinants of health also account for Indigenous needs.

Purpose and Research Questions

The overall purpose of this study is to explore how a youth's recovery conceptualization can impact (help or hinder), his or her process of community reintegration following release from a psychiatric hospital. To do this, the study will employ the perspectives of both youth and workers who serve youth (perspectives to be compared and contrasted as a way to understand system complexities) to answer the following research questions:

1) How do youth conceptualize their own mental illness and recovery process?

2) How is community reintegration pursued by youth?

3) How does a youth's recovery conceptualizations impact the community reintegration process?

Overview of Study Design

This study will follow an exploratory qualitative methodology. It has been determined that an exploratory approach is essential due to the lack of existing literature on the topic, and the need, therefore, to develop a foundational understanding of the topic

(Creswell, 2013). The benefit of using such a qualitative methodology within mental health research is that qualitative methodologies are able to explore the intricacies of the issue, often beyond what a quantitative lens could. This methodology allows for the individual voice of the participant to be appreciated. This is a high priority, partly due to the exploratory nature of this study, but also due to the literature trend which too often ignores the voices of mentally ill youth (LeFrancois, 2008).

The overarching approach to this study is a process case study (Merriam, 1998). Utilizing this approach to a case study allows for a flexible qualitative approach and suggests the use of participant interviews, document review and researcher reflexivity. This study will be a multi-modal, social theory case study on the process of recovery following hospitalization (note- this is not a case study tied to a singular place or person, but rather an in-depth examination of how recovery is carried out by youth in the community and community-based mental health centers after hospitalization).

As the purpose of this study is to explore youth recovery conceptualizations and experiences with community reintegration in a more complex, multi-perspective way, two populations were interviewed. The first group was two youth, ages 16-25, who were hospitalized for mental health concerns in the past two years, subsequently released and were attempting to reintegrate into their communities, facilitated by local community-based mental health centres around an Eastern Canadian city. The second participant group were two workers at one of the community-based mental health centres being accessed (for confidentiality reasons it cannot be stated whether these participants directly served the youth participants, though they all come from the same environment). These workers are involved in community reintegration in varying ways (i.e. education or

centre recruitment). After giving consent, participants were invited for a one-on-one interview in which they will be asked questions regarding their experiences with recovery and community integration. A document review of online material published by the workers' centre was also utilized to make the case study more robust.

The study's analysis method will apply Braun and Clarke's (2006) thematic analysis onto the transcripts of the semi-structured interviews and online documents. Thematic analysis is a well-known qualitative method, in part due to the robust nature of it (Braun & Clarke, 2014). The method has been used to report the reality of participants through minimal organization of their own words into recurring themes or patterns (Braun & Clarke, 2006). The organizational properties and style of thematic analysis allows for the integrity of the voices of those interviewed to be maintained. This method relies on coded data from a data set (in this case from interviews with youth) and a rigorous data analysis procedure to condense and clarify codes into central themes (Braun & Clarke, 2006).

The theoretical framework employed in this study will be social constructivist in nature. As topics such as space, community and the social construction of illness states vs. the medical model will be important within this study, the results of this study will be connected to social constructivism theory. How youth construct ideas of community, illness, connections and space may have interesting implications or relationships to the theory as well, as these ideas are very much socially constructed and dependent on aspects of power and privilege, social relations and experiences. Finally, as this study will connect two separate fields of study (recovery conceptualizations and community reintegration), there is no major theory accepted within the literature for this new topic.

While it is recognized that the two most common recovery conceptualizations are positioned in two very different theoretical camps, the researcher's positionality follows that even science is socially constructed in its hierarchy and methods, especially its results, and therefore, it can be argued that social constructivism theory will remain appropriate, despite the results which may occur.

Significance for Health Promotion

Mental illness is not isolated to a state of sickness or incapacity to function. It is, in fact, entwined with the idea of mental well-being (Canadian Mental Health Association, 2008). Therefore, even though an illness may be present, it is important that a lens of health promotion be applied. In focusing only on the illness and the related limitations, the potential for more fulfillment, comfort, or satisfaction are being ignored for those with mental illnesses. Mental well-being can be influenced by social relations, life purpose, sense of belonging and inclusion (Canadian Mental Health Association, 2008) and these aspects are also very important to the process of community reintegration. Because of this, the idea of increasing the success of community reintegration following hospitalization is important to the mental well-being of youth with mental health concerns. In studying how recovery conceptualizations can better facilitate this process, those involved in mental health promotion can seek to be better informed on how to ensure youth diagnosed with a mental illness remain as healthy and successful as possible within their communities.

In relation to aspects of the Ottawa Charter for Health Promotion applicable to mental health, building individual skills for healthier lives is important (World Health Organization, 1986). Recovery conceptualizations are very individual and personal

positions within the mental health system. In examining the relationship these conceptualizations have on community integration, health promoters can find better ways to frame recovery (and related skills) to promote increased life success for youth with mental health concerns. Another aspect of the Ottawa Charter that applies to mental health promotion is that of creating a supportive environment for the promotion of health (World Health Organization, 1986). By including both the youth perspective and the perspective of those who serve them, a deeper understanding of the process of community reintegration can be gleaned. This duel perspective is important for system cohesiveness and effectiveness, as the needs and perspectives of the youth need to match what the workers are using to help limit times in which youth feel they are not understood, or served properly. Therefore, the current research can be used to inform health promoters as to whether the best recovery frameworks, and community reintegration approaches are being written into the policies driving the community-based paradigm shifts addressed above (Piat & Lal, 2012).

Finally, the social determinants of health, laid out originally for Canadian health promoters in The Ottawa Charter (World Health Organization, 1986), are important for understanding recovery in its entirety. The social determinants of health expanded upon by Raphael (2004; 2006) will become important during the results and discussion chapters as the social determinants of health incorporate all aspects of life, something community-based mental health centres include in their activities and treatments. For example, stable work and access to food, both social determinants of health (Mikkonen & Raphael, 2010; Raphael 2004; 2006) will all be reported as important for mental health recovery. Other elements outlined in the literature review, such as school access,

are social determinants of health and show the breadth of a life-long recovery.

Chapter One Summary

This study will combine two separate fields of research (recovery conceptualizations and community reintegration) within the context of a demographic group that is often dismissed by researchers and practitioners due to perceived inabilities within the group. The study will utilize a qualitative exploratory methodology and thematic analysis method to determine how a youth's recovery conceptualizations affect his or her process of community reintegration. This chapter has demonstrated the importance of this study because of its novelty and potential to fill a major gap within the literature, while also relating it to pillars of health promotion that better enable health through empowering service users to learn helpful skills and creating supportive environments (World Health Organization, 1986). Chapter Two will further explore the existing literature surrounding recovery conceptualizations and community reintegration, especially within the youth context.

Chapter Two: Literature Review

Living with a mental health concern can be very difficult, especially when one is young. As the majority of chronic mental health concerns develop by the age of 21 (Public Health Agency of Canada, 2006), the same time period that vital development is occurring, it is important to understand how living with a mental health concern can shape a youth's future trajectory. For example, youth who experienced a mental illness with a higher degree of symptom fluctuation were less likely to participate in school or employment (Green et al., 2013). As experiencing a mental health concern during the developmental period of youth can have such long lasting effects, it is vital for research and practice that we understand how the transitions experienced by youth in the system, such as community reintegration following psychiatric hospitalization, can be made as smooth and successful as possible.

The Canadian Mental Health System

Canada has followed a similar trajectory in mental health system development and treatment approaches as countries like the United States (Ramon, Shera, Healy, Lachman & Renouf, 2009). Prior to the 1950s, institutionalization was the most frequent method of mental health treatment (Ramon et al., 2009). While deinstitutionalization occurred around the 1960s due to the invention of chlorpromazine, a contested time for the mental health community, this action did not greatly improve Canadian mental health practice and policy (Ramon et al., 2009). There is still a general consensus that the mental health system in Canada is failing service users (Ramon et al., 2009), often due to its fragmented nature, which results in major gaps in service provision (Kutcher, Hampton & Wilson, 2010). This lack of faith in the mental health system has led to an increase in the lobbying

from service user groups in an attempt to turn the system into one which is more patient-focused (Ramon et al., 2009).

It is also important to understand the history of the mental health system in Nova Scotia, the province selected for this study. Mental health services have not developed in the same fashion as other health care systems have in the province (Leighton, 1984). Since the creation of mental health policy within Nova Scotia's government in the early 1900s, the progress and development of the system has not occurred steadily and has faced various barriers including economic stability and a cultural opposition to change (Leighton, 1984). Within Nova Scotia, regionalization of care has resulted in lack of bed space for patients and a movement from inpatient units to outpatient programs and community centres due to a lack of financial stability (Hanlon & Skedgel, 2006). Also, due to the economic issues, the general practitioner to patient ratio is far below the national average except for in Halifax and Sydney, causing inadequate mental health care access for those in rural areas (Hanlon & Skedgel, 2006), as GPs are the primary mental health service providers for rural patients (Vasiliadis, Lesage, Adair & Boyer, 2005). Finally, many Nova Scotian youth cannot access private services for economical reasons so therefore must go through the public system, a slow and fragmented system (Ungar, Liebenberg, Dudding, Armstrong & van de Vijver, 2013).

Canadian Mental Health Policy

As a country involved in the World Health Organization, Canada is expected to follow the International Declaration on Youth Mental Health, as it was involved in the creation (International Association for Youth Mental Health, 2013). Unfortunately, the Declaration is not binding, but rather, is available as a highly emphasized guiding

document for best practices implementation for youth (Coughlan et al, 2013). This Declaration was created in 2011 but launched in 2013 to formally address best practices for treating youth with mental health concerns and was created as an attempt to stem the alarming rates of suicide among youth worldwide (Coughlan et al., 2013). Within the document, youth-appropriate care is stressed as being vital for creating an effective system (Coughlan et al., 2013). Unfortunately, due to the vague nature of the Declaration, there has been misinterpretation of what an effective system looks like and the traditional power relations between patient and professional have been reinforced (LeFrançois, 2008). Thus, youth continue to lose agency in the system by being seen as passive and incompetent beings (LeFrançois, 2008). Ironically, the Declaration actually addresses the failings of a paternalistic mental health system for youth, but due to the vagueness of the wording, and the inability to enforce the Declaration directly, this has not been adequately addressed in practice (Coughlan et al., 2013).

Mental health policy within Canada is split up between provincial and federal legislature, with certain NGO and social justice organizations, like the Mental Health Commission of Canada, also creating their own policies (Kutcher, Hampton & Wilson, 2010). The neoliberalist ideologies currently pushing policy in fields such as trade and globalization, have also begun to influence the mental health system through viewing service users as a commodity (Edgley, Stickley, Wright & Repper, 2012). Commodification of service users has resulted in service users being seen as more of a profit source, rather than someone to help from a more moralistic desire (Edgley et al., 2012). This, of course, is problematic considering the need in mental health for humanistic, individualized and compassionate care.

Provincially, Nova Scotia does not have a youth specific mental health policy (Kutcher, Hampton & Wilson, 2010). The province also, as of 2010, had not undergone any of the steps outlined by WHO for creating a youth specific mental health policy or programming (Kutcher, Hampton, & Wilson, 2010). Nova Scotia is one of the 10 provinces and territories that had not done this (Kutcher, Hampton & Wilson, 2010). Within Nova Scotia, youth mental health has been included within lifespan policy (birth-death) and this is expected to continue (Kutcher, Hampton, & Wilson, 2010). This trend of expansive, non-specific policy can be seen in the Nova Scotian provincial policy report *Together We Can* (mental health policy) and its update (Government of Nova Scotia, 2015). Within the five major policy points outlined in the report, only two actions were created specifically concerning the younger demographic, one to do with the SchoolsPlus program to identify at risk children and youth and intervene in the school system and the other to increase funding towards a family support program for parents of children with mental health concerns (Government of Nova Scotia, 2015). This update stated that youth mental health was being successfully addressed through early intervention- though this meant only within school-aged children and youth and only through schools (Government of Nova Scotia, 2015). This leaves a major gap in youth policy for any youth existing outside the school system, a common issue with severe cases of psychosis, and for those who require much more support than SchoolsPlus can provide.

Current Trends in Canadian Mental Health Practice

For Canada as a whole, there has been a push towards practice that is focused on recovery as long-term coping rather than the curing of symptoms (Ramon et al., 2009). The Canadian system emphasizes the elements of recovery that involve community,

personal empowerment and increasing feelings of belonging (Ramon et al., 2009), as can be seen in recovery-supporting collective movements such as Bell's *Let's Talk*. This change of best practices has not been met positively by the community-based organizations expected to deliver it, as the decision was made in a top-down manner without adequate consultation of the community-based groups expected to front this change (Piat & Lal, 2012). The recovery movement, among professionals, is being seen either as a fad or something which has always existed in an unnamed form and therefore now has been unnecessarily mandated by an overarching, unknowing government (Piat, & Lal, 2012). The new changes were also seen as inapplicable to some groups expected to use it, as this recovery-based approach does not mesh well with traditional, biomedical treatments (Piat, & Lal, 2012). This does not mean that all Canadian mental health professionals are against the new emphasis put on recovery, it is just to say that there is growing frustration with all the perceived failings of the Canadian mental health system (Piat, & Lal, 2012).

Despite this change in national best practices, the implementation and usage of this new paradigm has not been as successful as it could have been due to a hesitation to support it under the long-standing Harper government (Ramon et al., 2009). Perhaps, this is why there is so much frustration concerning the new recovery best practices, as those involved felt that they were missing the guiding principles and leadership required to find success in this change (Piat, Myra & Lal, 2012). The current Trudeau government has made efforts to include mental health as a top priority within their budgeting and has promised an increase of 200 million dollars to mental health for Indigenous peoples in the next five years (Trudeau, 2017). This, therefore is promising for improving the Canadian

mental health system, including community-based programming.

Youth Mental Health

Canadian Statistics in Youth Mental Health

Within the Canadian context, there is debate as to whether the prevalence of youth mental illness is increasing in the way mass media would have one believe (McMartin, Kingsbury, Dykxhoorn & Colman, 2014). The varied perspectives within the literature are due to a difference in methodologies within studies, as well as the lack of collected, timely data and the access to it (McMartin et al., 2014). In younger youth (10-15) there has been a stability in the prevalence of anxiety and depression since 1998, though a decrease in conduct and aggression related issues of the same age demographic and depression in those aged 14-15 (McMartin et al., 2014). There has been an increase in the prevalence of ADHD in youth aged 10-13, however, the prevalence of those aged 14-15 has remained stable over the same time period (McMartin et al., 2014). Suicide rates in the same demographic experienced a decrease prior to 2006, when the rates stabilized and have not since experienced a significant change (Rhodes, Bethell, Carlisle, Rosychuk, Lu & Newton, 2013). Of the youth hospitalized for a suicide attempt, males presented with more variability in the method, and in general, a youth suicide attempt was more likely to result in admission to a psychiatric facility after 2006 than before (Rhodes et al., 2013). Despite the stability or decreases seen amongst youth mental illness prevalence rates, it has been posited that the reported increases may actually be happening due to the increased mental health literacy amongst those commonly in contact with youth, however, because treatment and diagnosis are still not being accessed, the statistics do not follow (McMartin et al., 2014).

Youth Experiences with Mental Health Concerns

It has been shown that youth who experience relative stability in their symptoms tend to be of a younger age (Green et al., 2013). Perhaps this is due to more severe concerns, such as psychosis, developing at a later age than some anxiety or mood disorders (the biomedical labels for illness will be used throughout this literature review as the terms are what are used most often in the literature, however they will not be forced on the present study's participants because unlike the literature review, their labelling is their choice) (Public Health Agency of Canada, 2006). This stable symptom group also tends to develop an awareness of the onset of their disorder at an earlier age (Green et al., 2013). This awareness, and potential for earlier, and greater, access to services, may be why youth with stable symptoms also experienced a better life outcome, as determined through functioning ability (Green et al., 2013).

Youth within the mental health system are frequently considered incapable of exerting their agency and thus, denied the ability to be an active contributor to their mental health treatment plan (LeFrançois, 2008). Perhaps this is why there is the belief that the mental health needs of youth are predictable (Anderson & Lowen, 2010), as they are frequently only determined by the psychiatric system (LeFrançois, 2008). This belief may be very different if the system were less hierarchical and exclusionary to the voices and opinions of youth; as youth have reported their treatment suggestions only being seen as valid if they matched the existing treatment plan of the professionals working in the system (LeFrançois, 2008). Youth from LeFrancois's (2008) study (hospitalized for a mental health concern in a psychiatric unit) reported feeling frustrated about the way they are regarded as incapable of rational and informed decisions, while also reporting that

they were not given the chance to become informed (LeFrançois, 2008). Youth with a moderate-to-low diagnosis severity reported to be most satisfied with their relationships with the mental health system and professionals assigned to them (Green et al., 2013). Again, this seems to point to this group being seen as more capable, and thus being given slightly more consultation as practitioners report believing youth should be allowed input, but frequently do not allow this due to safety and a perceived lack of maturity of the youth (LeFrançois, 2008).

Outside of the traditional mental health system, youth still experience differences in mental health concerns compared to adult counterparts. This is problematic, as much of the guiding theory of mental health in youth frequently derives from research in adults (Kranke, Floersch, Kranke & Munson, 2011). Unfortunately, this often leads to gaps in the research, or inadequate clinical approaches, such as that addressed above, as it has been shown that youth do not experience mental health concerns in the same way adults do (Kranke et al., 2011). This difference can also be found in the daily issue of self-stigma, or internalizing mental health stigma (Kranke et al., 2011). When youth are asked it becomes apparent that youth remain secretive about their mental health concerns most often to protect social standing and peer relations, whereas adults use this practice of secrecy most often to maintain employment security, though other reasons may certainly result in this secrecy (Kranke et al., 2011). Youth are much more concerned about their social relationships after the development of a mental health concern than adults are (Kranke et al., 2011). Accepting the idea of having a mental health concern, especially when medication was used, was difficult for youth due to the self-stigma that had been internalized by listening to peers use derogatory slurs towards those with mental health

concerns (Kranke et al., 2011). Thus, for youth, this often led to lying to peers as to what their medications or behaviours meant, even going so far as to not take required medication when in the presence of peers (Kranke et al., 2011).

While there is little known as to how youth conceptualize their recovery (Windell, Normab & Malla, 2012), recovery from a mental health concern in youth is understood as two-fold: coping with the concern and maturation (Braehler & Schwannauer, 2012). Recovery in youth must involve reconciling and coping with the symptoms and other challenges caused by the mental health concern, while also going through the maturing process as an average youth would (Braehler & Schwannauer, 2012). When originally experiencing the mental health concerns, youth may feel as if they have lost their sense of self, potentially leading to feelings of grief, or may employ denial as a technique to deal with the mental health concerns prior to pursuing recovery (Braehler & Schwannauer, 2012). This coping is often done in maladaptive ways, such as through self-medication, which can thus further the challenge of pursuing a successful recovery (Braehler & Schwannauer, 2012). As a whole, the higher the functioning level of the youth, the less negative the coping strategies employed (Brawhler & Schwannauer, 2012). For all functioning levels, prior to and during the recovery process, youth often felt the loss of peers due to their mental health concerns (Braehler & Schwannauer, 2012).

Recovery from a Mental Health Concern

Recovery is a contested topic within the literature as there has been no consensus on how to operationalize the concept (Bonney & Stickley, 2008). This, of course, makes studying the concept difficult. The trajectory of recovery from a mental health concern is not explicit, nor predictable, though there are elements of the process which are

frequently experienced (Chang, Heller, Pickett, & Chen, 2013). Usually, there are four main steps to reaching a recovered state, though these steps vary individually in how they are achieved and the importance which is placed on them (Jacobson, 2001). These four steps involve the original recognition of the mental health concern, obtaining treatment, learning agency within the healthcare system and then obtaining social support (Jacobson, 2001). As per research previously addressed, the step of achieving agency within the system may be very difficult for youth and thus, it is difficult to predict if this model is accurate for all youth.

Despite the variety in recovery trajectories, it has been found that social support is the most important aspect of a successful recovery (Chang et al., 2013). Other important aspects to the recovery process are the types of symptoms to be recovered from and the length they have been experienced for (Chang et al., 2013). These factors were also seen as predictors for long term success in youth recovery (Green et al., 2013). It has been found that the majority of people who are in the process of recovery from a mental health concern (usually in the literature a state intertwined with the DSM definitions of illness) reach a state of recovery that has satisfied them, with over a third of those not recovered expecting to reach a recovered state in the future (Windell, Norman & Malla, 2012). The smallest percentage of the population believe that recovery is a lifelong process (Windell, Normab & Malla, 2012), though potentially, this may change in Canada if the new recovery policies and practices that frame recovery as a lifelong process become more popular. The satisfaction with recovery that a person experiences, and the associated journey, is strongly related to the success one finds in community reintegration and avoiding readmission to psychiatric hospitalization.

Recovery Conceptualizations

A recovery conceptualization is a general approach to recovery. Again, like the recovery process, there is no single conceptualization as these conceptualizations can vary between service users, professionals and the general public (Edgley, Stickley, Wright & Repper, 2012). Policy makers can also drive the recovery conceptualizations most accepted within an area, as is being seen currently in the Canadian context with recovery-oriented care, a best practice based on the conceptualization known as the recovery paradigm (Bonney & Stickley, 2008). Recovery conceptualizations can be reduced to two main fields of thought, the technical and recovery paradigms (see below sections and Background Chapter for a note on terminology choice) (Jacobson, 2001). Also, these paradigms are often unnamed by those who utilize them due to being unaware of their existence, despite, potentially, explicitly following a paradigm when the user's approach is analysed (Windell, Normab & Malla, 2012).

Unfortunately, there is very little known about how recovery is approached in those recently diagnosed with a mental health concern (Windell, Normab & Malla, 2012). Because many mental health concerns develop at a young age (Public Health Agency of Canada, 2006), this then means that there is very little known about the recovery conceptualizations employed by youth. As recovery conceptualizations have the potential to make an important impact on the success of a person's recovery, understanding how youth conceptualize their recovery has the potential to make a positive impact on the long-term life of a youth (Windell, Normab & Malla, 2012).

Technical paradigm. The technical paradigm is, essentially, the traditional biomedical approach to recovery (Bracken et al., 2012). As addressed in the Background

Chapter, the term technical paradigm was chosen over terminology like the biomedical or disease model, because the case study has been heavily influenced by the researcher's background and thus, research from a psychology background was used more heavily. However, this paradigm can also be thought of as biomedical, in which a mental health concern is pathologized and presented strictly as a disorder (Deacon, 2013). In order to reach a recovered state under this model, one must return to their previous, 'healthy' mental health state (Bonney & Stickley, 2008). Treatment is carried out in the same way as it would be for a physical condition, with symptoms being targeted until removed and administered in a way that the illness often remains discrete from other issues within the patient's life (Bracken et al., 2012). While the social influences of mental health concerns are not ignored, they are believed to be less important than the biomedical causes of the mental health concern (Bracken et al., 2012). The treatment system utilized for this paradigm tends to strictly involve the mental health system in the traditional, rigid sense, with physician visits and medication being the primary treatment method (Bonney & Stickley, 2008). This paradigm is strengthened by the medical system's connections to the pharmaceutical industry and by being accepted in society as the normal and most acceptable approach to resolving mental health concerns (Bonney & Stickley, 2008). The individual, recovery-oriented, care now promoted in Canada at the community level is often incompatible with this paradigm and thus, there may be challenges in creating a smooth, holistic system within the country (Bonney & Stickley, 2008).

Recovery paradigm. The recovery paradigm is what Canada has currently been progressing towards (Piat & Lal, 2012). As with the technical paradigm, there are other terms for the recovery paradigm, such as the biopsychosocial model, however, again,

aswith the technical paradigm, the literature used in the present review has informed the term chosen (Deacon, 2013). This paradigm in Canada is much newer than the traditional technical paradigm which dates back to institutionalization and has been influenced by scholars such as Chamberlin (Edgley et al., 2012). In its current state, the recovery paradigm emphasizes functioning and personal responsibility for a person's mental health concern conditions (Edgley et al., 2012). Also, unlike the technical paradigm, health and illness are not seen as dichotomous ideas and the understanding that learning to cope with the condition over the long-term is vital (Sterling, von Esenwein, Tucker, Fricks & Druss, 2010). A person's individual strengths in regards to their recovery and abilities are seen as more important than the illness that has placed them in the mental health system (Gagne, White & Anthony, 2007). Treatment under the recovery paradigm is less deterministic than the technical paradigm, emphasizes multi-disciplinary collaboration to create a sense of community (Edgley et al., 2012) and is arranged with the idea that every door is the right door to access services (Gagne, White & Anthony, 2007). This is difficult to implement as the traditional psychiatric and hospital system does not easily fit within this collaborative paradigm due to remaining entrenched in the technical paradigm (Bracken et al., 2012).

Within the recovery paradigm, there are several sub-approaches to recovery known as the political, and spiritual models (Jacobson, 2001). In the political paradigm of recovery, one achieves recovery through politicizing themselves (Jacobson, 2001), an approach often seen mixed with the recovery paradigm for those who participate in governmental lobbying and protesting (Costa et al., 2012). The spiritual paradigm involves searching for a meaning beyond the immediate experiences of the mental health

concern and the associated restrictive mental health discourses (Jacobson, 2001).

Youth Psychiatric Inpatient Treatment

Following a severe mental health concern, inpatient treatment may need to occur. Inpatient treatment often occurs as a result of the longstanding belief that it is best for all to remove a person with a severe mental health concern from their community to a treatment facility until the person has returned to a normal health state (Mackain, Smith, Wallace & Kopelowicz, 1998). Youth who are hospitalized are most likely to present with a mood disorder (Carlisle, Mamdani, Schachar & To, 2012). For those hospitalized with suicidality and suicidal ideations, the youth were most likely to be female and of an older age, with previous suicide attempts and self-harm behaviours, and to have been referred to through the school system, often in relation to a conflict with peers (Grudnikoff et al., 2015). This suicidality was also frequently predicted by the comorbidity of an adjustment disorder, the relation to peer conflict thus being understandable as well (Grudnikoff et al., 2015). Youth who presented with suicidality were also less likely to have been treated within the formal mental health system, but more likely to be accessing mental health treatment from a guidance counselor within their school (Grudnikoff et al., 2015).

The process of psychiatric hospitalization can potentially result in mixed emotions and reactions among youth. Being admitted, and thus taken out of society, can make youth feel even more stigmatized, especially during the length of the inpatient stay (Edwards et al., 2015). In contrast, youth can also feel more accepted if they are in a psychiatric facility that allows them to be surrounded by young people who also have mental health concerns (Edwards et al., 2015). Outside of emotions related to their social

network, youth can feel frustrated and powerless in the relationship they have with professionals within the psychiatric facility (LeFrançois, 2008). This poor relationship with the professionals can be damaging, as having a positive relationship with professionals and feeling as if their needs are being taken seriously, is important for recovery (Green et al., 2013). These feelings and experiences must be dealt with during the process of community reintegration to ensure success.

In a smooth and efficient system, mental health treatment will not end after release from a psychiatric facility. Unfortunately, in Canada this is often not the case (Carlisle et al., 2012). When youth are released from a Canadian psychiatric hospital, less than half are seen by any type of healthcare professional within the first month and only a third of youth see a psychiatrist during this time period (Carlisle et al., 2012). The statistic of being seen by a healthcare professional jumps up to nearly three-quarters of all youth who have been released from hospitalization after a year (Carlisle et al., 2012). The youth who do access services are most likely to be residing in an urban area, be male, of a high socioeconomic status and diagnosed with a psychiatric or mood disorder (Carlisle et al., 2012).

Transition. An important aspect of the discharge process following psychiatric hospitalization release in youth is that of the transition between life stages and places, especially considering that this stage in a youth's life is already full of change (Rosenberg, 2008). This is especially important when the youth is between the ages of 16-25, as this is considered within the literature to be the at-risk age for youth transitions due to age-outs and biological and social changes (Vorhies, Davis, Frounfelker & Kaiser, 2012). In the present study's context, the main transition for youth participants is the

process of leaving hospitalization and returning to their parent's home or a supervised home of the state. However, the other transitions that occur during this time period cannot be ignored either. In theory, youth may actually be entering a phase of transition through social structures, such as moving from their parent's house or transferring to another school, at the same time as being released from psychiatric hospital. As research question two in the present study is addressing how youth pursue community reintegration, potentially through a multitude of methods, the successes they find during this process would be helpful for determining policy to streamline community reintegration transitions from hospitals.

Transition is not automatically successful following institutionalization in a hospital (Rosenberg, 2008). It involves finding relative independence in regards to various aspects of adulthood, including responsibility for finances and stable housing (Jivanjee, Kruzich & Gordon, 2009). A successful transition has been shown to reduce the potential risk for readmission due to the importance placed on social reintegration and thus, social support, which is vital to recovery (Chang et al., 2013). There is far more to a transition than simply a physical movement, making it an individualized processes and at times, rather complicated (Rosenberg, 2008). Too frequently, when this process is done improperly, youth will regress in their recovery and may be re-hospitalized or become involved in more systems than just mental health, such as the carceral system (Jivanjee, Kruzich, & Gordon, 2009).

Readmission. Considering the relatively low rate of youth mental health treatment access following release from a psychiatric facility, it is not surprising that readmission, or returning to the hospital for further treatment following release, is a

concern in the demographic. In an analysis of the youth who were readmitted to psychiatric hospital, it was found that the shorter the stay a youth had within a hospital, the more likely it was that a youth would need to be readmitted in the future to the hospital for another mental health crisis (Yampolskaya, Mowery & Dollard, 2013). Poor case management, often manifesting in the quantity over quality of services a youth is cycled through, is a predictor of readmission (Yampolskaya, Mowery & Dollard, 2013). This is due in part because mental health resilience, or being able to cope with a situation, in youth is related to the quality of services youth are exposed to, rather than the number of services they are cycled through (Ungar, Liebenberg, Dudding, Armstrong & van de Vijver, 2013). Due to the funding crisis within the mental health system, addressing this issue and relieving the burden of excess, often indiscriminate, service usage, while also at the same time addressing the issue of high readmission rates is vitally important for the mental health system. This can be done, at least in part, through ensuring a smooth community reintegration process following release from a psychiatric hospital.

Community Reintegration

Community reintegration is the process of returning to a place, be it social or geographical, after being away for a period. Community reintegration involves the reforming of the relations the person had to his or her family and friends and re-engaging with important social structures such as the school system (Mackain et al., 1998). In the context of this study, the youth are returning to the larger HRM community, along with more niche communities like their school or university system. The youth may have been in a psychiatric hospital for a short period of time (72-hour crisis watch) or for a longer treatment stay. They also may not have been removed from the community of their own

volition, creating complex emotions for youth attempting to reintegrate.

Community reintegration in youth is unlike that in adults, as adults have primarily determined their own identity prior to this occurring, whereas youth are still in a period of identity formation (Braehler & Schwannauer, 2012). While an individual's identity is subject to change throughout their life, and this is quite a normal process, the present study will from this point on refer to identity change not in response to daily life and socialization, but rather in direct response to hospitalization and thus an abrupt removal from one's expected path (and thus expected identity maturation). Mental health concerns can create immediate changes to a life trajectory and thus, a youth who develops these at a time where they may have previously been concentrating on the more usual identity formation of a teenager, will have far more to reconcile compared to others in their cohorts (Braehler & Schwannauer, 2012). Part of this identity formation and reconciliation after release from hospitalization is in choosing how to accommodate not only their mental health concern, but their understanding of their recovery as well.

Any treatment progression made during the inpatient time must be transferred from the hospital to not only their family and community at large, but also to the school environment where youth must balance their emotional challenges with the academic ones required to advance with their peers (Savina, Simon & Lester, 2014). These societal structures, like schools, therefore are more important aspects of the community reintegration process for youth than adults (Savina, Simon & Lester, 2014). In youth, community reintegration is also aided through mentoring and the opportunity to learn skills, such as employment related ones, which may not have been able to occur prior to the development of the mental health concern and subsequent removal to a psychiatric

hospital (Jivanjee, Kruzich, & Gordon, 2009).

From the perspective of family members, it is believed that the most important aspect of the community reintegration process is to continue to progress and reach goals which allow the youth to feel empowered, while also returning to their peers and previous social relations (Jivanjee, Kruzich, & Gordon, 2009). Blatant symptom related behaviours were also related to parental perceived barriers to reintegrating into the community and the youth being further isolated by others (Jivanjee, Kruzich & Gordon, 2009). This disconnect between what youth desire to pursue during reintegration, such as the frequent acts to isolate or hide themselves from an identity of someone with a mental health concern for social stability reasons, and what their parents do may explain the tense relationships between youth and parents that often occur following community reintegration (Braehler & Schwannauer, 2012). This tension was lessened if a youth was of a higher functioning ability (Braehler & Schannauer, 2012), though this may also be connected to social abilities being stronger and thus being able to comply with parental desires.

Emotionally, the frustration at parents and guardians is not the only response to the recovery and community reintegration process that youth experience. Often, the fears associated with this process lead to isolation and mistrust of others following release so as to avoid peers discovering their mental health concern (Braehler & Schwannauer, 2012). This fear may also lead to the adoption of a false identity of one who is free of a mental health concern (Braehler & Schwannauer, 2012). For those with a low-functioning ability, there may be an inability to adequately plan life goals and be independent in the community (Braehler & Schwannauer, 2012). There may also be issues with indifference

and loss of affect in regards to the process, especially when psychosis is present (Braehler & Schwannauer, 2012). For youth with a higher level of functioning, there tends to be a grieving process of what was lost during their period away from the community that involves anger prior to the acceptance period (Braehler & Schwannauer, 2012). While community reintegration is a difficult emotional process, it is one that a youth with high functioning will find easier to take responsibility for (Braehler & Schwannauer, 2012). Anxiety is a common emotion felt among many youth undergoing this process, especially in regards to their peers and whether they will be accepting or further isolating (Savina, Simon & Lester, 2014). These emotions are not ones which youth can deal with alone and thus, accessing community supports are vital.

Community-Based Mental Health Centres

Community-based mental health centres in the context of this project, as previously touched on, are centres located outside the traditional medical system that traditionally focus on recovery within the community and outside the hospital. Canada is currently moving towards a system which relies more heavily on the recovery movement within these centres (Piat & Lal, 2012). Many other countries are also moving towards valuing recovery, yet there are challenges with this, as recovery in the community is poorly defined (Le Boutillier et al., 2015). Trying to define recovery for these centres, however, is very problematic and is frequently criticised by all involved (Le Boutillier et al., 2015), creating a catch-22 for operations. Literature has shown that, even without defining recovery, focusing on characteristics like empowerment is very beneficial within a community-based mental health centre (Jorge-Monteiro & Ornelas, 2016). It has also been shown to be important if providers within the centres, provide respect for consumers

and helping consumers feel respect for themselves regarding recovery (Russinova et al., 2011). Thus, it is not about the boundaries of what is thought to be possible, but what the consumer feels to be possible.

There is a belief that recovery-oriented programming is strictly for those who have experienced psychosis and thus need support for existence within the community (Slade et al., 2014). However, this is not true (Slade et al., 2014). Community-based mental health centres are useful for those who are still experiencing acute crises issues, as well as those traditionally seen as not requiring this service for community integration, like those who are not experiencing psychosis (Slade et at., 2014).

The usefulness across consumer populations is because there are many benefits for those with mental health concerns to join community-based mental health centres. Community-based mental health centres that utilize a focus on recovery through empowerment and community integration has been shown to be highly beneficial for youth (Jorge-Monteiro & Ornealas, 2016). This type of community programming has been shown to have an improved capacity for guiding those in its programming through employment and housing initiatives for recovery, rather than programs which do not focus on empowerment and related characteristics (Jorge-Monteiro & Ornealas, 2016).

For youth, the support services deemed as most important are those that are strongly community-based and involve skill building elements (Agnihotri, Keightley, Colantonio, Cameron & Polatajko, 2010). These supports are most beneficial because they can reflect what youth will be forced to deal with outside of the mental health system during transitions and thus both work to increase community reintegration while also teaching skills to aid future success (Agnihotri et al., 2010). Unfortunately, there is

very little known on how effective these community-based programs are for youth when undergoing community reintegration (Agnihotri et al., 2010), as the challenges and benefits addressed above are from a mostly adult perspective.

Community-based mental health centre workers. The workers of community-based mental health centres experience are vital for the success of the programs. However, they do experience many challenges, because of the current Canadian mental health system, as alluded to previously. This movement towards recovery without operationalizing the definition, has created challenges because of conflicting expectations (Piat, & Lal, 2012; Le Boutillier, et al., 2015). Managerial service and personal recovery often have differing perspectives and expectations, yet, may all be expected in the same institution and by the same workers (Le Boutillier et al, 2015). The conflicts caused by this has resulted in higher burnout and exhaustion in workers as they attempt to fill too many roles within a single position (Green, Albanese, Shapiro, & Aarons, 2014). Role overload may also result in workers in feeling disconnected from their consumers (Green et al., 2014), an issue considering consumers appreciate a connection and understanding with their providers regarding pursuing recovery (Russinova et al., 2011).

Other Community Supports for Successful Community Reintegration

Integral to a successful community reintegration is finding community support. The impact of community-based mental health centres have has already been addressed, but there are other points of contact youth have when undergoing community reintegration. Again, like most things regarding mental health, there is no uniform approach or consensus surrounding which community supports are the right combination for any one person (Tew et al., 2012). The service supports found within the community

are needed to ensure recovery continues to progress, especially ones which can help with the symptoms of a mental health concern (Chang et al., 2013). This support may be in the form of service support or social support. However, social support is seen as being more important than the services accessed (Tew et al., 2012). This social support, when coming from peers, has been deemed very important for the long-term maintenance of community reintegration in youth (Mirza et al., 2008).

School. What is known about community reintegration in youth through a support system is primarily through schools and employment programs, understandable due to the captive audience and collecting grounds those social structures entail. The school system is one of the first places a youth will return to, following release from psychiatric hospitalization (Savina, Simon, & Lester, 2014). Schools have been studied in this capacity, albeit infrequently, like the majority of youth mental illness community reintegration (Savina, Simon & Lester), as schools are set up in such a way that they can be used as a central point for mental health services and work to circumvent some system barriers (Stephan, Weist, Katoka, Adesheim & Mills, 2007). Schools have also been working to implement anti-stigma programming (Stephan et al., 2007), important in order to minimize the stigma that can lead to isolation for youth with mental health concerns (Jivanjee, Kruzich & Gordon, 2009). Considering this, it has been posited that schools are the most important location for youth community reintegration as they have the potential to provide services needed to maintain the recovery advances that occurred in hospital while also providing social support for the youth (Savina, Simon & Lester, 2014). Unfortunately, research on youth community reintegration following psychiatric hospitalization only began in 2008 (Savina, Simon & Lester, 2014) and therefore, it is

hard to tell if schools are in fact the most important location for community reintegration, or if they are simply the most researched, important to understand as youth will age out of the school system before they reach the end of the at-risk transition age (Vorhies et al., 2012).

Employment. Considering the age-out which occurs in the school system, it is also important to consider how employment helps to maintain community reintegration and recovery success in youth. Employment, and the related elements required to maintain and advance within a career, have important implications for feelings of belonging in the greater community (Killackey et al., 2016). Youth with severe mental health concerns found more success in returning to work when this process was done through an individual placement program, allowing for mentorship (Killackey et al., 2016). Skills required for obtaining successful employment and community reintegration over the long-term are connected to how long a youth is enrolled in an individual placement program (Vorhies et al., 2012). This type of program is especially important for those with psychosis as they tend not to have a stable past experience with employment (Vorhies et al., 2012). Perhaps this is because psychosis tends to develop at the same age (Public Health Agency of Canada, 2006) as many are pursuing their first formal jobs and thus, by being removed from the community to a psychiatric facility, this cannot happen. Individual employment placement can also provide social and emotional support for the youth (Vorhies et al., 2012), similar to what can be found in schools and deemed important for a successful community reintegration (Savina, Simon & Lester, 2014).

Purpose and Research Questions

The overall purpose of this study is to explore how a youth's recovery conceptualization can impact, be that help or hinder, his or her process of community reintegration following release from a psychiatric hospital. The research questions are as follows:

1) How do youth conceptualize their own mental illness and recovery process?

2) How is community reintegration pursued by youth?

3) How does a youth's recovery conceptualizations impact the community reintegration process?

Chapter Two Summary

This chapter has outlined the current literature concerning youth mental health in Canada, how recovery is conceptualized and pursued, how mental health concerns can cause youth to be removed from their community and the challenges of their subsequent return. As can be seen in this literature review, there are distinct gaps in the literature, namely the absence of knowledge of how youth conceptualize their recovery (Windell, Normab & Malla, 2012) and how community reintegration can occur outside of direct school or employment programming among youth with mental health concerns (Savina, Simon & Lester, 2014). These gaps will be addressed in this current study by exploring how the recovery conceptualizations youth employ following release from psychiatric hospital can impact their recovery, as facilitated through community-based mental health centres. The following chapter will outline the specific methodology and methods that will be employed to complete this study.

Chapter Three: Methodology

Methodology, Methods, and Design

This study used an inductive, exploratory qualitative methodology due to its ability to discover and understand the meaning of a certain phenomenon, experience, or subjective reality of an individual (Crowe, Inter, & Porter, 2015). In healthcare research, qualitative methodologies of knowledge generation allow for an expansion of the traditional quantitative data that practices and policies are often based on (Braun & Clarke, 2014). This is especially important within mental health research as there are so many intricacies to the reality of those experiencing mental illness which must be considered.

This need for a deeper understanding of said intricacies fits well with a social theory case study on the *process* of recovery following hospitalization in relation to recovery conceptualizations. Case studies recognize, despite beliefs in the opposite, that there is importance to a context-dependent knowledge generation, and thus the specific nature of the methodology is not an automatic hindrance to research (Flyvbjerg, 2006). It also allows for flexibility within the method (Merriam, 2009), important considering the relatively small literature base concerning youth community reintegration and an extremely relevant feature for this current study.

The driving methodology for the present case study was Mirriam's (1998) case study work which, as previously stated, allowed for a flexible qualitative approach that utilized participant interviews, document review and researcher reflexivity to build a robust knowledge base. While there are multiple forms of case studies, the present work utilized a process case study methodology (Mirriam,1998). A process case study is not a

case study of a person or place or single case or experience. It is not exclusively tied to, nor focused on, the individual people or places involved, but rather the *what* and *how* involved, therefore providing a deep understanding of the process, and appreciating the participants, while centralizing an experience, not an individual.

The process detailed in this case study was recovery, specifically recovery as part of community reintegration for youth following hospitalization. As per Mirriam (1998), by bounding a case-study by philosophical parameters, such as a process or phenomenon, one can detach the methodology from any one person or place as a central focus. Due to the present case study being bounded the process of recovery, it is far easier to protect the anonymity of places or people as the case study is not *about* them, in any way more than another qualitative study with a variety of participants is individually about them. It was this that made a process case study an appropriate choice for the present study because the methodological approach helped protect the participants by focusing on their experiences rather than their identities while also illuminating the practices that allowed for (or did not) their successful recovery within the context of community reintegration. The process case study also allowed for an in-depth examination of a very specific process which had the potential to illuminate social theories and practices, while also providing information that can be used to form future studies of a less narrow nature, arguably a more common occurrence in research (Becker et al., 2012).

The theoretical framework for this study was social constructivism. Social constructivism appreciates the multiplicity of life experiences, rather than attempting to reduce such experiences to a singular, *right* one (Creswell, 2014). The subjective nature of this worldview fits well with qualitative research and was especially helpful for the

current study due to the inclusion of social, cultural and historical aspects of the creation of meaning (Creswell, 2014). This was important as this study considered mental illness as something apart from the dichotomous biomedical approach. While there are indisputable biomedical elements to some mental illnesses, it was recognized that the language used to describe the nature of various mental illnesses is not intrinsically medical, or designed specifically for such a purpose, but rather utilized from a wider language to construct societal understandings of mental illness (Walker, 2006). Finally, social constructivism allows for the researcher to be included within the study's positionality and allows that to impact the study's analysis (Cresswell, 2014). As can be seen in the positionality section of this chapter, this is important for the current study, while also being a modality for this case study (Merriam, 1998). Social constructivism also fit well with the chosen methodology as the case study used Braun and Clarke's (2006) work to tease out themes found during the analysis. In fact, Braun and Clarke (2006) explicitly addressed that this analysis method was designed in such a way to make it highly compatible with a social constructivist worldview.

Participants

Two groups of participants were used for this case study. The first group was the youth actively participating in community reintegration as part of their recovery process. They provided a first-person viewpoint on operating within the community during recovery. The second group was that of the workers who served them within the context of a community-based mental health centre. This voice may not have had any first-person experience, but rather was primarily used to provide information regarding how the system operated from someone who was an insider within the institution, rather than an

outsider trying to access it, as a youth was. Their voices served to both confirm, and provide a contrasting perspective, to the youth and thus, the inclusion of this participant group provided a more robust series of findings.

Recruitment was for youth participants aged 16-25 years, and included all genders and identities. The only criteria for youth participation in the study were meeting the age requirements and having been hospitalized for a mental health concern and released sometime in the past two years (done so that long-term community reintegration was still ongoing, or recently finished). This wide acceptance was done for several reasons. The age range was chosen as many mental health concerns tend to develop during the period of emerging and young adulthood (Public Health Agency of Canada, 2006) and those within this age range tend to be highly impacted by socialization, an important aspect of community reintegration.

Regarding recruitment inclusion/exclusion, not limiting the participants to those of a single diagnosis allowed for the spectrum of mental illness to be present. The lack of an exclusion based on diagnosis was done to appreciate the multiplicity of experiences that are not necessarily predictable or predetermined by a medical label, as well as to not exclude those without a medical label, or those who chose not to accept the label given to them. This study did not limit the validation of experiences worth studying to one illness or treatment trajectory. The study's researcher has chosen in her life to utilize the biomedical definition for her mental health concern, however she recognizes this is not something all will do and thus recognized the choice the youth made themselves regarding their own definition. This is also why the researcher chose not to include demographics as the youth disclosed as they chose to and thus, respecting a youth's

agency was more important than taking a specific position on the medicalization of mental health concerns.

Two youth were interviewed for this case study. Both were females within the age range (18 and 21) who had been hospitalized in long-term stay units multiple times. Their diagnoses were varied and comorbid and included anxiety and eating disorders (it was not a requirement for the participants to disclose official diagnosis, as this has a bias towards a medicalized perspective that was not being sought in this project. However, they did choose to reveal information during the interview regarding their diagnosis). Jenna (alias chosen by participant) was the oldest participant (21) and was in university within the same city as the community-based mental health center she was recruited from. She had been hospitalized multiple times, both in the child and adult system. Em (alias chosen by participant) was much younger than Jenna (18) and had left high school prior to graduating but was excited to pursue a diploma in a local training program that started within a few months after spending a time homeless in the city.

The second group interviewed was made up of two community-based mental health workers. They were from a small centre serving youth of the age bracket interviewed, and of all identities and stages of the recovery process. Mike (alias chosen by participant) was a community support worker who was involved tasks such as resume development and recovery planning. Mike disclosed that he had no first-person experience within the mental health system, while Alyssa (alias chosen by researcher as the participant did chose her own when asked) did not disclose the nature of her experiences. Alyssa was a peer support worker who was involved in much first-contact work with youth new to the centre.

Setting and Recruitment

The overall study was completed in the HRM region of Nova Scotia, Canada and within community-based mental health centres that served youth. Youth participants were recruited from various community-based mental health centres, whereas workers were recruited from a single centre as that participant group arose from a recruitment issue and project change (to the current process case study). The organizations involved were the ones which serviced youth experiencing a variety of mental health concerns and stages of the recovery process within the city. These community-based locations are often important steps for youth in HRM following release from a psychiatric hospital if youth were looking to maintain treatment outside of traditional clinics due to the wide range of supports, traditional and alternative, which could be found in them.

Initial recruitment of youth was done through posters (see Appendix A). The posters were placed in the centres by the researcher, or by the centres themselves depending on permission. Interested youth were asked to contact the researcher via the poster and after initial contact, a formal recruitment letter was emailed to the potential participant (Appendix B). Youth who completed the interview were also asked to inform any peers who had also been hospitalized for a mental health concern of the study, so participants could be gathered using a snowball technique (see data collection for more information). This technique was not successful, but more information on this can be found in the limitations section of the discussion chapter. A $15 Tim Hortons card was given to each participant for agreeing to take part.

Worker participants were recruited via a direct email to the address posted on their center's webpage (Appendix C). The potential participants were asked to reply to

the researcher, with a one week follow up sent should no answer be given (Appendix D). The worker participants were given a $20 Tim Hortons card for participating (the increase in value done between youth and worker recruitment in an attempt to get more youth participants, however this was not successful and no youth approached the researcher during the $20 recruitment period. The smaller amount for the youth was not a response to their age or privilege but rather was the result of various research ethics changes that came after the youth interviews).

The interviews were held in a private space on the Dalhousie University campus. This reduced the chance for unintended public disclosure of the youth participant's mental illness, and therefore, will avoid the negative impacts that non-selective public disclosure can have (Corrigan & Matthews, 2003). Public disclosure was not a large issue for workers however, as their institution was supportive of these interviews and provided such an endorsement in writing. Prior to the start of the interview, the participant went go over the consent form again with the researcher. Participants were given a chance to pick their alias for privacy before the recorder was turned on. The interviews continued in a semi-structured nature until the questions were finished. Following the interview, a pamphlet of services (designed and disseminated by the IWK hospital) was given, and consent to include interview quotes and aliases in the analysis portion of the study was once again sought. The interviews took, on average, an hour to complete.

It was important to be cognizant of anxiety and other mental health issues which may make the interview difficult or uncomfortable for participants. To make the participants more comfortable, several support items were provided on the interview table. These included a bowl of candy and, several basic fidget toys and a stress ball.

These may seem frivolous, but in reality, had the potential to add a high level of comfort for the participants and were utilized by them.

Data Collection

Data collection was a multi-modal (interviews, researcher reflexivity, and document review), social theory case study of a process. The interviews were completed by the primary researcher only, in face-to-face interviews with one participant at a time. This not only increased levels of confidentiality, as sensitive topics were discussed, but also aided in the interpretation of the data during analysis due to the familiarity with that transcript required for a deep level thematic analysis (Braun & Clarke, 2006). Using a semi-structured interview guide, participants were asked questions for a period of approximately an hour, as dictated by the length of the participants answers (Appendices H and I). The data collected related to the experiences youth have with community reintegration and their individual recovery conceptualizations.

The interviews were audio-recorded to allow complete transcription of the interview data. Following the interviews, participants were given the opportunity to redact portions of the interview or the interview as a whole, prior to it being included within the larger data corpus for analysis. This opportunity was given in recognition of the personal nature of mental health concerns, as well as because people in various stages of recovery, and diagnosis acceptance, were be interviewed. This opportunity was open until the end of the recruitment period but was not utilized by any participants

A document review of information placed online from the chosen community-based mental health centre was also carried out to round out the case study's data corpus. The document review utilized documents, such as community reports and newsletters, put

online by the community-based mental health centre and thus was in the public domain. These documents were examined for recurring themes or information that either matches or counteracts the information produced through the two sets of interviews. All information taken from the online reports were completely de-identified. This information was used to make the full data corpus more robust.

Data Analysis

Interviews

Thematic analysis is a robust framework, frequently used in qualitative work due to the systematic nature of the method (Braun & Clarke, 2014). While this study had an overarching methodology of a case study, which is often associated with a more in-depth narrative analysis, the researcher chose to use a structured approach to analysis by using thematic analysis for the interview analysis. Thematic analysis has been well accepted within qualitative research (Crowe, Inder, & Porter, 2015). The researcher felt it was important to have a methodology that provided firm guidance considering the reflexive nature of another modality (researcher reflexivity) and the third which looked to confirm or counter the results of the interview analysis without any explicit steps (document review). Choosing thematic analysis for the transcript interview analysis instead of developing a case study narrative throughout the entire project helped balance the level of structure in the analysis. Considering the hesitancy surrounding case study results for policy and decision makers, and the goal of this project to provide recommendations to better the system, it seemed an appropriate choice to utilize, at least partially, a previously accepted form of analysis.

Thematic analysis allows for the interpretation of a volume of qualitative data (in

this case interview transcripts and online documents) through the analysis of overarching patterns (Crowe, Inder, & Porter, 2015). This method was chosen in part because of its flexible interpretive nature, but also because it allows the integrity of often unheard voices to remain intact (Braun & Clarke, 2006). This study utilized a realist thematic analysis framework to understand the reality of undergoing community reintegration with mental illness and the experiences related to this process (Braun & Clarke, 2006). Realism is a framework which allowed for both the description and examination of the reality experienced by participants (Braun & Clarke, 2006), important due to the potentially reality-altering nature of certain mental health concerns.

In order to carry out the analysis, each interview was transcribed by the primary researcher and stored on the researcher's password-protected hard drive as script. Each individual script was then reviewed by the researcher for accuracy with the recorded interview and to ensure formatting is correct. Once accuracy was confirmed, all identifiers within the script were removed and the chosen alias of the participant was added to the document name and in any script blanks caused by the removal of personal identifiers. This process, and the subsequent studying (read and reread) of the transcripts, was the first step in completing a thematic analysis and was completed with each transcript as it was transcribed, as recommended in Braun and Clarke (2006). All data was coded by the primary researcher to ensure familiarity with the data and its complexities prior to analysis. With the achievement of familiarity with all transcripts, the second step of the analysis began which involved the coding of all documents (Braun & Clarke, 2006). To do this, the data was coded directly on interview transcripts using a colour coding procedure with code-supporting quotes being copied onto a master

document of all codes. After reviewing the codes, and a solidification of them through the removal of repetition or vague wording, the process of searching for main themes began (Braun & Clarke, 2006). This process continued until the themes were fully decided upon and then following a review of them, the themes were clearly defined and written up in a coherent narrative (Braun & Clarke, 2006). Following this, the analysis was complete (Braun & Clarke, 2006). Throughout the entirety of this process, Microsoft Word programming was used to manage the transcripts and master-code and theme documents.

Document Review

The third modality for analysis in this case study was a document review that followed guidance and suggestions found in Bowen's (2009) document analysis work. The document review occurred after the thematic analysis of interview transcripts. This portion of analysis served to situate the answers of the participants who were interviewed both against and within the perspective of the administration of a community-based mental health centre (the publisher of such reports), as per Bowen's (2009) work on document analysis and suggestion of using documents as a way to situate other data in a larger context. The document review also expanded on the data that could be used for the case study (Bowen, 2009), which Merriam (1998) discussed as important for increasing the robustness of a case study.

The document review examined five documents (all the newsletters and community reports which were available online and thus within public domain). The material within the documents was studied and compared and contrasted to the information found within the interview thematic analysis. The passages within the documents were read for their deeper meaning (i.e. program legitimacy), as well as the

surface quotes (for the purpose of comparing language, priority of issues and solutions, etc.) (Bowen, 2009). The purposes, audiences, credibility and biases of the documents were also considered as this data would help explain the underlying meaning of each passage within the chosen documents (Bowen, 2009). Once all five documents were reviewed for their content and latent meanings and purposes, the findings of the analysis were situated within the larger social, political and economic climate of the community-based mental health centre as a way to bring depth and context to this section of the case study.

Ethical Considerations Summary

The youth participants of this study are traditionally seen as vulnerable because of their age and mental health concerns. Imposing the label of vulnerable and its connotations on the youth was done only in terms of research ethics, not to reinforce the social issues around mental health stigma. Safeguards were put in place in the case that the youth did feel vulnerable and oppressed.

The youth participants were also recognized as being marginalized due to the societal stigma of mental illness which pushes those experiencing mental health concerns outside of the accepted and understood. The youth being interviewed were undergoing the process of community reintegration and attempting to find a new space within society but still in a marginalized space. In order to safeguard this process, the participants were provided with support items, as previously stated, to add an element of comfort to the interviews and following the interviews, were given a pamphlet of existing services within the HRM region that the participants could access. Also, participants were accepted within a community-based mental health centre. These centres employ their

own counselling staff and frequently operate peer-support programming. Therefore, participants already have a support staff to access, should it be needed, which decreased the risks of this study. The researcher is not aware of any conflicts of interest with the participants.

For worker participants, they were not recognized as being part of a marginalized or vulnerable group. They are adults who were holding down employment, and are trained to work in mental health. Their centre was fully supportive of the project and its employees participating in the studies. Thus, risks or discomforts were low. The time commitment for an interview was the biggest discomfort, but there was a chance that participants may have been uncomfortable with providing information about their workplace. None of the interview questions directly asked about a participant's work habits, or their relationships at work and all client information was asked in a way that was generalized and suggested most common occurrences surrounding recovery in the community. This was done to lessen any chance of risk or discomfort. It was also stressed that participants would not be linked in any way to their workplace, which remained unnamed and all identifiers were removed from their transcripts. Participants were also reassured that they could decline to answer any question or leave at any time with no negative repercussions.

Consent and Privacy

After contact was made, youth participants were provided with a formal recruitment letter (Appendix B) and consent form via email (Appendix E), and worker participants were provided with a consent form in relation to their recruitment letter (Appendix F) and given the opportunity to ask any questions they may have. Following

this, a date and time for the interview was selected with the participants. Prior to the start of the interview, the researcher went over the consent form again, answering any questions arose and then began the interview should consent be granted. As part of the informed consent process prior to the start of the interview, it was made explicit that participants could leave at any time without penalty and should they choose not to have their data included, it would be destroyed. Once the interview was completed, the participants decided if they were still amenable to their data being included and if not, the data was destroyed. This was done so as to ensure the consent procedure was explicit and participants were comfortable with, and aware of, their right to withdraw at any time with no penalty.

Participants were recruited from community-based mental health centres in which, for youth, their identity as someone with a mental illness had already been disclosed to workers and fellow youth in the programs and the workers had a position of power within the centres. As already stated, this disclosure and the location of the interviews (either the centre or a private, neutral, non-marked space), acted as a protective feature against non-selective disclosure and the potential negative effects of that. All consent forms were kept in a locked filing cabinet. This was the only space where the participants' real names were written as all transcripts and analysis documents utilized the participants' chosen aliases. The consent forms had a number in the corner which corresponded to a linking document where the aliases were kept (a correspondence with consent forms was needed in case transcript review was requested by a participant to find the correct one). This linking document can be seen in Appendix G and was done to further protect the privacy of participants. Data was audio-recorded on a recorder and

then immediately transcribed afterward and deleted. All transcripts and coding documents were kept in a locked filing cabinet on a password-protected file on the researcher's external hard drive.

Risks and Benefits

There were several potential risks to participants in this study. These risks related to the nature of the material being discussed in the interviews. As youth participants were speaking about their time in hospitalization and the struggles that they have felt as they attempted community reintegration, there was a chance for the youth to feel emotional and vulnerable when relating this information to the researcher. Youth may not have had the opportunity to process their illness and the recovery before their interview and thus confronting the realities of their illness and recovery may have been difficult. Worker participants did risk disclosing something about their work which potentially should not have been disclosed. However, as previously stated, the centre provided written support for their employees' involvement and none of the questions asked about the workers direct work habits or personal practices; instead they focused on the process of recovery of youth who have been involved their centre from a more top-down perspective.

As stated above, the participants were provided with pamphlets containing mental health services in the area designed by a local hospital and had access to the centre they were enrolled in's support staff and programming. This helped mitigate issues surrounding a mental health crisis, should one have arisen for the participants (a crisis did not occur during any interview). The support items were also used to help participants calm any stress they may have experienced during the interview. Also, to help mitigate interview stress, it was emphasized that participants could withdraw at any time should

the interview become too overwhelming for them.

There were no immediate direct benefits to the participants aside from the $15-$20 Tim's Card and any candy they may have consumed or taken with them following the interview. Youth participants may also have felt a return of their agency through being interviewed and allowed to tell their story, a conclusion found in Lefrancois's (2008) work on children and youth in a psychiatric hospital. The indirect benefits were (and are) more widespread. The indirect benefits for the participants involved feeling that they were helping to inform policy and practice change recommendations, so future youth may experience a higher degree of success when undergoing community reintegration following hospitalization. The information found in this study will also be used as support for advocacy work surrounding personal empowerment and recovery in youth in the mental health system.

Researcher Details and Positionality/Reflexivity

The researcher was the sole interviewer and only person involved in the coding and analysis of the data. The supervisor acted as a peer reviewer for the creation of interview questions and as an independent reviewer of the data analysis process. The relevant experiences of the researcher include a B.Sc. honours degree in psychology and sociology and current enrollment in a Health Promotions Master's program. Within the undergraduate degree, the researcher completed two different research methods courses (including qualitative, quantitative and mix-methods), an advanced design and analysis course and a specifically qualitative methods course. Another statistics course was taken during the Master's program. The psychology honours (and sociology minor) degree included two research projects, a thesis and an independent study within the context of

the qualitative methods course. The thesis involved interviewing social stakeholders (or workers) involved in the care of children and youth with complex health conditions, often youth with severe mental health concerns. The independent study the researcher completed was a spatial analysis of youth mental health access in Nova Scotia (the location for the current study), therefore the researcher has an academic background in both the population and mental health system to be studied. The TCPS 2: CORE ethics certificate was also obtained by the researcher. Outside of academia, the researcher has spent several years engaged in mental health advocacy work with a variety of charities and groups, specifically involved in youth help-seeking, the impacts of stigma and students with mental health concerns in academia. As this advocacy work has taken place in Nova Scotia and New Brunswick there was the potential for participants to have a knowledge of the researcher. No conflicts of interest were expected despite this, as there had been no prior working relationships with the youth or workers who were recruited.

It is important to consider several attributes of the researcher as direct interactions with the participants will occur. The researcher is young (at the higher end of the youth participant recruitment range). For youth participants, this age was helpful as the researcher was seen as a member of the cohort and therefore the youth may have been more comfortable in answering the personal and sensitive questions surrounding their experiences. Unfortunately, if youth participants found themselves anxious around their cohort, this would present the potential to be challenging to be open and candid during the interview. The support items seemed to be more helpful negate this issue as youth participants were quite open and expansive in their answers.

Most importantly, it should be noted that the primary researcher identifies as

someone who is both an insider and outsider, occupying the "space between" the positionality dichotomy (Kerstetter, 2012). The subject being studied is not one the researcher has experience in, yet, identifying openly as a mental health consumer has an intrinsic element of community understanding to it. As Dwyer and Buckle (2009) stated, a qualitative researcher with an insider perspective is not automatically different in quality, the researcher is simply different in approach.

The participants were made aware of the insider status of the researcher following the participants answering questions about their own recovery conceptualizations and beliefs, so as not to bias those answers of participants. It is typical that participants are more candid and honest in their interviews when they are aware of a researcher's insider status (Dwyer & Buckle, 2009) and this certainly occurred in the present study.

Chapter Three Summary

This study utilized a robust and systematic qualitative framework known as thematic analysis (Braun & Clarke, 2014) to provide structure for analysis for the process case study bounded by the context of recovery as an act one undertakes (Merriam, 1998). The process being explored was the experience of community reintegration and recovery conceptualizations of youth from a small Eastern Canadian city. The two youth participants, Jenna and Em, were between the ages of 16-21 and had been hospitalized for a psychiatric condition within the last two years. The worker participants, Mike and Alyssa, were employed at a community-based mental health centre in the same region. This method allowed for the integrity of the participants' voices to remain intact (Braun & Clarke, 2006), and authentic, an issue in youth mental health work as highlighted by Lefrancois (2008), while also placing the youth within the context of the greater system.

Through careful consent procedures, being cognizant of non-selective disclosure and the provision of support items during the semi-structured interviews, the ethical concerns of this study were minimized.

Chapter Four: Results

The overall purpose of this study was to explore how a youth's recovery conceptualization can impact (help or hinder), his or her process of community reintegration following release from a psychiatric hospital. To do this, the study utilized the following research questions:

1) How do youth conceptualize their own mental illness and recovery process?

2) How is community reintegration pursued by youth?

3) How does a youth's recovery conceptualizations impact the community reintegration process?

The answers for these research questions were sought utilizing a process case study bound by recovery in the community, utilizing Merriam's (1998) method.

As introduced within the methodology chapter, four participants were interviewed for the case study. The youth, Jenna and Em, and the workers, Mike and Alyssa, were interviewed and the participant groups were analysed separately for codes and then the codes from both sections were collated and themes were determined. All newsletters (3) and community reports (2) that were published online from the community-based mental health centre the workers were employed at were also analysed for their content. The documents were used, as Merriam's (1998) suggestion, in a review to increase the robustness of the case study findings. Also, the researcher has addressed her subjectivity and perspective on the matter of the results.

Interview Results

Primary Codes

A breakdown of the codes within the themes can be found below. A total of 20

codes and 10 sub-codes developed from the youth interviews and 20 codes and 8 sub-codes developed from the worker interviews. While the codes developed slightly differently between the two sets of interviews, there were many similarities across them. For example, both groups talked about a lack of a specific operational definition of recovery, however youth addressed the requirements for reaching a state of recovery in a more grounded, daily functioning way whereas workers spoke about this same process as a hierarchy developed through social expectations (i.e. returning to work being a sign of recovery success). This allowed for both youth and worker codes to be combined into a total of four themes regarding community reintegration of youth following psychiatric hospitalization and their recovery conceptualizations.

Table 1 is the breakdown of the codes in relation to the research questions. Codes that arose from youth interviews are italicized, whereas the worker interview codes are not.

Table 1.

Codes and sub-codes in relation to research questions from both participant groups.

Research Questions	**Youth Code**	**Worker Codes**
How do youth conceptualize their own mental illness and recovery process?	Mental Health vs. Physical Health	Recovery Definition
	Recovery as Day-to-Day Functioning	Hierarchy of Recovery
	Recovery as Individual	The Typical Lifestyle
	Recovery as Acceptance of a Lifelong Process	Recovery as Lifelong
	Requirements for Recovery	Recovery as a Non-Linear Process
	Personalization of the Condition	Agency and Acceptance

Research Questions	Youth Codes	Worker Codes
How is community reintegration pursued by youth?	Feeling Out of Control	Control -Needs Changing Throughout Recovery
	Relationships to Community Infrastructure - In Hospital	Changes Leaving Hospital
	Tricking the System /Taking Matters Into Their Own Hands	System Literacy
	Returning to the Community Challenges - Employment - School	Changes in Identity
	The Health Care System	Personal Changes -Returning to Relationships -Returning to Negative Habits Doing Things Slightly Differently Working at a CBMHC Issues with Hospitals -Personal Experience Shaping Recovery -Setting the Tone Issues with Government Programming/Funding -Wait Times Support -Family Support -In School
How does a youth's recovery conceptualizations impact the community reintegration process?	Recovery and Relapses	Aging Out/Transitions
	Life Goals	Moving on from the CBMHC
	Dream Service	Goals
	Hospital Treatment -Staff Experiences	Socialization

Research Questions	Youth Codes	Worker Codes
How does a youth's recovery conceptualizations impact the community reintegration process?	Coping Methods - Unhealthy - Relearning/Learning New Methods Afterwards -Feeling in Control Life Experiences as Learning Recovery Lessons (or Lack Thereof) while in Hospital Awareness of Others Struggles Relationships in the Community After - Family -Social -Fear from Others	Art as Catharsis

Research Question One: How Do Youth Conceptualize Their Own Mental Illness and Recovery Process?

Youth conceptualized their mental illness and recovery in varying ways. There was no central way recovery was conceptualized, though it did skew towards the recovery paradigm in which functioning was valued and mentioned more than any other approach to recovery. Em's goal, when asked about what recovery meant to her was: *"Um, becoming, well maybe not becoming, but growing into a functioning human being. A functioning adult maybe, depending on your age."* This was also noted by Mike, a worker who often dealt with clients seeking the expected final steps of recovery (employment and education):

> *"Um, it is not the type of thing that I said has a beginning and an end. A lot of times with mental illness it is something that you need to learn to independently live with and uh, instead of uh, you know, having the notion that someday you'll be cured, because it's not really reality."*

This functioning was seen as life-long and a process which was individual. There

was no set hierarchy of recovery steps, despite beliefs that there was one expected by society and thus the process was very non-linear. This reality was in distinct opposition to what society desires with the technical paradigm and it was noted that this desire vs. reality was apparent in the changes in one's recovery conceptualization across the process. Jenna broached this subject regarding how her idea of recovery changed from before hospitalization to afterwards: *"I also didn't know a whole lot about recovery before my uh, first admission, so I think they kind of played a part of shaping what I learned about recovery so, yeah."*

There was a recognition of the technical paradigm, but with the understanding that it would not be met, at least for some. Becoming symptom-free was something that others, with fewer apparent problems, experienced, and thus living with the mental health concern became a higher priority. This did not mean that there was not a slight bitterness towards those who did appear to be succeeding within the technical paradigm, as Jenna addressed during her interview:

> *"Yeah. It's definitely complicated and I mean, even me, I've tried to figure out, because some people I've been in the hospital with are totally recovered and I'm like, well how? But then when I'm looking at people it's like, well if they didn't have any comorbidity, they're just in the hospital for their eating disorder and well they've recovered and then- well I don't know. Maybe it's easier? You just have one thing you struggle with? I don't know, I still haven't figured it out, why some people completely recover and others don't. Why some people struggle for longer than others. It's kind of a really complicated thing…"*

This difference in recovery chances, as well as a change in recovery definition as

addressed above, was also echoed by Alyssa as something she had noticed within her work as a community-based mental health worker:

A: Um, and it, like, it could look completely different depending on the person. But definitely a striving for the next day to be a little bit better.

S: Okay, great. So, it's really not focusing on the medical definition.

A: Not necessarily, no.

S: Do you think throughout their time, their definition of recovery changes.

A: Oh yes, definitely. Yup.

While the youth more frequently employed the recovery paradigm as their conceptualization, the paradigms were not dichotomous. This is expected as the researcher herself, while preferring the recovery paradigm, does not view her recovery as something which is only guided by the recovery paradigm. There is a space for both of the main paradigms within recovery. For example, Jenna had a close relationship with the professionals in the hospital system and was used to more technical paradigm elements (such as psychiatry and medication), though she had recently included more recovery paradigm-based programming into her treatment through the community-based mental health centre. This lack of a dichotomy ultimately shows how the mental health system as a whole must include teaching on both paradigms and allow youth to choose the mixture that best suits their needs, instead of maintaining the traditional hegemony in the hospital and teaching only technical paradigm-based treatments.

Research Question Two: How is Community Reintegration Pursued by Youth?

The process of community reintegration begins in hospital. This is due to the shaping experiences of hospitalization which teach both views and lessons on recovery,

and also less than savoury views of stigma. Em had a negative experience within the hospital system and spoke at length about her poor treatment. In this quote, she refers to the room she was locked in and its covered window:

> *"So you can't see out, so people can't see in. I brought a lighter with me and lit it on fire because I was so upset they wouldn't let me see outside. That's all I wanted, was to see out the window. So I scrapped a little off and would look out and see the people. There's a little garden and playground down there I could see. In there you feel like an animal. And it's stressful."*

Jenna reported a very different and positive experience. Unfortunately, she seems to be in the minority as Alyssa, a worker, reported not hearing may positive stories coming from hospital stays and Mike had concern about how the way things are handled in hospital and the impact that can have on community-reintegration and a continued usage of mental health services:

> *"And also, like, a lot, I personally think, a lot of someone's outlook on how they can reach out for support depends on how they were treated at that first hospitalization. You know? Like there's a lot of different aspects that can go into it that come with mental illness, like paranoia, and stuff like that, and just from some stories that I've heard and stuff, it's not always dealt with in the most compassionate way which can really put a damper on someone really engaging in their recovery and going to see their psychiatrist."*

Often, community reintegration came with an abrupt change in lifestyle because of the move between a regulated and heavily supervised location to one in which their own agency once again became a possibility. Jenna, who had discharged herself, and thus

returned to this state of control potentially before she was ready, addressed this:

> *"Yeah, so the first few weeks after discharge was really rough. Like I had a lot of symptoms, I was struggling a lot, but then I kind of, managed to get things back on track so I um, yeah, so, it was, it was an adjustment. I think maybe those first few weeks was, was, an adjustment because I was like, because I had, it's like an adjustment getting, because if you were used to like 24-hour care it's like a big difference, just like going to being at home all the time, so yeah, so yeah, it was an adjustment. But, anyways, I got through it."*

This sentiment was also echoed by Alyssa as something experienced in the youth she worked with at the community-based mental health centre:

> *"I think like a couple of people have spoken to the lack of agency they have within the hospital and feeling like they're being monitored and everything they're doing is being tracked. And then once they get out they're not really sure what to do without that if it has been a longer stay."*

Youth are at an age where independence is sought, and experimentation was not unexpected. Agency and acceptance are highly valued, and this came up multiple times in the interviews. Thus, the beginning stages of community reintegration could become even more challenging as one attempted to return to post-secondary education, personal habits, solitary living or intimate relationships.

As Mike alluded to, experiences before hospital release, and immediately after, often set the tone for how successful recovery and community reintegration was. This is why, according to Mike, a smooth and positive reintegration process in vital: *"Right, if you can give someone positive reinforcement before they get negative reinforcement then*

they are more likely to continue on that behavior." However, circumstances outside of the youth's own control can often make this difficult, such as returning to social relationships and community infrastructure as noted by Em:

> *"But coming out was like, everyone is scared of you all of a sudden. Like what are you going to do? Why were you locked in there? Are you going to kill me? Are you going to shoot up the school? Like, random questions like that. No. Like if you broke your arm you'd go to the hospital. (laughs)."*

As previously noted, there seems to be an expectation of the path to be taken throughout recovery. The end goal was often returning to (or starting) employment, or formal education. Mike spoke about this: *"I think the education and employment is a goal that I see all the time because I think that's where people think that's where they need to be to have a typical lifestyle, you know."* The expectations of work and formal post-secondary education were often seen as unavoidable, and as the mark of success to be reached at the end of a recovery process. Because of this, the worker's community-based mental health centre suggested that other goals which often more helpful in creating a foundation for success to come first, such as achieving social security before taking part in in an apartment showing. This does not make other goals any less noble to strive for, yet it has become a job of the community-based mental health centre to reverse beliefs from neoliberalism which states there is only one way to be successful, something Mike addressed during his interview:

> *"I think society gives us the reflection that to be a functioning member you need to be in the work force and you need to have a full time job and you need to do and be these things and that, that's what people see as typical so that's what they*

want to be a part of, you know? So, I think that puts a lot of stress on people wanting to achieve them. And you know, there's obviously the mind state that to be able to get a good job to be able to sustain you, you need an education. So, it's kind of like one thing leads to another and that's just kind of the vision that we've created of a successful person, um in society, so that's definitely a reflection of what people think they need to be which couldn't be any farther from the truth."

This imagined path could be abruptly changed throughout the process though, perhaps by changes in age which resulted in the need to transfer services, the development of a new mental health concern, or a plateau experienced for a variety of reasons. Recovery is not a linear process, and neither are the services which have been put in place to address the mental health concerns. Therefore, it is a constant process of reforming one's identity and continually learning to react and do things differently as the need presents itself. Adaptation for success requires personal acceptance and thus, learning to respect oneself becomes a vital lesson to be taught at a community-based mental health centre.

Research Question Three: How does a Youth's Recovery Conceptualizations Impact the Community Reintegration Process?

How a youth conceptualizes their recovery has a major impact on how they enter, and continue to exist, within a community. Conceptualizations may influence the services they access and how they approach their future, as, for example, those who employ a technical paradigm may focus more on the services which use medical interventions and rely more heavily on clinicians, whereas those who follow a recovery paradigm may seek out less traditional approaches, as Em has done: *"I play drums with my hands. I actually*

play drums, so it helps put my mind- music and art are huge things for me, so if I can just do things that will help at different times as well, like it's very strategic. But you learn."

Sometimes this learning process can be quite extended and during this process there are backwards steps and plateaus can occur. It is understandable that mental health consumers may push back from authority, especially when their lives have been in such flux with their mental health concern and control is something desperately sought. Em was very honest about her experiences in this, as she rebelled heavily after her release from hospital, including dropping out of high school:

> *"I was a little shit disturber when I was there [inpatient and outpatient services] but actually when I got back into the real world, quote on quote. I was like, oh, none of this is going to help me. I wouldn't even try. And, like, my dad would tell me all the time, like you gotta do breathing exercises because you can't just sit in your bed, all day, every day and do nothing (laughs). So, he took me to the doctor and was like, you gotta do breathing exercises so it was like six people telling me the same thing, so I was like, oh, maybe I should do breathing exercises. So I* did. *And a lot of practice later here I am. So it was me being stubborn and then later realizing oh, they're not wrong. And like experiences. And dealing with things. And getting so fed up with things and not being able to function and like fine.* Fine. *I'll try this."*

Control may also be sought in other ways. For Jenna, control was, and continues to be schooling, as she is currently in a senior level of post-secondary schooling, and continued to remain in classes while in hospital, despite her doctor's orders. It provided a structure that other aspects of life may not have been able to:

Um, and I was saying that I've always been high functioning and I just wanted to specify that um, I have always been high functioning in my academic life. I have not always been high functioning in all areas of my life. I'm very non-functional when it comes to my social life (laughs), so that's a really big struggle for me. Um, I've never really been able to work, either. It, like, causes me too much anxiety. But I've also always been in school so I don't know, without being in school if I'd be able to do it or not.

Ultimately, no matter the way one conceptualizes their recovery, it was noted that it is the attitude a youth applies to their recovery that is the most important for reaching a state of success, as noted by all participants, including Mike:

Um, but outside of that, I, you know, it takes, like attitude. You know, attitude plays a big part towards it, how your view of your mental illness is. I think that measuring a lot of how you're going to engage in your recovery and um, but yeah, we could use some more successes.

Motivation to recover is also vital to the process, yet because of the nature of certain mental health concerns, this can be rather impossible. Thus, it often does not matter how one conceptualizes recovery if there are days when progress goes backwards, as noted by Jenna, who is struggling with depressive issues:

I think that part of it too, is that how much, I mean a big part is how motivated you are, and maybe, how much hope you have for yourself. Like if you, if you feel like, you're really confident about it, then you might have that willpower and you can make it happen, like, that component of motivation may be stronger, so, but for me, the, the lack of motivation that I struggle with is a part of my depression

too so, it's, like, really hard (S: Umm hmm), but anyways…

In this, there is the complexity of mental health concerns. Sometimes, it is not a question of acceptance or motivation, but rather the belief that there is the possibility for better days within the future and the opportunity to remain functioning. Em noted the challenges, but also the belief that the challenges of a mental health concern are not only negative, but also are a learning experience: *"I don't think anything has been easy (laughs)… Everything has been a struggle but it's not a bad thing I guess."*

Themes

Four themes captured the codes (Table 1) found in the interviews. These themes can be found in Table 2. The breakdown of the above codes in relation to the themes, from both youth and worker interviews can be found in Tables 3-6 and the themes themselves will be further explained in the discussion chapter.

Table 2.

Themes regarding recovery conceptualizations as part of community reintegration in youth.

Theme
1. Recovery in, and in spite of, a failing system: "they have no sweet clue at all"
2. Returning to the Community: "It was an adjustment"
3. Recovery as a return to a state of control over one's life? "now there's a light and I know I want to be here"
4. Community-based mental health centres as a support for youth: "I feel like many more CBMHC would be great."

Theme 1: Recovery In, and In Spite Of, a Failing System: "They Have No Sweet Clue at All (Em)"

Theme one addressed the issues of pursuing a state of recovery in the Nova Scotian health care system, something which required much resilience and outside

support, as well as a determination to learn a degree of system literacy in order to navigate such a convoluted system.

Table 3.

Codes for 'Recovery in, and in spite of, a failing system.

Youth Codes	**Worker Codes**
The Health Care System	Working at a CBMHC
Tricking the System/Taking Matters into their Own Hands Recovery	Issues with Hospitals - Personal Experience Shaping -Setting the Tone
Hospital Treatment Programming/Funding - Staff Experiences	Issues with Government -Wait Times
Recovery Lessons (Or Lack Thereof) While in Hospital	-System Literacy
Mental Health vs. Physical Health	

There are many issues within the mental health system in Nova Scotia, and Em was very blunt about that, explaining: *"But the mental health system here is complete and utter garbage in a sense. They're trying, but it sucks."* From waitlists that are months long to thousands of people without a doctor, it is a challenge to navigate the system, especially considering its often-disconnected nature. The youth within this study have experienced this problem first hand, from both the public and private sectors, as the community-based mental health centres involved were of a private nature, yet they were hospitalized in public hospitals.

The waitlist times and overburdened healthcare professionals, can present some major safety issues for youth. As Mike pointed out:

> *"And one thing that I've also noticed as well, people, people, often when they make the choice to reach out for support, it's not a big window. You know, like, someone, like, someone who may live on the streets, have no really, solid support*

system in place, doesn't, has never really considered medicating, medication therapy, because it's never really been an option for them, but they come in one day, and they're like, 'man, this is enough, I need to do something about this. I know I've been against medication, but I want to give it a try.' And then we're like 'this is great, you're taking the step forward' and we fill out the referral form and they don't get to see anyone for three months."

Mental health issues are time sensitive, especially if one is in a crisis. Because of the waitlists, youth are being forced to turn to crisis intervention once it becomes too hard to wait to get into the intended services. Considering the negative stories of the crisis responses in hospital reported during this study, this is very concerning. Mike and Alyssa addressed the importance of an immediate positive influence following hospital release is needed for a more successful recovery trajectory and thus waiting for services and being without anything, but crisis intervention may be detrimental to the potential for success. It is also not enough to rely on informal family supports while the youth wait for professionals. Informal and formal supports are very different entities, as Mike brought up regarding accessing appropriate supports following hospitalization: *"I think, I think understanding the systems that are in place that they're going to need to access and I think that's different from [family] support."*

It is interesting to note that the participants did not blame the professionals for the condition of the mental health system in Nova Scotia. The participants blamed the government for the current failures they experienced and recognized that professionals were just as much a victim of the system as they had been and do not have enough information on mental health conditions to override this system issue. Em points out this

understanding during her interview, saying: *"So, they have no, kind of, I think they know they don't really know, but I think they also think they kind of do know. They're working on it as well. But, no, I don't think they've got any clue and they're hauling ass to find a way to help."* Mike also addresses how the dysfunctional system affects his own clients and work habits during his interview, stating:

> *"There's a lot of difficulties in, and a lot of things that can be improved upon, but I also understand the restraints within the government that make it more difficult. It puts a lot of onus on, on, you know, staff, even though it's difficult, and they go through a lot of compassion fatigue and trying to be empathetic is something that needs to be taken into consideration."*

This statement from Mike will further be explored in theme four regarding how community-mental health centres have been trying to operate within the gaps of the traditional health care system. However, ultimately, this poorly run mental health system can cause even more of an adjustment for youth following release from hospital than if the system that met all their needs.

Theme 2: Returning to the Community: "It was an Adjustment (Jenna)"

This theme regarded the transition youth underwent after leaving hospital, sometimes multiple times throughout their youth. Returning to the community was both challenging and positive, as different aspects of the return carried with them different meanings and requirements. It is a process of reshaping one's life in accordance to the new identity taking shape throughout the process.

Table 4.

Codes for 'Returning to the Community.'

Youth Codes	**Worker Codes**
Community Relationship Support	Support
	-Family Support
	-In School
Returning to the Community Challenges	Personal Changes
	-Returning to Relationships
	-Returning to Negative Habits
	-Changes in Identity
	-Doing Things Slightly Differently
Relationships to Community Infrastructure	
- Employment	
-School	
-In Hospital	
Life Experiences as Learning	
Life Goals	
Relationships in the Community After	
-Fear from Others	
-Family	
-Social	
Awareness of Others Struggles	

Once released from hospitalization, not only do the youth have to adjust to operating in a new stage of the traditional medical system through outpatient and community services, but they must also return to everything else that makes up the community. This is often not an easy process, as Mike explains, stating: *"I don't think there is much to slip back. Not even going back home, you know? You need to readjust that life."*

Alyssa addressed some of the infrastructure and supports that youth were separated from and how trying to reacquaint themselves after experiencing hospitalization can be difficult with this comment: *"Often, they haven't been able to maintain work while they're in the hospital, or housing if they weren't living at home, so things like that are often harder to get back to and there is more paperwork surrounding*

those things as well and I think that's a big barrier as well." The document review provided several examples of the difficulties of returning to a life outside the formal hospital system and the statement was also reflected in the interviewed youth. Jenna reported the overwhelming stress of returning to the community after the hospital, except for in her schooling, which she kept up during her time in hospital (this may have helped in her re-entry to the formal space of post-secondary education):

> *"Trouble? Um, well, I guess I had trouble returning to the full functioning, like, I function in my academic life, but it's pretty much the only area of my life that I can decently function at. Like it requires all my energy, so I have nothing left over for other aspects of my life like social, romantic, anything else. So, I don't do much else besides school stuff. Yeah."*

This suggests that having a continuity between the hospital and outside community for all necessary infrastructure and relationships may help bridge gaps and lessen challenges for youth following release.

Returning to a community involves resuming acting within pervading ideologies after hospitalization may have paused this need and navigating recovery within that. Operating within neoliberalist ideologies had an impact on how youth viewed their own goals and successes in recovery, as reported by the current study's participants. Neoliberalism is reflected in how participants framed the 'typical life' and the frequency of statements that involved employment and post-secondary education, shown in both the document review and interviews. Jenna felt a lot of pressure to perform at the same level as her classmates who had not been hospitalized because she was competing against them for future employment and graduate studies and these future directions did not allow for

time spent recovering:

> *"And I feel so under accomplished in comparison to people in my program because I have a few gaps in my resume from being in the hospital where other people are like spending time like, working in research labs and doing all this stuff and like, I started volunteering in a research lab in first year and then I had to like, stop because I was like in the hospital for like a few months and then classes were starting and then I just didn't have time between like my hospital stuff and like then I was doing like an outpatient clinic and they had like a structured schedule there so you had time"*

Em did not feel this same sort of pressure, but she was also negatively treated at her workplace and struggled to sustain herself financially because her mental health concerns interfered with worktime breaks and behaviours. Her bosses did not understand the need for accommodations, leaving her with the opposite issue from Jenna- a resume with too much on it:

> *"And I never started working until I was 17. I'm 18 and I've had over 10 jobs. Over this year. My first job was in February of this year and I haven't had a job in about a month because my last one was Quiznos. So, I've had 10 jobs in less than a year. And they're like 'why have you had so many jobs.' It's like 'oh, here we go.' You're going to fire me too, but I just need $100. I need to eat. Just work for a week and then you'll fire me, I swear."*

Mike and Alyssa both addressed how they worked at their community-based mental health centre to suggest smaller, more manageable goals to the youth before tackling employment or post-secondary education, yet the pressures of existing within the

current structures outside of the centre cannot be dismissed. While the centres served as islands where recovery could be pursued, youth did not live there, nor were they financially supported by their centre. It is understandable then, why youth would push so hard to return to employment and education, even disregarding professional opinions on this, as Jenna did.

While formal structures like work and employment were often extremely important for youth following release from hospital, they also had to return to the informal relationships they were separated from while in hospital. This could be particularly tricky if the stay was long. Jenna had been hospitalized for several months and returning to her friends was difficult because of missed time and an inability to communicate with them while in the hospital. Jenna still struggled with returning to this part of the community, a year out from her release, stating:

> *"Part it's hard because I just have anxiety about being, like going to parties and stuff, and I have a fear, like I can't drink because of the medications I'm on and I have a fear like, I don't know, and just, it makes me a little bit uncomfortable. And like I also just feel like I miss out on a lot of just normal things that people do, like, like, going out and drinking and like, I don't know. And people are just taking about it. The other day I made myself go out because my friend invited me and I thought it was going to be just two people and it ended up being six people and they were all talking about random parties that they'd been to and I just felt left out from the whole conversation."*

This return to informal relationships was daunting because those on the outside did recognize the absence of the youth after hospitalization. While youth, after release from

hospital, needed to find a spot in the community for their new identities and needs, the old spot they had left still remains and has a place in the lives of those who remained outside. Youth may try to re-enter that old space without change, or may try and avoid it completely. Mike addressed how returning to certain old habits and relationships can be very detrimental to treatment: '*Cause ah, when you first come out and you are freshly out of the hospital, you feel isolated and you feel like you don't have a great support system and one thing that I know, the streets will always support you, and not in a positive way, but they're there.'* Youth need the opportunity to explore who they are after hospitalization without feeling pressured to return (or enter) to negative habits and locations because they seem to be the most accepting.

Theme 3: Recovery as a Return to a State of Control Over One's Life: "Now There's a Light and I Know I Want to be Here (Em)"

While the previous theme addressed returning to the community, this one refers more to a return to individual characteristics. Following release of hospitalization, youth felt the need to pursue independence, control and agency over their life trajectories. The health care system has been set up in such a way that it is pervaded with the ideology of one must save oneself, and despite the community-based mental health centres doing their best to help avoid this, neoliberalist beliefs still affect youth.

Table 5.

Codes for 'Recovery as a return to a state of control over one's life.'

Youth Codes	**Worker Codes**
Coping Methods - Unhealthy -Relearning/Learning New Methods Afterwards -Feeling in Control	Goals
Feeling Out of Control	Changes Leaving hospital
Personalization of the condition	Socialization
	Control -Needs Changing throughout Recovery

Hospitalization is often associated with extreme amounts of control, but it is control exerted *on* the youth, not *by* the youth. While control and independence following release from hospital might not be to the level the youth desire, there is an automatic increase in both because of the very nature of a community compared to a hospital. Mike believed that allowing the youth the opportunity to take control over their lives was one of the most important steps for recovery, stating:

> *"You know, just control, making you feel like this is not the end of your life, you know, you're not dead, you're, you're just got some new obstacles and some new things you need to take into consideration, and once you give yourself the time to navigate that, and figure out what's going to work best for you, then you know, you can start to move forward to a typical life."*

Leaving the hospital creates a huge lifestyle change for the youth because they once again have agency outside of the Panopticon (or the central point of observation from those in power over those not in power that results in behaviour policing) (Foucault,

1995) of the nurse's station. Em specifically addressed this experience when she spoke about how the glassed-in nurse's station was placed in the middle of the room and in the line of sight of all patients' rooms, though all interview participants mentioned this experience in some form. Youth may still be observed outside of the hospital, depending on medical and relationship supports, but it is without the overwhelming control of a hospital that can feel so intrusive. An example of this intrusiveness was how Em was not allowed tampons for fear she would cut the strings off and use them to hurt herself. Having access to the personal hygiene products of one's choice following release may seem so simple but shows the marked difference between the community and the hospital.

While youth have more control over their bodily autonomy (at least to the degree allowed by their minds), the youth may also experience more control over relationships. Within hospital, visiting hours are restricted and social interactions are limited often to those also within the hospital ward. Relationships in the community may not be aware of the hospitalization, and thus this can cause the loss of friendship, as both Emma and Jenna addressed. Once outside of the hospital, as already addressed, youth may choose to return to old relationships without change, for better or worse, may choose to make new relationships or may alter the types of relationships previously held. The heavy importance placed on socialization within the community-based mental health centres are helpful for this because it provides a safe space where a youth can choose to interact with those who belong to the same peer group as they do.

Moving beyond the sick role, defined in the background chapter as the deviant, also means assuming some degree of control over one's mental health state. Utilizing the

recovery paradigm as their primary conceptualization did seem to help youth take some control over their futures through the acceptance that recovery would be a life-long process, instead of striving for an often disappointingly impossible symptom-free state. Windell, Norab and Malla (2012) also found this in a portion of their participants as this control was seen as a subjective action which reduced negative feelings resulting from still having symptoms. Em experienced this, stating in the interview:

> *"I have my moments, when I'm like 'I cannot deal with this anymore, and I will not.' But, especially recently, there's moments where I need to go to the hospital now, but then what is the hospital going to do. So I sit here and breathe it through because I know it will end, it's just getting through it in the moment is like, 'oh, my Lord.' It's getting through it. Once I'm through it I can go again for a little while."*

The need to assume control over one's health can be challenging considering the neoliberalism pervading the health care system as youth are forced to learn system literacy and navigate the system for themselves, a challenging concept for anyone. There is little help through the disjointed Nova Scotian health care system because service users are expected to save themselves and unfortunately, the success stories in the interviews and document reviews all held an element of 'needing to be one's own hero' or 'tricking the system to working for their needs'. Mike addressed the way the system is set up to fail because of this, stating: *"So, you know, it's, it's a blatant oxymoron. You're not making things accessible for people in the best way they can use them to work through their recovery then they're going to be less likely to engage."* Altering the way those with mental health issues are viewed by society, may allow access to change and better

support recovering youth to take a more successful control over their own health autonomy.

Theme 4: Community-Based Mental Health Centres as a Support For Youth: "Many More Community-Based Mental Health Centres Would Be Great. (Alyssa)"

Theme four focused on the community-based mental health centres that youth were accessing and their relation to recovery, as well as the relationship a worker has with their youth client's recovery. For youth, these centres were supports that helped them find independence, such as through helping to write resumes and apply for social assistance and locations where socialization can be safely sought. The workers employed at the centres put much into their jobs and that created frustration and feelings of being overwhelmed. It is not unsurprising then, that workers tended to talk more about the community-based mental health services in the specifics they were involved with, whereas with youth talk of the centre they were enrolled in was woven through interviews in a much more implied or general sense, especially in comparison to their hospital experiences.

Table 6.

Codes for 'Community-based mental health centres as a support for youth.'

Youth Codes	**Worker Codes**
Dream Service	Setting the Tone
Life Goals	Moving on from the CBMHC
The Health Care System	Art as Catharsis
Hospital Treatment	Working at a CBMHC
-Experiences	
	Aging Out/Transitions

A community-based mental health centre, when it employs a recovery paradigm as the ones in this study did, is vital to helping youth navigate the gaps created by a lack

of system literacy, as well as providing holistic mental health services insofar as funding was made available. Having an institution in the community that focused on recovery is also very important because it does not create a spatial divide between youth and their community in the way that a hospital does. While in a hospital Em felt like an animal because even her windows were covered over so she could not see the families playing outside, yet within the community-based mental health centre she talks about her favourite spot being a window seat where she sits to read. Having services that are accessible are very important for youth, especially considering the needs most youth have outside of individualized treatment plans.

Community-based mental health centres like the ones studied in this project limit their age range to help create a group of peers that members can relate to. Peer similarity is used as a first step in fostering positive socialization within the community-based mental health centres, as socialization and social relationships are important in recovery (as addressed in previous themes). Jenna also found this social element to be helpful, stating:

> *"I'd say [the centre] which I go to. [The centre] has been a big part in my recovery because like, there's people that understand and like, I don't, I'm usually not embarrassed to talk about things there and um, yeah, like people are just really supportive and the programming helps to add some structure but at the same time not like an isolating structure…"*

Alyssa addressed how her community-based mental health centre used the social opportunities as a door to teaching independence and life skills, stating: *"Okay, so we have programs and stuff surrounding different stuff. And some of the things are*

surrounding recovery skills but it's kind of hidden within other things [i.e. art nights] *as well."*

Despite the positive opportunities for recovery given to youth within community-based mental health centres, the centres are not without fault. Mike addressed that the centre he is employed at feels some competitive pressure with similar organizations over funding and this can lead to protectiveness over one's territory and siloing. Mike felt very strongly about how siloing due to funding protectiveness was preventing youth from receiving the best possible help in pursuing recovery, and this was made obvious with this statement:

> *"Um, and I think I think that in the line of support, and the different supports we can provide, that's still an issue with competition between resources. I also think it's something that's been identified as a problem, you know? Um, I think it's just finding a great way to break down that barrier and help the people"*

In the document review, this need for funding and proving legitimacy will be further explored. When siloing in maintained, youth are not able to have seamless transitions between services should they experience new needs or have aged out of their previous service locations.

Document Review

The material analysed as part of the document review were two community reports, years 2015 and 2016 and three publications that are similar to a newsletter or zine from 2018-2017, all from the same centre. Community reports were two pages in length and followed the structure of a cover story(ies) and then financials for the year and the newsletters were four pages in length and followed a structure of four individual articles,

with at least one being focused on a single member of the community-based mental health centre. Not all material is directly attributed to someone within this study's parameters, however it is safe to assume those being quoted have experience with very severe mental health concerns considering the centre's purpose. Table 7 shows the breakdown of the five available articles giving what they were, the topics covered and the observations, as per Bowen's work on document review (2009).

Table 7.

Materials included in the document review with community-based mental health centre abbreviated to CBMHC.

Document	**Material**	**Observation**
Community Report 2016	Cover story is a youth who entered the CBMHC after hospitalization. Story about being held accountable and setting goals and now holding others accountable. Second page was financials.	There was a clear connection portrayed between a success story and the financial information.
Community Report 2015	Cover story is a series of stats in one section and a vignette of a participant. Stats included that they had 178 members and served 151 meals as part of their programming through the year. Second page is financials	Similar connection to other community report. Stats show the relation that the services the CBMHC provides in to their financials.
Newsletter April 2018	Cover story about a male with mental health concerns who had problems with medication effectiveness. CBMHC was used as a transition from formal There is a success story and system after financial issues. Following articles were a crossword puzzle, an article about gut and brain health	Publication is colourful and meant to be used, suggested by the crossword puzzle and info about healthier eating habits it includes points about education and employment which are important in

Newsletter April 2018	and then their peer support group.	public perceptions of usefulness.
Newsletter December 2017	Cover story about a female who developed PTSD as a result of a violent family home. CBMHC provided services to help with financial trouble, such as through their own food bank. Other articles about facts surrounding mental health concerns, a wedding that raised funds for the centre in honour of a family member and a day in the life (2nd person).	This is a colourful publication. The success story shows how CBMHC can be a second home and used as addresses the multiple services available to help do so. The use of the wedding article reinforces the idea of a second home.
Newsletter July 2017.	Cover story is about the centre's peer support training and peer mentorship program. Following articles are about seasonal mental health concerns, mentioning their running group, the story of a trans youth who benefitted from the centre's LGBTQ+ support group and the stats on the centre, such as their expansion and prediction of a doubling of members by 2020.	Colourful publication with pictures of members and clip art. It also contains helpful information meant to inspire better habits with the article about how mood improves in spring and thus should be taken advantage of. The success story includes distinct mention of a financial donation from their client.

The material has distinct commonalities between the interviews and the documents provided by this community-based mental health centre. While not every code is directly addressed, to be expected considering the comparison between short publications and hour-long interviews with specific questions to try and address all avenues of the research questions, several were. For some quotes, it was impossible to tell

who wrote, or spoke, them. Thus, both worker and youth codes will be combined in regard to their application to the documents. There is much overlap between their meanings derived from the interview, so this should not be of much concern. These codes can be found in Table 8.

Table 8.

Codes from the interviews also found in the documents.

Youth Codes	**Worker Codes**
Relationships to Community Infrastructure	Goals
-Employment	Changes Leaving Hospital
-School	Transitions
Coping Methods	Personal Changes
-Relearning/Learning New Methods Afterwards	Support
-Feeling in Control	Socialization
Life Goals	
The Health Care System	
Relationships in the Community After	
-Family	
-Social	
-Fear from Others	

The codes of support and relationships within the community were addressed in multiple documents. For Bella (renamed from the documents), this was viewed as just as vital as the traditional system, reflecting the holistic need for care found in the interviews:

> *"For me, the social side of recovery was just as important as the medical support I received. Connecting with other people made me feel life was worth living again… People without judgement who understand who understood what coping with mental health problems really was life (Community Report 2015)."*

The option to participate in a social outlet was very needed for those dealing with a mental health concern, especially when they have been pushed away from those relationships formed prior to hospitalization, and thus this quote also reflects the

socialization code.

The codes of relearning/learning new methods afterwards, goals, control and relationships to community infrastructure were all evident in the document review. An example is this quote from the December 2017 Newsletter from an unnamed source:

> *"You get help crafting a resume and registering for classes. You even learn how to start a discussion with profs and employers about your mental health, should you start to feel overwhelmed again. Knowing you can come in for help with homework or questions puts you at east. You've set yourself up for success, and can't wait to start the semester again."*

The sentiment was also addressed in the April 2018 Newsletter: *"Every Monday, a group of young people come together and practice ways to become more motivated and mentally healthy. The group talks about anything from how to stay on track with goals to the refreshing benefits of Spring Cleaning."* There were services mentioned in the documents which were not explicitly spoken about in the interviews in the way Mike had spoken about creating resumes for those ready and looking to go back to work or how Alyssa addressed her experiences filling out social assistance forms and in transition work. Kristal (renamed from documents) spoke about how services in the wider community but made accessible through the community-based mental health centre, made a huge difference in creating a state of health and control in her life: *"This place is different. You're allowed to be yourself here. It's amazing. You can shower and do your laundry here. They have a food bank. I've been struggling with food for so, so long, and it's an option again now. I don't have to choose between rent and food (December 2017 Newsletter)."*

In the interviews, Jenna and the workers spoke about the importance of community based mental health centres for filling the gap created by the traditional health care system and Em spoke at length about her use and benefits from it. Paul (renamed from documents) also voiced this opinion: *"There aren't really any other services for youth like [CBMHC] and it's open and available the majority of the time It would definitely leave a void if it were to disappear tomorrow (Newsletter July 2017)."* This seems to be a general conclusion across participants and is an idea portrayed within all documents, especially considering their usage of popular desires within a neoliberal society- education and employment, as noted in the 2016 Community Report from an unnamed source: *"Having this support has made it easier for me to transition bringing school and work back into my day to day life."*

There were no major differences in the information given between the publications and the interviews. This suggests a validity of the interview material and vice versa. The differences lie within the way the data is presented. Interviews were much less formal and flowed in a more organic nature, whereas documents were very structured. It is perhaps cynical to observe the data from the document review as contrived to provide a certain image of the centre, but it is still a valid conclusion of the document analysis. This is not something to be blamed on the centre considering the need to create a sustainable financial future in the current fiscal climate in which neoliberal managing styles require constant legitimacy confirmation. But rather, this finding illuminates what is viewed as important in published documents for furthering a cause. The frequency of mentions of employment and education, as well as the clear mention of a client working through the program and then making a donation back does not seem to

be a coincidence. They seem clear reinforcement of the value of such a centre when neoliberalism suggests one must be a contributing member of society in the most traditional sense. While the interviews tended to concentrate more on the social aspects of the centre and included cautions against for youth to focus only on returning to employment or education before being ready, interviewees still mentioned it; just not with the same frequency in comparison to other goals.

Researcher Reflexology

Having an insider position was helpful in this research. This position was always revealed during the interviews. I waited until after the questions which asked about a participant's understanding of recovery and its possibility. This way I was able to keep a distance from the potential biasing towards different paradigms during these questions. Revealing my positionality was very important so it was worked in without fail because of the subjective nature of the analysis. My positionality has been integrated since the very beginning of the study and therefore, it would not be right to exclude it from the interview, especially when it informed the line of questioning.

For youth interviews, there was a comradery instantly formed after I announced my positionality. No longer was I a researcher asking probing questions to take away to the ivory tower of academia. I was a peer, a comrade in arms against mental health concerns. The change in youth participants was visible after I revealed my positionality as someone their age with severe OCD and PTSD. There was an immediate understanding of what it meant to live with a mental health concern, as Em even asked for me to let her know if I grew upset at the conversation, the same cautioning I gave the participant prior to starting the interview. The conversations, while more casual after the

reveal, became more in-depth as we engaged in reciprocity of life stories. I suspect this difference may not be the case in communicating with all youth with mental health conditions, but because these youths were from locations where peer-to-peer communication was expected and encouraged, this type of sharing was easier. Not having experienced hospitalization also allowed me to sit and listen when the youth spoke about their experiences without any comparison to myself and the youth knew that. I believe that to be truly evident in the candor with which Em spoke about her experiences. In general, it was this relationship formed with the participants during the interview that I feel lends a realness to the results that an outsider would not have been able to access, for better or worse.

The reveal during the worker interviews did not have the same effect of comradery but did also alter the atmosphere of the interview. For workers, it seemed that revealing my positionality lent an air of credibility to my research. I recognize that I am, for workers, still a youth myself, so there was, at times, a tension about me asking about their work with those with mental health concerns, as if they expected me to view the youth as outsiders and objects to be studied at a distance rather than worked with. After the reveal, statements like “Oh, so you know then” were said in a more relaxed way and communication, while still more distant than with the youth interviews, flowed more naturally afterwards. The workers were fiercely protective of their clients, and rightly so, and knowing that I could just as easily have been one of their clients seemed to reassure them that I would do right by their information.

This case study would not have developed in the way it did had it not been approached from a position of both outsider-insider positionality. I could understand the

youth, at least to a degree, as I have never experienced hospitalization, while also being able to see the worker perspectives and follow the interview and their usage of jargon because of my academic and employment history. As evidenced in the interviews, the results were bolstered because it was easier for me to integrate into the population, and thus the information I was granted would not be given to someone they felt could not understand or protect the community in a way only an insider could. The results are bound by the process of recovery, including my own journey. The voices, while fragmented into quotes and codes, are still as true and appreciated as they were the day of the interview and it is with that appreciation that I continue on to discuss the implications of the study's results.

It cannot be dismissed, however, that my interpretation of the results was coloured by my own recovery conceptualization, that of the recovery paradigm. As a Nova Scotian, I have years of experience within the province's health care system and have had both amazing and horrible experiences. It is fair to say this has coloured my opinion of the system in which this study was situated in. It is also fair to attribute some of my biases to my educational background which combines psychology, sociology and critical disability studies. I do feel our medical and psychiatric systems serve a purpose that we are not able to do without, yet I do see our mental health system as intrinsically flawed and often as a more politically acceptable form of incarceration for community 'undesirables'. I have always been able to assert my own agency over treatment trajectories and feel confident enough to impose my own labels on myself and disregard the labels others chose for me- and as someone who has worked with major Canadian mental health charities and presented my own story to over a thousand people at this

point, they have at times been quite alarming. I do not identify as a psychiatric survivor as I have not been traumatized by the system as many have been so despite my often (for psychiatric and biomedical systems) militant stance on their approach to mental health, I am still able to see the benefit to both sides of the argument and am willing to put faith in both sides as required. This relative neutrality for my disciplinary background has helped me to consider the answers to this case study in a more balanced way than someone who has been traumatized by the mental health system, yet still in a way that seeks radical transformation and believes much better can be achieved.

Chapter Four Summary

Four themes were determined out of a total of forty codes (twenty from each participant pool). There was significant overlap in conversation topics between youth and worker interviews, as well as the material found within the document review, lending a robustness to the results as each backed up the other. The reflexive piece of this case study addressed the relationship an insider perspective can create with the participants and how this lends a level of validity to the results because there was the knowledge that we (myself and the participants) could be honest with each other. The themes found during this process and the implications of all three modalities of results will be further examined during the discussion chapter.

Chapter Five: Discussion

There was no single way youth pursued recovery, and thus no way to put a single definition on what recovery means for youth who have been released from hospital. However, despite the differences in the way recovery was pursued, youth employed the recovery paradigm during the process. As addressed in previous chapters, the recovery paradigm is a conceptualization which stresses functioning rather than symptom erasure, and understands recovery as lifelong, rather than fixed to a specific life stage (Edgley et al., 2012; Gagne et al., 2007). In this study youth saw recovery as something that was non-linear in its challenges and something they would deal with for the foreseeable future. Thus, the youth needed to learn to function within their circumstances to remain in the community. A more in-depth exploration of how the themes and document review answer the research questions (or do not) will be explored in the following section. Policy recommendations and future directions in research that can help better serve the youth will also be addressed.

Research Question Answers

How do Youth Conceptualize Their Own Mental Illness and Recovery Process?

The youth did not directly state what their recovery conceptualization was at any time throughout the various modalities within this study in a way that was a concrete, operationalized definition. This absence of firm language is not surprising considering this language is often inaccessible and the idea of having a choice over how one recovers is not often made clear in the traditional medical system. However, as evidenced throughout themes one to three, youth who utilize community-based mental health centres as part of the community reintegration process employ the recovery paradigm as a

way to understand their own experiences and future trajectories. Youth are clear in their knowledge that recovery for them means functioning and not the symptomology checklists they have learned to subvert.

Theme three regarding to a return to control can also be incorporated into the answer to the first research question. Youth have chosen their own recovery trajectories, in whatever capacity they can, (not including socializations that lead to varied importance of goals or limitations because of their conditions). The control taken from them within the traditional medical system is returned following release from hospital, though there are suggestions that some youth maintain that sense of control over their lives even within psychiatric hospitals and this knowledge of their own needs beyond that of an authority figure is helpful in maintaining their chosen identity (such as Jenna continuing to express her academic values by taking distance classes).

The use of the recovery paradigm is not a surprising finding considering the youth were recruited through a community-based mental health centre. These institutions as a whole, in the Canadian context, have had a push towards following the recovery paradigm (Ramon et al., 2009), and the findings in theme four on community-based mental health centres reflect this appreciation for recovery. The youth in this study shaped their views on recovery in relation to their experiences and what they had been exposed to, and regularly attended community-based mental health centres, furthering the suggestion that youth in this population are employing the recovery paradigm.

While the present study did provide a general answer to how youth in this demographic (community-based mental health centre attendees) conceptualized recovery, it does not illuminate how youth outside this demographic conceptualize their recovery.

Youth showed that they are impacted by their experiences so different experiences may yield different conceptualizations. It is also not known whether the recovery paradigm results in higher levels of self-perceived success in recovery for youth than another conceptualization might, though the youth in the present study were striving for that success and were achieving it (at least so far as the researcher could deduce).

How is Community Reintegration Pursued by Youth?

Community reintegration was viewed as a process. It was seen as a series of entrances back into, and almost unexpectedly, exits from, their previous community spaces. The way a youth has developed their identity before and during hospitalization can drive this reintegration process. For example, Jenna maintained her identity as a studious person by taking classes while in hospital, and then returned quickly to university following release. Tew et al. (2012), found a similar importance of identity in their work with community reintegration and suggested that increasing the ability for individuals to maintain what their identity was before hospitalization (including relationships and (in)formal infrastructure access) is extremely important for recovery post-hospitalization.

Experiencing hospitalization during the youth stage can cause issues with developing their future selves to a much higher degree than youth without mental health concerns (Braeler & Schwannauer, 2012). Within a hospital, the identity the youth has previously developed is frequently forcibly changed to that of the sick-role by those charged with treating the youth (Braeler & Schwannauer, 2012; Lafrancois, 2008). Outside of the hospital, some of that control is returned and youth can once again begin to choose how their identity is developed. It would be faulty to expect a return of total

control considering societal ideologies around mental health, however, youth have the opportunity to begin to shape their identity again, especially by using selective-disclosure around those who are unaware of their mental health concerns (Braeler & Schwannauer, 2012; Corrigan & Matthews, 2003). Windell, Norab and Malla (2012) found that youth do not always feel the desire to reform the exact same identity they had before being pressured into the sick role during hospitalization and thus, this suggests that youth are taking control over their identities moving forward.

Community reintegration, as show in themes two (Returning to the community) and and three (Recovery as a return to a state of control over one's life), as well as the document review, is a process that is strongly influenced by a return to control over one's life and identity, as well as a major adjustment to such a change from twenty-four-hour care. While in the hospital, youth are often completely isolated from their social groups and families, depending on their situations and support systems, and this can cause issues returning home (Edwards et al., 2015). However, despite peer challenges, youth in the current study reported having a parent with whom they were very close and felt to be their biggest supports during, and after, hospitalization.

Having a positive social support can be very helpful in reengaging with the community and creating more comfortable social environments for recovery to be pursued (Tew et al., 2012). This is obviously not the case with all youth who are released from hospital, as Em no longer had a strong relationship with her mother and youth reported, and were reported, to frequently lose many friends from prior to hospitalization. BEACAUSE OF …Returning to outside relationships can be negative or toxic depending on the circumstances and therefore can be quite damaging to the recovery process (Tew

et al., 2012). Thus, negative relationships and interactions are something the community-based mental health centre tries to prevent by increasing positive experiences immediately after becoming introduced to the youth. Goals are set and achieved within the centre, in part by helping youth realize their self-worth which is often lost during hospitalization. (Re)learning self-worth can help youth find control over their future direction and current relationships.

Community-based mental health centres like the ones studied in this project limit their age range to help create a group of peers that members can relate to. Having a similar peer group during mental health service delivery can help bridge gaps between formal services and the youth's personal life (Rosenburg, 2008). Group similarity can also increase feelings of acceptance within the youth, important for a successful community reintegration (Edwards et al., 2015). Should these groups center around positive behaviours and finding successes (at least to a degree), like some activities and groups suggested within the document review, it is possible that even more of a positive outcome can be found for youth because they are able to see the potential for a better quality of life than they might have in that moment (Davidson et al., 2006).

The youth within the present study had been released from hospitalization over a year prior to the interview. The findings of the various modalities of analysis do not provide answers of how community reintegration is pursued while the process is still in its infancy. The youth in this study spoke about the mistakes they had made during community reintegration in the past tense and the workers spoke about the topic in a more conceptual way. Also, while the workers addressed community reintegration for various mental health concerns, the way various conditions beyond those of an anxiety or

depressive nature pursue community reintegration to any depth was unable to be teased out and would require a different participant group.

How does a Youth's Recovery Conceptualizations Impact the Community Reintegration Process?

A youth's recovery conceptualizations impact their approach to community reintegration and the successes and failures during it by acting as a guidance for the process in a similar way that an epistemology would guide a research project. The recovery paradigm in this study suggested youth valued functioning and sought for outlets to cope with functioning issues, such as art therapy. The community-based mental health centre the workers were employed at valued this type of service and even used it to help serve those who had not yet left hospital by taking recovering youth to institutions to teach art. The tagline for theme two is "being out is strange", and the third theme regards control. Combining the two, being out of the hospital and returning to the community means adjusting to the idea of controlling one's own recovery and no longer being forced to trying and using all the various services the hospital, as Em said, "laid out like a bazar", something foreign and strange to life in the hospital.

When youth determine which services they want to try because they fit with how they want to pursue their recovery, these services must be accessible immediately. The idea of control was commonly brought up during the analysis, especially in the interviews (as reflected in theme three), and control over one's services and treatment is an important element of recovery. Having services that are accessible are very important for youth, especially if they consider the needs most youth have outside of individualized treatment plans, such as finding independence and fostering social relationships

(Anderson & Lowen, 2010).

The social opportunities given by community-based mental health centres can help create a social agency in the youth which allows youth to feel more in control and capable over their social decisions (important considering the relationship developments and explorations traditional at this age) (Davidson et al., 2006). By creating positive social relationships within the context of the community-based mental health centre, and thus a level of social reintegration, elements of recovery can be more successfully pursued that are often very hard for youth (Chang et al., 2013). In learning how to generalize the skills taught in mental health services in a safe space, community reintegration success may be increased (Savina, Simon & Lester, 2014). Through this, youth can start also rebuilding a degree of control over their mental health concerns and the separation from community the mental health concern created.

Considering the issues of the Nova Scotian mental health system, the youth in the study have had to learn a way to make the system work for them, should they wish to succeed, a troubling neoliberalist set up which privileges those with support systems or high functioning abilities. A neoliberalist system often presents the largest challenge for those attempting to pursue recovery (Edgley et al., 2012). Because of the neoliberalism pervading the Canadian system in order to create higher degrees of economic efficiency there has been a cutting of programs, and a narrowing of professional mandates (Edgley et al., 2012). Edgley et al.'s (2012) findings make sense in context of this study's findings, as those who employ the recovery paradigm, which the youth in the study did, relate their recovery to taking responsibility for their own actions and outcomes. Unfortunately, this need to take personal responsibility seems to be one of the only ways

to successfully navigate the neoliberal health care system. The results also reflected this in how youth often took subversive actions regarding their treatment within hospital, discharging themselves or finding ways around the daily self-reflective activities meant to establish mental stability. Youth understood the system in Nova Scotia did not work, and took action, for better or worse.

In order to try and prevent the youth from falling victim to the faults of the system, workers overextend themselves to continue to provide high levels of support while dealing with issues such as increasing client lists and reductions in funding (Green, et al., 2014). While Alyssa stated in her interview that *'many more [her community-based mental health centre] would be great'* in regard to youth accessing flexible and individualized services outside of the traditional system, a double meaning can also be taken because more community-based mental health centres would lessen the burden of duties on the workers. Because Canada is moving towards a vision of recovery that supports community and utilizes the recovery paradigm (Ramon et al., 2009), it is hoped that this overburdening of the workers who are already providing this type of service will be lessened.

As both youth, and the community-based mental health centres, involved in this study employed the recovery paradigm as their primary conceptualization, the modalities of analysis did not show how youth with a different recovery conceptualization would pursue community reintegration. It cannot be known whether youth with a different conceptualization would place such an importance on learning to function and utilize non-traditional services in the same way that the youth in the present study did. The answer as to whether the approach youth took for community reintegration in the context

of the recovery paradigm would hold true for other geographical locations and thus act as a framework for the process can also not be determined. This would require various groups of various mental health concerns in various geographic locations, though the similarities in the process and perspectives within the modalities in this study do suggest a strong start for a framework for community reintegration using the recovery paradigm.

Policy Recommendations

While this study revealed the importance of community-based mental health centres and how youth using the recovery paradigm is helpful for subverting some of the difficulties of the mental health system, the study also revealed some things that can be improved upon. Using the findings of this case study, several recommendations can be made for policy makers and those involved in implementing best practices within the recovery community.

1) Actions must be taken against the siloing between the traditional medical system and community-based services and centres that prevent communication and smooth transitions. It needs to be understood that youth have discharge needs beyond immediate release and health management and their social needs must be treated as having the same importance as their mental health. Also, making these services accessible to youth under their own directive during, and after, the transition is important, because it allows for them to take control over their own mental health treatment.
    a. To do this, a discharge and transition planner must be made available for psychiatric hospitals and these planners must place importance on more than the basics of returning to school or the family home. This

position can help youth transition into social spaces and help prevent the poor information exchange between services that provide a barrier to smooth community reintegration.

   b. Prior to release, the transition planner should meet, at least several times, with the youth in order to understand their wants and needs, rather than simply relying on the expected (such as connecting a student with their school's guidance councillor), as this study showed the capability and agency youth can use. This individual understanding can help navigate the issues surrounding various levels of ability and desires found within a population with mental health concerns.

2) There is a need for more community-based mental health centres. This study shows the importance of having a space within a community to engage in recovery. The spatial separation and isolation that the hospital causes can be a major challenge for youth when they are ready to reintegrate into the community, while attempting to maintain their recovery skills. Thus, having a space which helps merge both is vital. Within the literature, it is shown that this type of mental health service is important for furthering a youth's development because it gives them the opportunity to practice the skills they will need as they age (Agnihotri et al., 2010). Within the region of the study, the opportunities for accessing this type of centre is limited and it would be highly beneficial to have centres with different focuses and specialties that still offered flexible and holistic services.

   a. Opening more centres is a financial burden, however, having locations

within the community may help the overwhelming backlog within the mental health care system, that is costing money to maintain. Funding could be found by reducing the extremely top-heavy health-care system in appreciation of the clients the system serves over those who sign the paperwork.

b. On a smaller scale, working more community-based programming into the existing services could help. For example, creating spaces in hospitals that are designated for art therapy, or allowing youth in the psychiatric hospital to be taken on day-trips outside the hospital to maintain a connection with their community, especially when the youth are on long-term stay units, may be very helpful in aiding recovery and community reintegration following release.

3) The opinion of youth need to be appreciated more. Youth are treated as if they have very little ability to decide what is best for themselves when dealing with a mental health concern (Lafrancois, 2008). Of course, not all youth will have this ability, and allowing them to make all their decisions may be dangerous but a blanket treatment of youth is also detrimental. Jenna addressed this during her interview when she spoke about being in the children's hospital at the age of seventeen and having her parents sit through every meeting with her psychiatrist, making it hard for her to talk about what she desired out of life and treatment. Understanding what the individual youth can and cannot do, without the preconceived notions of their lack of ability, is vital for youth to get the most out of their recovery.

a. Including youth who are first person voices on psychiatric hospital boards as full and legitimate members would help increase the youth voice and perspective within the units. Youth are not as removed from the psychiatric hospital situation as outside administration might be.
b. Teaching the recovery paradigm within psychiatric hospitals to the same degree recovery under the technical paradigm is taught would allow youth the opportunity to be better informed in their recovery possibilities, as youth reported learning about recovery from their institutions. Youth may find the recovery paradigm resonates more with them, or they may not, but it is important to provide more of an opportunity for that possibility.

4) Some smaller recommendations include:
   a. Taking the frosting off windows within psychiatric facilities so youth do not feel as separated from the outside community.
   b. Providing youth with more abilities to communicate with those they choose to while in hospital to maintain relationships they wish to. Perhaps a more accessible community computer (it's history could be monitored for problematic websites) in the wards would be helpful in this.
   c. Allow youth to choose if they wish to use information disclosure contracts so as to facilitate inter-agency communication on their behalf instead of assuming the youth would not want their information shared (as Mike addressed in his interview).

d. Encouraging open-door policies whenever and wherever possible can help make services more accessible. The community-based mental health centre Mike and Alyssa were employed at operated in such a way, but furthering that to other services, like the Department of Community Services, or community health clinics, would make youth more able to exert their control over what services they should want to access. Should an open-door policy not be possible, encouraging all spaces to be safe spaces for youth with mental health concerns, and for those services to be recognizable as such, may also be helpful in helping youth feel as if they can choose such a service without risk. Perhaps a recognizable sticker, a la the Pride sticker, stuck to office doors, would be an easy way to show a space as safe for youth with mental health concerns.

Health Promotion Implications

Recovery, as this study has shown, is not entirely about one's access to medical treatments. In fact, this study points to the idea that the social determinants of health (Raphael, 2004) are of even more importance to recovery. When living with mental health concerns and conceptualizing them using the recovery paradigm as the youth did, understanding how to function with remaining symptoms is highly valued. The community-based mental health centres the youth in this study used provided a location where learning how to function in all aspects of life, even minor things such as participating in spring cleaning, is integrated into the program. In fact, the community-based mental health centres in this study used the social determinants of health (Raphael,

2004) as a part of their recovery work, helping youth find secure and safe housing, teaching nutrition and providing a food bank, as well as taking youth out to local green spaces for a running club.

The Ottawa Charter places importance for mental health and well-being on creating supportive environments (World Health Organization, 1986). The results of this study show how community-based mental health centres can be a supportive place for youth pursing recovery and community reintegration, and thus should be viewed as vital services for mental health promotion. Mental health promotors should see value in the community-based mental health centres that utilize the recovery paradigm over the technical paradigm and if they cannot access the centres for their clients, they should still appreciate and attempt to utilize the skills and values of these centres in their own work.

Limitations

The largest limitation within the study is the very small sample size of four participants, two from each participant group. Two youth participants were all that could be found after months of recruitment and the worker numbers had to be matched to that to help prevent one group overpowering the other in the analysis. It also should be noted that Alyssa was not quoted frequently within the present work as her interview was substantially shorter than the other three participants. Perhaps this low number if youth was because of how recruitment was done. Perhaps different wording on the posters would have resulted in more participants as the wording on the poster may have implied a requirement of a long-term stay only, which was not the intention and only realized after recruitment had finished. As this is a master's thesis on a timeline, extending the project by several more months to go back to ethics and get a new poster and then recruit again

was not possible. Therefore, there is the potential for this study to be picked up as a pilot study and the information found within could be used to structure a larger project in future. A larger recruitment group would allow for data saturation in the themes and an expansion of the ideas presented in this study, as it cannot be said that data saturation was reached in the current study. However, structuring this study as a case study has helped reduce the negative impact of a small participant base.

The very nature of case studies provides limitations on the research in the current data driven and positivistic academy. This can even extend to qualitative research as a whole. The study is not generalizable to every youth experiencing community reintegration. This study, despite attempting robustness by having multimodal data, still only contains non-visual minority, female identifying and heterosexual (as reported through various statements by participants) youth participants. Someone who experiences intersectionality with other marginalized groups, such as sexual or visual minorities may have a very different narrative (Crenshaw, 1989). The results may also have been very different had the youth been male or male-identifying considering the current stigma surrounding male mental health and emotional expression. Within the worker population there was both a male and female identifying participant who worked with youth of all identities, and a spectrum of genders (and sexual identities) was found within the document review, so the study is not without some variance.

The geographical location of the case study can also be considered a limitation to its generalizability. The location of a small city in Atlantic Canada would certainly provide a different experience for youth pursuing recovery than that of a larger city or smaller town. The city used in this study is in a province with many challenges with

health care funding and the city does not have many options for youth for a community-based mental health centre with which to associate themselves. Rurally, this would be expected to be even less, however the social situation may be very different (the author herself is from a very rural area in Nova Scotia and experienced that first hand). A city may have more services available on paper, but this may not translate to experiences, both in service access and social reception. This case study was bound to the chosen city for practicality reasons and thus it became the story of the youth pursuing community reintegration in that location only.

Considering these limitations, one should be reminded that a case study is not supposed to be generalizable as a whole, but rather generalizable within a context (Flyvbjerg, 2006). This case study was concentrated on just a small part of the recovery process in a small population. Reaching a saturation of geographies and identities in this project was not possible for a multitude of reasons, but namely recruitment issues, yet this methodology allows for some leeway with this as it focused on the participants that were present, rather than those that were not. This search for other identities and experiences can be the mission of other projects and should not diminish the narratives of the current participants because of their relative surface homogeneity.

Future Directions

Recovery is a very individual process and thus one cannot hope to capture all experiences within a single study. This process is only something that will be understood to its fullest potential through increasing the literature base and being willing to study what is often deemed as irrelevant in literature- the youth voice in an appreciated entirety (Lafrancois, 2008). More identities and experiences should be studied, for example non-

heterosexual individuals, or those who come from varying geographic locations. The experience of a sexual minority youth in a rural community pursuing recovery may be very different than a youth, also of a sexual minority, located in Toronto. The experience, and recovery conceptualization, of a youth may also be very different than the present results if the youth utilizes formal health care system services to pursue recovery rather than community-based services as the present results showed that experiences in treatment can affect one's conceptualization. These conceptualizations could then affect how a youth pursues recovery. The differences in recovery experiences are things which can be teased apart in future work.

As Jacobson (2001) addresses, there is an irony in trying to make a theme out of the highly individualized process of recovery. Considering this, perhaps the future goal of this literature base is not to make grand sweeps across populations in an attempt to explain recovery for all in a single paper, but rather to concentrate on, or at least appreciate, the individual voice. Perhaps to do this, academia must turn to less traditional forms of knowledge generation and seek modes of study that return the power of being a knowledge holder to the participant rather than the researcher. Using methodologies like photo-voice to visually track a youth's recovery within a community setting may be an example of such a project.

Encouraging insider research would also be a valuable tool for attempting to do research on this group as they may better understand the challenges and experiences of youth pursuing recovery. Appreciating alternative knowledge holders is not something academia has done well in the past. Community-based research using insiders within the youth recovery community may be difficult but may turn out to be incredibly valuable

regarding policy recommendations because of their experiences in and with the group being studied. Health Promotion should desire this type of research considering the importance the discipline places on understanding the varied social determinants of health (Raphael, 2004) and appreciation of marginalized voices, but also because this type of research may serve as a way to return agency to a group which often has had that taken from them through hospitalization (Lafrancois, 2008). Thus, this insider-lead community-based research could also be considered an important part of an individual's recovery if research should be something they are ready and willing to do.

Conclusions/Chapter Five Summary

Community reintegration is an important step in recovery post hospitalization. Feeling a sense of belonging to the community one exists in is vital for those conceptualizing their recovery using the recovery paradigm (Edgley et al., 2012). Within this study, community reintegration in the context of a community-based mental health centre that employed the recovery paradigm allowed youth to return to their communities and regain control over their lives through providing safe spaces for socialization, goal setting (and achieving) and learning skills to reach recovery in the functioning sense. These results fit well with current research that suggests promoting the recovery paradigm (as youth reported having their recovery conceptualizations shaped through their experiences in the system) helps create a sense of agency and control over one's own health (Gagne, White & Anthony, 2007; Jacobson, 2001).

The current process-bound case study (Merriam, 1998) provided an in-depth exploration of how youth conceptualized their own recovery and the results lent policy recommendations for other communities looking to set up this type of service. Utilizing

the recovery paradigm within a community-based mental health centre embraces the social determinants of health (Raphael, 2004) as part of the recovery process. Mental health promoters should look to embrace the recovery paradigm for youth and community-based mental health centres as conduits for youth mental health success, and above all, should look to promote the youth voice as being just as legitimate as any service provider.

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Appendix A

Recruitment Poster

Appendix B

Youth Recruitment Email

Dear _____;

Thank you for contacting me regarding the study *Recovery Conceptualizations in Youth Undergoing Community Reintegration following Hospitalization.* I would like to now formally invite you to participate in a research study on the topic of recovery approaches as you reenter your community following release from a psychiatric hospital.

Objectives of the study:
1. Explore how youth think about recovery after being released from psychiatric hospital.
2. Explore how youth return to their community after being released from psychiatric hospital and the successes and failures of it.

Your involvement in the current study would consist of participating in a face-to-face interview. There may be some risks to participating in this study. You may find that talking to a researcher about your mental health recovery and belonging in the community could be upsetting and you could experience distress in relating this information to the researcher. In recognition of this, safeguards have been put in place to ensure your safety and comfort. The expected length of the interview (~60 minutes) may also be an inconvenience. If you wish to withdraw from the study, you may do so at any time without penalty. I have attached a consent form for further detail on this study and the risks and benefits.

This project will be carried out as part of the requirements of my Master of Arts thesis in Health Promotion at Dalhousie University. I will be supervised by Dr. Lynne Robinson throughout this study. This research has been reviewed by the Research Ethics Board at Dalhousie University. If you have any concerns or questions about your participation or how this study is conducted, you may contact the Dalhousie Research Ethics Board by phone [(902-494-3423] or by email [ethics@dal.ca].

I would like to thank you in advance for your time and consideration. After one week, I will send you a one-time follow-up email reminder. If you wish to participate, please respond to this email and we will set up a date and time for the interview. Prior to the start of the interview you will be asked to read, review and sign a consent form the researcher will provide (identical to the attached consent form).

Sarah MacCallum

Master of Arts Candidate, Health Promotion
Dalhousie University, Faculty of Health and Human Performance
Email: Sarah.MacCallum@dal.ca

Appendix C

Worker Recruitment Email

Recruitment Email (Subject Line: Research Study: Recovery conceptualizations in youth undergoing community integration following hospitalization)

Dear _____,

I am inviting you to participate in a research study on the topic of recovery conceptualizations in youth undergoing community reintegration in community-based mental health centres following hospitalization.
Objectives of the study:
1. Explore how youth think about recovery after being released from psychiatric hospital.
2. Explore how youth return to their community after being released from psychiatric hospital and the successes and failures of it.

You have been identified as a prospective participant through the staff page at Laing House.
Your involvement in the current study would consist of participating in a in-person interview. The risks/discomfort involved in this study is minimal, with the biggest one being the time commitment of the interview (~60 minutes). You will receive a $20 gift card from Starbucks or Tim Hortons (your choice) for your participation. If you wish to withdraw from the study, you may do so at any time without penalty. I have attached a consent form that gives you the full details.
This project will be carried out in fulfillment of my Master's Program at Dalhousie University. Dr. Lynne Robinson will supervise me throughout this study. This research has been reviewed by the Research Ethics Board at Dalhousie University. If you have any concerns or questions about your participation or the conduction of this study, you may contact Dalhousie's Research Ethics Board by email at ethics@dal.ca.
We would like to thank you in advance for your time and consideration. After a week, I will send you a one-time follow-up email reminder. If you wish to participate, please confirm with me. I will then contact you to schedule a convenient time for the interview and you will sign the consent form I bring (the same as the one attached) should you still be agreeable before the start of the interview.
Thank you,

Sarah MacCallum

Appendix D

Worker Reminder Email

Hello,

This is a reminder of the email sent to you a week ago, subject line "Research Study: Recovery conceptualizations in youth undergoing community integration following hospitalization" regarding participating in my study on recovery in youth. I have pasted the original email below this.
It would be very much appreciated if you could answer this email with a yes, or no (note, there are no repercussions for saying no, an answer is beneficial for scheduling).
Thank you,
Sarah MacCallum

Recruitment Email (Subject Line: Research Study: Recovery conceptualizations in youth undergoing community integration following hospitalization)

Dear _____,

I am inviting you to participate in a research study on the topic of recovery conceptualizations in youth undergoing community reintegration in community-based mental health centres following hospitalization.
Objectives of the study:
1. Explore how youth think about recovery after being released from psychiatric hospital.
2. Explore how youth return to their community after being released from psychiatric hospital and the successes and failures of it.

You have been identified as a prospective participant through the staff page at Laing House.
Your involvement in the current study would consist of participating in a in-person interview. The risks/discomfort involved in this study is minimal, with the biggest one being the time commitment of the interview (~60 minutes). If you wish to withdraw from the study, you may do so at any time without penalty. I have attached a consent form that gives you the full details.
This project will be carried out in fulfillment of my Master's Program at Dalhousie University. Dr. Lynne Robinson will supervise me throughout this study. This research has been reviewed by the Research Ethics Board at Dalhousie University. If you have any concerns or questions about your participation or the conduction of this study, you may contact Dalhousie's Research Ethics Board by email at ethics@dal.ca.
We would like to thank you in advance for your time and consideration. After a week, I will send you a one-time follow-up email reminder. If you wish to participate, please confirm with me. I will then contact you to schedule a convenient time for the interview and you will sign the consent form I bring (the same as the one attached) should you still be agreeable before the start of the interview.
Thank you,

Sarah MacCallum

Appendix E

Youth Consent Form

Project title: Recovery Conceptualizations of Youth Undergoing Community Reintegration following Psychiatric Hospitalization

Lead researcher: Sarah MacCallum, Dalhousie University, Sarah.MacCallum@dal.ca

Other researchers
Lynne Robinson, Dalhousie University, Lynne.Robinson@dal.ca

Funding provided by: Maritime SPOR Support Unit Studentship Award

Introduction

We invite you to take part in a research study being conducted by me, Sarah MacCallum, a student at Dalhousie University, completing a Health Promotion Master's Degree. Choosing whether or not to take part in this research is entirely your choice. There will be no impact on your mental health service access if you decide not to participate in the research. The information below tells you about what is involved in the research, what you will be asked to do and about any benefit, risk, inconvenience or discomfort that you might experience.

Should you have any concerns, questions or comments, please contact Sarah as many times as needed. If you have questions later, please contact Dr. Robinson, the project's supervisor.

Purpose and Outline of the Research Study

The current study will explore how the way one thinks about recovery impacts how one finds belonging in the community after returning to it from a period in a psychiatric hospital/ward. It will look at the successes and failures of this process, as well as exploring what recovery means to participants, and what it looks like.

Who Can Take Part in the Research Study

You may participate in this study if you are between the ages of 16-25, live in the HRM region and have been hospitalized for a psychiatric concern, and released, within the last two years.

What You Will Be Asked to Do

You will be asked during this study to attend a one-time interview that is expected to last a total of one hour. This interview will take place on the Dalhousie campus at Stairs House. During the interview you will be asked questions regarding your mental health recovery. The interview will be audio-recorded unless you wish for it not to be, for which the primary researcher will then take notes as you speak so your interview may still be included in the analysis. If you do not give permission for audio-recording, or note taking, the interview will not be able to continue, but you will still get a thank you gift

card and experience no negative repercussions to withdrawing. The usage of your direct quotes is also optional, but as with the note taking, your quotes will need to be included in the analysis (though will not be seen by anyone but the primary researcher and her supervisor).

If you would like, after the interview concludes (whether ended early or not) there will be cards available that have my contact information on them that can be passed along to others who may qualify for this study. Please know that you do not have to take one, and if you do take one you do not have to pass it along to anyone. No negative repercussions will happen if you do not take one or do not pass it along.

Possible Benefits, Risks and Discomforts
Participating in the study might not benefit you, but we might learn things that will benefit others by providing evidence for better mental health policy.

There are some risks to participating in this study. You may find that talking to a researcher about your mental health recovery and belonging in the community could be upsetting and you could experience distress in relating this information to the researcher. In recognition of this, safeguards have been put in place to ensure your safety and comfort.

In recognition of unexpected distress, you will be offered support items like candy and fidget toys during the interview and a list of supports that can be accessed in the HRM region following the interview. You may also choose to not answer questions due to the personal nature of them and may decline questions with no negative repercussions. If distress increases to a dangerous level due to the potential emotional element of some questions, and there is concern for your safety, the primary researcher is obligated to call campus security. This would be done to maintain *your* safety as they have procedures for distressed individuals. Should the security officers (as informed by the researcher) feel concerned for your immediate safety during the interview, or other's safety, in any way, 911 may be called.

It is highly suggested that you only conduct the interview if you feel able to answer questions regarding your mental health recovery (though you can decline to answer questions at any time throughout the interview). This is for your own mental health safety, as if you are not prepared to relate the information, you may experience psychological distress.

As all communication is through the format of email, you will assume any risks of access to your personal email. Email is not a secure medium in the sense that I, as a researcher cannot control who can access your emails and they can be linked to your personal identity. Please use an email that is only yours (not shared) and only if you feel comfortable with it and access it on a computer which is not shared, or shared only with those you feel comfortable with. Should any files be sent (i.e. for transcript review), they will be sent via a time secure file share program which after a period of three months will stop working and thus no one will be able to reach the file from the email link (I will also

delete those files on the same day).

Compensation / Reimbursement
To thank you for your time, we will give you a $20 Tim's Card or Starbucks Gift Card for attending, whether or not the interview is completed. You will be given the opportunity to choose which card you would prefer when setting up the interview.

How your information will be protected:
Your interview will take place in an unmarked space (i.e. no signs to refer to what is occurring inside) with only the primary researcher present to ensure your privacy will remain intact. No one will know who you are except for the primary researcher. The primary researcher will utilize the utmost caution in ensuring this. Consent forms, and the document matching your alias with your name (should you forget what your alias was when contacting me for reviewing transcripts) will be kept in a separate locked drawer than the transcripts and a digital copy of the consent forms and alias document will not exist. It should be known that the study's supervisor will have access to these drawers (as she has a key), but she is a registered psychologist and thus is obligated to adhere to a strict and stringent ethical and confidential code and thus your information will be kept private. Electronic transcripts and any analysis documents will only contain your alias and be de-identified, and will be encrypted and password protected and held on the researcher's password protected computer.

All data you provide will be transcribed and coded, then the audio file will be promptly deleted. Data transcripts will be stored in an encrypted password protected file on the researcher's computer, of which only she will have direct access to. De-identified transcripts will be seen by the study's supervisor. All files will have any identifiers removed and be titled the alias chosen by yourself prior to the start of the interview. All consent forms will be kept separate, in a locked filing cabinet in the researcher's supervisor's office. Any files sent to you (you will assume risks for utilizing your personal email as I cannot prevent others from accessing your personal email) will be through a time sensitive, file share link that I will send you. You will only have access to your transcript on this file share.

We will not disclose any information about your participation in this research to anyone unless compelled to do so by law. That is, in the unlikely event that we witness the potential for imminent danger to yourself or others, or suspect it, we are required to contact authorities.

Information that you provide to us will be kept private. Only the research team at Dalhousie University will have access to this information. We will describe and share our findings in the form of a thesis, presentations, summary reports and journal articles. We will be very careful to only talk about group results so that no one will be identified. This means that ***you will not be identified in any way in our reports***. Also, we will use your chosen alias in our written and computer records so that the information we have about you contains no names. Should you mention anyone or place by name in your interview, these will also be de-identified and removed, replaced by [name] or [location] in

transcripts to protect others you know, as well as working to make sure your transcript cannot be traced back to you through mentioned others. All your identifying information will be securely stored in the project's supervisor's office in a locked cabinet. All electronic records of transcripts (de-identified and only with aliases) will be kept secure in an encrypted file on the researcher's password-protected computer.

Data will be held for the length of time recommended by Dalhousie University in paper format in the supervisor's office to be destroyed after a period of five years. All electronic encrypted copies will be uploaded to a flash drive to be kept in the researcher's safe and then destroyed (flash drive included) after five years. Audio recordings will be erased as soon as transcribing is complete and if you do not want an audio recording done and instead allows for notes to be taken, the note paper will be shredded as soon as the information has been recorded into the encrypted files. Should you require the link for the secure time sensitive file share to view your transcript, following completion of their review, and any editing which is asked (and then reviewed), the file will be deleted from the site and thus can no longer be accessed. As the file link is also time sensitive, after the period you will also not be able to reach the document.

If You Decide to Stop Participating

You are free to leave the study at any time. If you decide to stop participating at any point in the study, you can also decide whether you want any of the information that you have contributed up to that point to be removed or if you will allow us to use that information. You can also decide for up to three months if you want us to remove your data. After that time, it will become impossible for us to remove it because it will already be analyzed. To withdraw your data, please contact the primary researcher via email (sarah.maccallum@dal.ca). By contacting the researcher to remove data, you take on the risk of using your email and thus it is highly suggested you use a private, non-shared email to maintain your privacy.

How to Obtain Results

We will provide the centres involved in recruitment with a short description of group results when the study is finished which would be made available for those within the centres to read. No individual results will be provided. You can obtain these results by visiting the community-based mental health centre you were recruited from in approximately April 2018.

Questions

We are happy to talk with you about any questions or concerns you may have about your participation in this research study. Please contact Sarah MacCallum at Sarah.MacCallum@dal.ca or Lynne Robinson at Lynne.Robinson@dal.ca at any time with questions, comments, or concerns about the research study. We will also tell you if any new information comes up that could affect your decision to participate.

If you have any ethical concerns about your participation in this research, you may also contact Research Ethics, Dalhousie University at (902) 494-1462, or email: ethics@dal.ca (and reference REB file # 2017-4210).

Other

See TCPS2 Article 3.2 for additional suggested consent form items that may need to be addressed for your particular study, such as conflict of interest, commercialization, and not waiving legal rights.

Signature Page **#_xxxx__**

Project Title: Recovery Conceptualizations of Youth Undergoing Community Reintegration following Psychiatric Hospitalization.

Lead Researcher: Sarah MacCallum, Dalhousie University, Sarah.MacCallum@dal.ca

I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I understand that I have been asked to take part in an interview that will occur at a location acceptable to me. I agree to take part in this study. I realize that my participation is voluntary and that I am free to withdraw from the study at any time, until three months after my interview is completed.

_____	_____	_____
Name	Signature	Date

I agree that my interview may be audio-recorded ☐Yes ☐No

- If no, I agree that notes may be taken during my interview ☐Yes ☐No

I agree that direct quotes from my interview may be used without identifying me ☐Yes ☐No

_____	_____	_____
Name	Signature	Date

I confirm I have completed the interview and agree that direct quotes without my name may be used.

_____	_____
Signature	Date

Appendix F

Worker Consent Form

Project title: Recovery Conceptualizations of Youth Undergoing Community Reintegration following Psychiatric Hospitalization

Lead researcher: Sarah MacCallum, Dalhousie University, Sarah.MacCallum@dal.ca

Other researchers
Lynne Robinson, Dalhousie University, Lynne.Robinson@dal.ca

Funding provided by: Maritime SPOR Support Unit Studentship Award

Introduction

We invite you to take part in a research study being conducted by me, Sarah MacCallum, a student at Dalhousie University, completing a Health Promotion Master's Degree. Choosing whether or not to take part in this research is entirely your choice. There will be no impact on your mental health service access if you decide not to participate in the research. The information below tells you about what is involved in the research, what you will be asked to do and about any benefit, risk, inconvenience or discomfort that you might experience.

Should you have any concerns, questions or comments, please contact Sarah as many times as needed. If you have questions later, please contact Dr. Robinson, the project's supervisor.

Purpose and Outline of the Research Study

The current study will explore how the way youth think about recovery impacts how they find belonging in the community after returning to it from a period in a psychiatric hospital/ward. It will look at the successes and failures of this process, as well as exploring what recovery means to participants, and what it looks like.

Who Can Take Part in the Research Study

You may participate in this study if you work at a community-based mental health center.

What You Will Be Asked to Do

You will be asked during this study to attend a one-time interview that is expected to last a total of one hour. This interview will take place on the Dalhousie campus at Stairs House. During the interview you will be asked questions regarding mental health recovery for youth who have been involved with the community-based mental health center you work at. The interview will be audio-recorded unless you wish for it not to be, for which the primary researcher will then take notes as you speak so your interview may still be included in the analysis. If you do not give permission for audio-recording, or note taking, the interview will not be able to continue, but you will still get a thank you gift card and experience no negative repercussions to withdrawing. The usage of your direct

quotes is also optional, but as with the note taking, your quotes will need to be included in the analysis (though will not be seen by anyone but the primary researcher and her supervisor).

Possible Benefits, Risks and Discomforts
Participating in the study might not benefit you, but we might learn things that will benefit others by providing evidence for better mental health policy.

There are some risks to participating in this study. It is expected that the biggest inconvenience will be the time it takes to complete the interview. However, you may find that talking to a researcher about your work to be uncomfortable. Please note that in no way will your place of employment be identified in the study, nor will your superiors be aware of your involvement or your answers. You will also not be asked about your work habits, or work relationships, but instead about your general experiences with youth undergoing recovery in the community. However, in recognition of unexpected distress, safeguards have been put in place to ensure your safety and comfort.

In recognition of unexpected distress, you will be offered support items like candy and fidget toys during the interview. You may also choose to not answer questions and may decline questions with no negative repercussions.

As all communication is through the format of email, you will assume any risks of access to your personal email. Email is not a secure medium in the sense that I, as a researcher cannot control who can access your emails and they can be linked to your personal identity. Please use an email that is only yours (not shared) and only if you feel comfortable with it and access it on a computer which is not shared, or shared only with those you feel comfortable with. Should any files be sent (i.e. for transcript review), they will be sent via a time secure file share program which after a period of three months will stop working and thus no one will be able to reach the file from the email link (I will also delete those files on the same day).

Compensation / Reimbursement
To thank you for your time, we will give you a $20 Tim's Card or Starbucks Gift Card for attending, whether or not the interview is completed. You will be given the opportunity to choose which card you would prefer when setting up the interview.

How your information will be protected:
Your interview will take place in an unmarked space (i.e. no signs to refer to what is occurring inside) with only the primary researcher present to ensure your privacy will remain intact. The interview will also take place away from your place of work on the Dalhousie campus. No one will know who you are except for the primary researcher. The primary researcher will utilize the utmost caution in ensuring this. Consent forms, and the document matching your alias with your name (should you forget what your alias was when contacting me for reviewing transcripts) will be kept in a separate locked drawer than the transcripts and a digital copy of the consent forms and alias document will not exist. It should be known that the study's supervisor will have access to these drawers (as

she has a key), but she is a registered psychologist and thus is obligated to adhere to a strict and stringent ethical and confidential code and thus your information will be kept private. Electronic transcripts and any analysis documents will only contain your alias and be de-identified, and will be encrypted and password protected and held on the researcher's password protected computer.

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We will not disclose any information about your participation in this research to anyone unless compelled to do so by law. That is, in the unlikely event that we witness the potential for imminent danger to yourself or others, or suspect it, we are required to contact authorities.

Information that you provide to us will be kept private. Only the research team at Dalhousie University will have access to this information. We will describe and share our findings in the form of a thesis, presentations, summary reports and journal articles. We will be very careful to only talk about group results so that no one will be identified. This means that ***you will not be identified in any way in our reports, nor will you be connected in any way to any other people interviewed***. Also, we will use your chosen alias in our written and computer records so that the information we have about you contains no names. Should you mention anyone or place by name in your interview, these will also be de-identified and removed, replaced by [name] or [location] in transcripts to protect others you know, as well as working to make sure your transcript cannot be traced back to you through mentioned others. All your identifying information will be securely stored in the project's supervisor's office in a locked cabinet. All electronic records of transcripts (de-identified and only with aliases) will be kept secure in an encrypted file on the researcher's password-protected computer.

Data will be held for the length of time recommended by Dalhousie University in paper format in the supervisor's office to be destroyed after a period of five years. All electronic encrypted copies will be uploaded to a flash drive to be kept in the researcher's safe and then destroyed (flash drive included) after five years. Audio recordings will be erased as soon as transcribing is complete and if you do not want an audio recording done and instead allows for notes to be taken, the note paper will be shredded as soon as the information has been recorded into the encrypted files. Should you require the link for the secure time sensitive file share to view your transcript, following completion of their review, and any editing which is asked (and then reviewed), the file will be deleted from

the site and thus can no longer be accessed. As the file link is also time sensitive, after the period you will also not be able to reach the document.

If You Decide to Stop Participating
You are free to leave the study at any time. If you decide to stop participating at any point in the study, you can also decide whether you want any of the information that you have contributed up to that point to be removed or if you will allow us to use that information. You can also decide for up to three months if you want us to remove your data. After that time, it will become impossible for us to remove it because it will already be analyzed. To withdraw your data, please contact the primary researcher via email (sarah.maccallum@dal.ca). By contacting the researcher to remove data, you take on the risk of using your email and thus it is highly suggested you use a private, non-shared email to maintain your privacy.

How to Obtain Results
We will provide the centres involved in recruitment with a short description of group results when the study is finished which would be made available for those within the centres to read. No individual results will be provided. You can obtain these results by visiting the community-based mental health centre you were recruited from in approximately May 2018.

Questions
We are happy to talk with you about any questions or concerns you may have about your participation in this research study. Please contact Sarah MacCallum at Sarah.MacCallum@dal.ca or Lynne Robinson at Lynne.Robinson@dal.ca at any time with questions, comments, or concerns about the research study. We will also tell you if any new information comes up that could affect your decision to participate.

If you have any ethical concerns about your participation in this research, you may also contact Research Ethics, Dalhousie University at (902) 494-1462, or email: ethics@dal.ca (and reference REB file # 2017-4210).

Other
See TCPS2 Article 3.2 for additional suggested consent form items that may need to be addressed for your particular study, such as conflict of interest, commercialization, and not waiving legal rights.

Signature Page **#_xxxx__**

Project Title: Recovery Conceptualizations of Youth Undergoing Community Reintegration following Psychiatric Hospitalization.

Lead Researcher: Sarah MacCallum, Dalhousie University, Sarah.MacCallum@dal.ca

I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I understand that I have been asked to take part in an interview that will occur at a location acceptable to me. I agree to take part in this study. I realize that my participation is voluntary and that I am free to withdraw from the study at any time, until three months after my interview is completed.

_____ _____ _____

Name Signature Date

I agree that my interview may be audio-recorded ☐Yes ☐No

- If no, I agree that notes may be taken during my interview ☐Yes ☐No

I agree that direct quotes from my interview may be used without identifying me ☐Yes ☐No

_____ _____ _____

Name Signature Date

I confirm I have completed the interview and agree that direct quotes without my name may be used.

_____ _____

Signature Date

Appendix G

Linking Document

0001	__(alias)_____
0002	_____
0003	_____
0004	_____
0005	_____
0006	_____
0007	_____
0008	_____
0009	_____
0010	_____

Appendix H

Youth Interview Guide

(**Script to be read to participant, word for word.)**
Thank you for agreeing to participate in this study. Please remember that you can withdraw at any time. All you must do to withdraw is tell me you would like to end the interview. This will have no repercussions. Do you have any questions before we start? (If no, recorder will be turned on)

Interview Questions

1. What does recovery mean to you?
    - Do you think you can recover?
2. What type of things did you learn about recovery (i.e through workshops, therapy, etc) while in hospital?
3. How do these things match or differ from how you see your own recovery?
    - Why is this?
4. What is it like being outside of the hospital again?
    - Have any aspects of your life (like relationships, school) changed?
    - Do you have any life goals regarding being outside of the hospital?
    - What have been the biggest challenges?
    - What has been the biggest help?
    - Have there been parts of your life you have trouble returning to?
    - What has been the easiest part of your life to return to?
5. What services would you like to access now that you are out of the hospital to help you with your recovery?
    - Why is this?
6. What prevents you from feeling in control of your mental illness?
7. What helps you feel more in control of your mental illness?

This concludes our interview. Is there anything else you would like to add regarding what we've talked about today?

Thank you for participating. If you would like, there are cards available that have my contact information on them that can be passed along to others who may qualify for this study. Please know that you do not have to take one, and if you do take one you do not have to pass it along to anyone. No negative repercussions will happen if you do not take one or do not pass it along.

Appendix I

Worker Interview Guide

(**Script to be read to participant, word for word.)**
Thank you for agreeing to participate in this study. Please remember that you can withdraw at any time. All you must do to withdraw is tell me you would like to end the interview. This will have no repercussions. Do you have any questions before we start? (If no, recorder will be turned on)

Interview Questions

1. What does recovery mean to you?
    - Do you think people can recover?
2. What type of things do you teach about recovery (i.e through workshops, therapy, etc) here?
3. How do these things match or differ from how youth see their own recovery?
    - Why is this?
4. What is it like for youth being outside of the hospital again?
    - What aspects of a youth's life (like relationships, school) change the greatest following release from hospital?
    - What are the most common life goals regarding being outside of the hospital reported by the youth here?
    - What things are the biggest challenges for youth in this stage?
    - What things are the biggest help for youth in this stage?
    - What are the parts of life that youth have the most trouble returning to?
        - How can this change/be supported?
    - What are the easiest parts of life to return to?
5. What services would you like to be able to provide youth once they are out of the hospital to help with their recovery?
    - Why is this?
6. What prevents youth from feeling in control of their mental illness?
7. What helps youth feel more in control of their mental illness?

This concludes our interview. Is there anything else you would like to add regarding what we've talked about today?