THE PROVISION OF PERSON-CENTRED CARE IN MENTAL HEALTH CARE SETTINGS THROUGH RECREATION THERAPY PROFESSIONALS

DEVAN MARK JOSEPH MCNEILL, MA, CTRS
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DEVAN MARK JOSEPH MCNEILL

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Dr. Sienna Caspar Thesis Supervisor	Associate Professor	Ph.D.
Dr. James Sanders Thesis Examination Committee Member	Associate Professor	Ph.D.
Dr. Lisa Howard Thesis Examination Committee Member	Assistant Professor	Ph.D.
Dr. Robert Kossuth Internal External Examiner Department of Kinesiology & Physical Education Faculty of Arts and Science	Associate Professor	Ph.D.
Dr. Bryan McCormick External External Examiner Department of Health and Rehabilitation Sciences College of Public Health Temple University	Professor	Ph.D.
Dr. Julia Brassolotto Chair, Thesis Examination Committee	Associate Professor	Ph.D.

DEDICATION

This dissertation is dedicated to my family. As the first to reach this milestone, I owe this achievement to your patience, love, and unwavering belief in me, even in the moments when I doubted myself. Your support has been my foundation. To my loving partner, Bradley, thank you for the countless conversations, the many adjustments in our lives, and your steadfast encouragement as I worked to complete this degree.

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To my colleagues and friends, thank you for the conversations, the laughter, the shared struggles, and the moments of encouragement that sustained me throughout this journey. Your presence made this work both possible and deeply enriching.

ABSTRACT

This manuscript-based thesis explores the complex dynamics that shape the practice of recreation therapy (RT) within mental health care settings in Western Canada, focusing on person-centred care (PCC), patient privileges, and the staffing practices of RT professionals. It aims to clarify how these factors interact to shape the quality of care and the experiences of both RT professionals and patients. In the first manuscript, a concept analysis was conducted to define and analyze the concept of PCC. This analysis identified five key attributes of PCC: care tailored to the person, active engagement, clear communication and active listening, a holistic perspective, and empathy and compassion. These findings emphasized the importance of fostering an environment that prioritizes personhood, highlighting the need for increased time with patients and the promotion of active listening. The second manuscript utilized institutional ethnography (IE) as a method of inquiry to examine how institutional practices surrounding patient privileges impact RT professionals' work. By analyzing data from institutional texts and 18 in-depth interviews, this research revealed that institutional practices around patient privileges influence RT professionals' ability to engage with patients and maintain therapeutic effectiveness. The study identified that variations in practices impacted patient and professional autonomy, privilege assignment, and patient attendance in RT programs. In the final manuscript, IE was used as a method of inquiry to investigate managerial structures and staffing practices that influence the work of RT professionals. Findings from this study suggest that managerial support, well-defined roles, and consistent staffing are essential to improving both the work environment for RT professionals and the quality of care provided to patients. Together, findings from these studies highlight the need for integrated approaches to mental health care that prioritize PCC, ensure clear and consistent institutional practices around patient privileges, and

address staffing challenges. This thesis contributes to a deeper understanding of how organizational and relational dynamics in mental health care can be optimized to improve both patient outcomes and professional well-being.

CONTRIBUTIONS OF AUTHORS

The manuscript presented in Chapter 2, *Person-Centred Care in Canadian Mental Health Settings: A Concept Analysis*, is the result of a collaborative effort. I acknowledge the significant contributions of Drs. Caspar, Sanders, and Howard. In particular, Dr. Caspar contributed to the conception of the study, data analysis, manuscript drafting, and provided overall supervision. Drs. Sanders and Howard contributed to the study's conception and manuscript drafting. This manuscript has been submitted to a Canadian mental health journal for publication, with me as the primary author and Drs. Caspar, Sanders, and Howard as co-authors.

The manuscripts presented in Chapter 3**,** *The Impact of Patient Privilege Policies on Recreation Therapy Practice in Mental Health Care*, and Chapter 4, *Exploring Management Structures and Staffing Practices in Recreation Therapy: Challenges and Insights from Mental Health Settings*, have not yet been submitted for publication. These chapters also reflect collaborative work with Drs. Caspar, Sanders, and Howard. The co-authors contributed to study conception, data analysis, and manuscript drafting. As with Chapter 2, I will be the primary author of these manuscripts, with Drs. Caspar, Sanders, and Howard listed as co-authors.

ETHICS STATEMENT

The work described in this thesis received research ethics approval from the University of Alberta Research Ethics Board, Project Name "THE PROVISION OF PERSON-CENTRED CARE IN MENTAL HEALTH CARE SETTINGS THROUGH RECREATION THERAPY PROFESSIONALS", No. Pro00127334, March 31st, 2023.

USE OF GENERATIVE AI

The use of Grammarly and ChatGPT, both generative artificial intelligence tools, played a significant role in supporting the presentation of this thesis. Its primary function was to assist with grammar checks and offer synonym recommendations. It is important to note that ChatGPT was not employed to generate new content or ideas; rather, it was used to refine and diversify the author's existing writing, enhancing clarity and variation in expression.

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LIST OF ABBREVIATIONS

IE	Institutional Ethnography
PCC	Person-Centred Care
RT	Recreation Therapy

CHAPTER 1: INTRODUCTION

Mental disorders affect one in every eight people worldwide (WHO, 2022) and one in seven Canadians (Public Health Agency of Canada, 2020). The World Health Organization (WHO, 2022) defines mental disorders as a condition that has clinically significant disturbances in thinking, emotional regulation, or behaviour. For example, individuals with schizophrenia may experience disturbances with hallucinations or delusions. These disturbances can cause significant distress and impair functioning in various areas, including social, occupational, and other activities, for individuals (Public Health Agency of Canada, 2020). Despite advancements in prevention and treatment, persons with mental disorders experience stigma, discrimination, and human rights violations (WHO, 2022). Globally, health systems are failing to respond to the increased needs of people with mental disorders, prompting the World Health Organization (2022) to call for the expansion and improvement of mental health services.

The recovery model has gained prominence in Canadian mental health services, shifting the focus from simply treating the patient to caring for the whole person (Alberta Health, 2017). It is important to distinguish this model from the recently introduced Alberta Recovery Model under the *Compassionate Intervention Act* (Government of Alberta, 2025), which centres on mandatory treatment for persons with substance use and addiction issues. Critics argue that this approach may risk (re)traumatization (Duggan, 2025). In contrast, this thesis adopts the recovery model as outlined by Alberta Health (2017), which prioritizes individual autonomy and supports self-directed decision-making in the recovery process.

Alberta Health Services defines recovery-oriented care as an approach that emphasizes working in collaboration with individuals to honour their choices, autonomy, dignity, and self-determination—moving beyond just symptom management (Alberta Health Services, 2020). In

its report, *Valuing Mental Health: Next Steps* (Alberta Health, 2017), Alberta Health promotes the use of person-centred care (PCC) as part of the shift towards the recovery model. PCC places the person receiving care at the centre of all health interventions and decisions and has been labelled as a more holistic approach to care than others, such as the medical model approach to care (Hebblethwaite, 2013). Person-centredness recognizes a person's individuality and reduces the authoritative relationship that may result from seeing the person as a patient (Slater, 2006). The Mental Health Commission of Canada (2016) prioritizes the use of PCC to improve the availability of quality mental health services.

The concept of PCC is growing in both practice settings and research literature (McKay et al., 2021). The concept of person-centredness dates back to the 1940s, when American humanistic psychologist Carl Rogers introduced it as a moral ideal of respecting a person's autonomy (Thórarinsdóttir & Kristjánsson, 2014). Carl Rogers was one of the first to conceptualize PCC in psychological practice, challenging traditional psychiatric approaches and asserting that individuals have the capacity to guide their own lives (Anderson, 2001). Placing the person at the centre of their care implies that they are actively involved in making decisions about their lives.

In the updated *Comprehensive Mental Health Action Plan* report, the WHO recommends that person-centred recovery-oriented approaches be taught to general and specialized health workers (WHO, 2021a). The WHO (2021b) suggests that PCC is a comprehensive, multidisciplinary, and inclusive mental health care system approach. However, a consensus on the precise definition and implementation strategy for PCC remains elusive among provincial, national, and international organizations, allowing for significant variation in its interpretation.

Previous research has highlighted a gap between organizations' public endorsement of PCC and the actual structural and cultural changes needed for its successful implementation (Hebblethwaite, 2013). McKay et al. (2021) suggest that PCC can be effectively implemented in mental health settings through clear communication, respect for individuals, and the identification of available choices, even when those choices are limited. Despite these insights, McKay et al. (2021) argue that there is insufficient evidence on how to best implement PCC across mental health systems or integrate it into policies universally.

Morgan and Yoder (2012) and Slater (2006) discussed personalizing approaches to PCC that encourage decision-making and autonomy of persons in care. However, they fail to fully address the level of engagement required from individuals in the care process. Active engagement involves persons being proactive in decision-making rather than passive recipients of care (Stuart, 2017). In coercive mental health care environments—such as involuntary settings where some force is used, such as locked doors—engaging individuals in decision-making can be particularly challenging. McKay and colleagues' (2021) scoping review of PCC in coercive settings identified ethical tensions, such as managing safety concerns and restricting choices and decisions. They propose a four-themed framework for PCC in a coercive mental health environment: (1) communication, (2) choice and control, (3) physical spaces, and (4) relationships. McKay and colleagues (2021) conducted a global literature review with limited Canadian content; therefore, this thesis offers a Canadian perspective.

While guidelines for implementing PCC exist in the mental health literature, they often lack conceptual clarity and a universally accepted definition (McKay et al., 2021). In the field of recreation therapy (RT), there is also a lack of consensus on the definition of PCC (Hebblethwaite, 2013). Nevertheless, many RT professionals are eager to adopt the PCC

approach in their practice despite structural, systems, and policy barriers (Hebblethwaite, 2013). One consideration in providing PCC in mental health environments—particularly involuntary—includes navigating legal frameworks such as Alberta's Mental Health Act, which restricts a person's choice and control to manage potentially dangerous behaviours (McKay et al., 2021). These restrictions complicate the implementation of PCC, in part due to the diverse perspectives among healthcare team members. Examining the social relations within organizations may provide insights into challenges faced in shifting to PCC practices. The purpose of this thesis is to explore how the work of RT professionals is socially organized in mental health care services and how this impacts their provision of PCC.

Discovering the Problematic

Discovering the problematic is the starting point of inquiry and an important step in institutional ethnography (IE) studies (Rankin, 2017b). The problematic focuses on people's experiences that require further investigation (Rankin, 2017a). The researcher must familiarize themselves with the experienced actualities to identify a problematic (Campbell & Gregor, 2008). The experienced actualities start with my years as an RT professional working in Canadian mental health services. For this inquiry, I draw on Caspar's (2014) framework for discovering a problematic by discussing my experiences and observations as a former RT professional working in mental health services, including inpatient and community settings. These experiences have shaped my thoughts on PCC and highlighted several institutional barriers that hinder its implementation in practice.

From Compliance to Critique: My Journey in Mental Health RT Practice

In the early stages of my career as a novice RT professional, I strictly adhered to the policies and procedures set by the mental health agency for providing care. In retrospect, I now recognize that these protocols were designed to control and prescribe treatment rather than promote individualized care. I found it alarming how easily I fell into the routine of following orders and institutional rules without question. Over time, I became increasingly uncomfortable with the highly medicalized focus of the care I was providing. I began to notice that my actions were inadvertently reinforcing a health system centred around the medical model, which was often at odds with alternative approaches such as PCC.

My daily work varied greatly depending on the individuals I was supporting in the community. Some days, I would work late into the evening, accompanying individuals to local events such as baseball games. On other days, I would facilitate a leisure education program for a small group of four individuals. I advocated to my manager for flexibility in my schedule to align better with the routines of the individuals in care. As a result, I sometimes missed the daily reports—a team meeting where each person's progress was discussed (typically held every weekday morning for an hour). By adjusting my schedule to prioritize the needs of the individuals I worked with, I challenged the team's traditional staffing and scheduling practices.

However, in my next position, I faced far less control over my work schedule. Divided between an inpatient mental health unit and a day program, I was assigned fixed hours with little opportunity to advocate for hours that suited the needs of the clients. Unlike my previous role, where I had the flexibility to adjust my hours, the rigid staffing and scheduling practices at this new agency was dictated by the team, with no flexibility for PCC. The absence of RT programs on weekends was particularly detrimental, leaving patients feeling bored, anxious, and lonely. Feedback from patients indicated that the discharge of peers on Fridays often led to feelings of

anger and distress that lasted through the weekend. The restrictive nature of this position left me frustrated, as I was unable to provide the holistic care that I had been able to offer in my previous role.

In another experience within a mental health hospital's day program, I was explicitly told by my manager that my role was limited to providing recreation activities—an approach that overlooked the more comprehensive aspects of RT practice. This restriction prevented me from conducting the necessary assessments to understand the individuals' strengths, interests, needs, and capabilities. Instead of offering personalized care, I was relegated to delivering non-personalized activities designed merely to pass the time. Despite my attempts to advocate for a more person-centred approach, my efforts were stymied by my manager's clear directive that assessments were not part of my job description, even though they were technically included.

Reflecting on my experiences as an RT professional within various mental health institutions, I have come to recognize a persistent tension between institutional expectations and the principles of PCC. The problematic lies in how these institutions often prioritize rigid structures and medicalized models over individualized and holistic care. In practice, I observed how institutional constraints often limited RT's potential to foster meaningful engagement and well-being. These constraints include inflexible scheduling, restricted scope of practice, and an undervaluation of RT services. These institutional barriers are not only obstacles to practice but also central to my research, which explores how care is structured and delivered within mental health systems. My lived experience within these systems now informs a more critical lens through which I examine institutional practices. It makes me question what is deemed "standard" or "appropriate" care, and to explore how RT can challenge these norms to better serve persons

in mental health settings. Ultimately, my research seeks to challenge the way things are usually done to create a system that works better for the people in care.

Recreation Therapy

The Canadian Therapeutic Recreation Association defines the profession as a "health care profession that utilizes a therapeutic process, involving leisure, recreation and play as a primary tool for each individual to achieve their highest level of independence and quality of life" (Canadian Therapeutic Recreation Association, 2021). They further clarify that an RT professional "uses forms of recreation, leisure, and play as treatments modalities to support purposeful and meaningful interventions that are based on individual strengths and values, and are guided by assessments" (Canadian Therapeutic Recreation Association, 2021). Genoe et al. (2021) argue that this definition of RT aligns closely with the principles of PCC, as it focuses on the individual's strengths and holistic well-being. Therefore, RT professionals are able to use PCC as an approach that aligns with the Canadian Therapeutic Recreation Association definition.

Austin (2018) suggests that the roots of RT's are closely aligned with applied positive psychology, which shares humanistic values with PCC. According to Heyne and Anderson (2012), "Recreation and leisure are also considered strengths because of their potential to produce innumerable benefits" (p. 110). Unlike the focus on illness and outcomes (e.g., the medical model), strengths-based practice focuses on the benefits and values that recreation can provide for one's overall well-being (Heyne & Anderson, 2012). A strengths-based approach centres on a person identifying their own goals and interventions of interest. Heyne and Anderson (2012) emphasize the importance of establishing a trusting relationship between the person and the RT professional, which facilitates collaboration and empowers the individual.

This trusting relationship shifts focus from an outcome-based approach to a process-based approach, which places the person seeking care at the centre of their health decisions.

Literature on RT also recognizes the potential of the "person-centred model" in practice. In the *Study Guide for the Therapeutic Recreation Specialist Certification Examination,* Stumbo and Folkerth (2018) highlight the importance of focusing on a person's dreams and goals, aligning with the PCC philosophy. Austin (2018) also advocates for the adoption of "person-centred therapy" in RT, linking it to positive psychology, yet he too fails to provide detailed examples of how PCC can be operationalized in RT practice. Pedlar and colleagues (2001) were among the first to suggest that the connection between RT and person-centredness had virtually no real examples. In interviewing patients about their perspectives on the role of RT professionals on the unit, Pedlar and colleagues (2001) found that "the demands of running particular programs took precedence over patient's preferences" (p. 22).

A seminal contribution to the discourse on PCC in RT is Shannon Hebblethwaite's (2013) article in the *Therapeutic Recreation Journal*. Like Austin (2018), Hebblethwaite states that RT is well-positioned to adopt a person-centred approach due to its humanistic roots. However, Hebblethwaite (2013) also identifies significant structural, systemic, and policy barriers that hinder the successful implementation of PCC in practice, despite its inclusion in organizational mission statements. RT professionals in the study discussed structural barriers (e.g., scheduling bathing and eating) that conflicted with offering RT services using a PCC approach (Hebblethwaite, 2013). The practitioners also discussed administrative pressures to provide quantity rather than quality care in practice, making them feel like "statistics run the show" (p. 25). This article provides a foundation for understanding how both the institution and

RT professionals value person-centred care but are not empowered or enabled to fully implement it in practice.

My Standpoint

In IE, the standpoint refers to the point of inquiry—how things work for the individuals or groups in a particular position or site (Smith, 2006). For example, Smith (2006) discusses a study where she took the standpoint of single parenthood from the mother's perspective. Smith highlights how IE can uncover the structures and processes that shape people's lives and return knowledge to them about how things are organized (Carroll, 2010). Winton (2019) further emphasizes that IE researchers focus on the individuals who are engaging with them, whether through speaking, reading, or other forms of interaction. The goal of IE is to examine the tensions and contradictions that arise within institutions from the standpoint of a particular group (Rankin, 2017a). The knowledge generated from this standpoint builds an understanding of how activities are coordinated and organized (Rankin, 2017a). For this study, my standpoint was RT professionals working in mental health settings in Alberta, Canada.

Institutional Ethnography

I employed IE as a method of inquiry to explore the delivery of PCC in Canadian mental health services. IE is distinct from traditional methodologies and is often described as a 'sociology for people' (Carroll, 2010), a 'method of inquiry' (Carroll, 2010; Rankin, 2017b), and an 'alternative sociology' (Winton, 2019). Dorothy E. Smith, the founder of IE, has dedicated her career to refining this methodology, which emphasizes the lived experiences of individuals within institutional settings. Smith's academic journey, which included completing her PhD at Berkeley and teaching at the University of British Columbia and the Ontario Institute for Studies

in Education (OISE) at the University of Toronto, was deeply rooted in her commitment to social change. Through her collaborations with unions, women's groups, and professional associations, Smith sought to understand and address the ways oppression functions in society (Carroll, 2010).

Smith's reflections on her sociological training led her to reconsider traditional methodologies, noting, "I remember thinking that all this sociology I've been learning doesn't really seem to have anything to do with living" (Carroll, 2010, p. 15). This realization inspired the development of IE, which begins by examining the experiences of individuals directly involved in an institutional setting. Rather than focusing solely on individuals, IE investigates the social processes that shape their daily activities within institutions (Smith, 2005). In the fall of 2018, I had the privilege of attending a session co-led by Dorothy E. Smith and Susan Turner in Toronto. Smith's enthusiasm for IE, even in her early nineties, and her dedication to teaching novice researchers left a lasting impression on me.

IE is grounded in its own epistemological and ontological principles for gathering empirical evidence (Rankin, 2017a). In a conversation at the University of Victoria (October 23rd, 2017), Smith provided the rationale for IE's unique approach. She emphasized the importance of examining participants within their 'social structure,' focusing on the coordination of their actions within institutions, workplaces, and organizations. This perspective led Smith to simplify IE's ontology: it examines what people do—how their actions coordinate with those of others, including their thoughts, language, and emotions.

PCC has been a central focus in prior IE research in healthcare settings. Caspar's (2014) study, for example, used IE to explore PCC in long-term care facilities, focusing on the perspectives of resident care attendants (RCAs). Caspar (2014) found that RCAs often relied on their own skills and assessments rather than consulting residents' care plans. Additionally, the

lack of access to team members for sharing resident information emerged as a significant barrier. Through IE, Caspar uncovered how the social organization of long-term care facilities shaped the delivery of care.

IE: Central Concepts

Institutional Ethnography relies on several core concepts to guide research projects. In my study, I focused on three central concepts: ruling relations, social relations, and texts.

Ruling Relations

Ruling relations are social relations established by those in power, often operating at a distance from the local site (Rankin, 2017a). These relations shape how work is carried out at the standpoint level and how it is represented. Ruling relations often remain hidden, even to the workers involved. For instance, in my experience, my manager set the work schedule for RT professionals to align with the schedules of other allied health staff. This ruling—imposed without consideration of the specific needs of the individuals in care—illustrates how such relations govern and constrain the work of RT professionals. By using an IE approach, these hidden ruling relations can be made visible (Rankin, 2017b).

Rankin (2017a) provides an example from a post-secondary institution where IE was used to uncover ruling relations within a university's grade appeal process, which favoured faculty over students. In this case, faculty members worked to gather evidence to justify failing students, reflecting the institution's priorities. This example illustrates how ruling relations can influence work practices, often to the disadvantage of vulnerable individuals, such as students.

Social Relations

Smith (2005) defines social relations as more complex than typical human relationships. In IE, social relations refer to the coordination of people's activities within organizational contexts, often without their conscious awareness (Campbell & Gregor, 2008). These activities are socially organized, and examining them reveals how individuals' actions are purposefully coordinated within an institution. For example, in my work in mental health care, daily reports served as a formal process for team members to communicate about each client's status. This was one of many informal instances of social relations that coordinated team members' actions. By studying these relations, we can understand the connections that go beyond what is immediately observable.

Texts

In IE, texts refer to the material forms of work—such as paper, images, electronic forms, and communications—that mediate social relations (Smith, 2006). Texts are crucial in IE as they enable researchers to uncover translocal social relations that influence local practices. For example, standardized RT assessments dictate what questions are asked, how assessments are described, and their duration. Texts shape and coordinate people's activities in ways that may not always be visible or fully understood by the workers themselves.

Boss texts are a specific category of texts that facilitate large-scale ruling relations within institutions (MacKinnon et al., 2020). For example, legislation and political processes in mental health services function as boss texts that control the actions of RT professionals without their input or awareness. MacKinnon and colleagues (2020) illustrate how boss texts influence healthcare practices, such as the collection and testing of laboratory samples, and how these texts similarly shape the work of RT professionals in mental health services.

Purpose and Significance of the Study

This study investigates PCC practices among RT professionals in mental health services. By exploring the socially organized work of RT professionals, this research seeks to provide a fresh perspective on PCC and improve mental health services for individuals accessing care. Recognizing the personhood of those receiving care expands our understanding of how care is provided and perceived (Slater, 2006). This research aligns with the Mental Health Commission of Canada's (2016) strategy to enhance mental health services, marking a pioneering investigation of PCC within the context of Canadian mental health services.

Study Aim and Research Questions

The aim of this study is to examine how institutional structures empower or hinder RT professionals in delivering PCC. Two research questions guide this IE study: (1) How is the work of RT professionals socially organized in mental health services? (2) How does the social organization of RT work support, enable, or impede PCC?

Organization of Chapters

This dissertation follows a manuscript-based format to facilitate the rapid dissemination of findings through scholarly publications. In Chapter One, I introduce the research project, outlining its purpose, significance, and guiding questions. In this chapter, I also describe the methodological approach used in Chapters Four and Five and include a personal reflection on my experiences as a former RT professional in the mental health field.

In Chapter Two, I present a concept analysis of PCC in mental health settings from a Canadian perspective. Through this analysis, I identify five defining attributes of PCC, which

then enables me to enhance conceptual clarity of the term and offer practical implications for mental health care delivery in Canada.

In Chapter Three, I employ IE to explore the influence of patient privilege policies on RT practice. Drawing on interviews with RT professionals from three sites in Alberta, Canada, this chapter highlights how variations in policy implementations impact patient and professional autonomy, privilege assignment, and patient attendance in RT programs.

In Chapter Four, I use IE to explore the institutional factors influencing managerial support and staffing practices among RT professionals. The analysis illustrates how these institutional factors affect both professional experiences and the quality of care provided to clients.

In Chapter Five, I conclude the dissertation by summarizing and synthesizing the key contributions of this study. In this Chapter, I reflect on the implications of this study for mental health services, highlighting the contributions of my research to the field, and propose directions for policy and practice.

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CHAPTER 2: PERSON-CENTRED CARE IN CANADIAN MENTAL HEALTH SETTINGS: A CONCEPT ANALYSIS

ABSTRACT

Background: Despite its widespread use in health literature, there is limited understanding of person-centred care (PCC), especially in Canadian mental health settings.

Aim: This paper aimed to clarify the concept of PCC for a more comprehensive understanding in the context of Canadian mental health settings.

Methods: An eight-step concept analysis was completed to clarify the understanding of PCC.

Findings: This analysis identified five defining attributes: care tailored to the person, active engagement, clear communication and active listening, a holistic perspective, and empathy and compassion. Implications for practice include changes to the mental health system by prioritizing time with persons in care, providing more choices, and demonstrating active listening. By recognizing personhood in care practices, practitioners can improve their ability to understand how care is perceived and provided.

Keywords: Canada, Defining Attributes, Mental Health Disorders, Person-Centred Care

INTRODUCTION

Person-centred care is a frequently used term in healthcare literature, particularly older adult literature (Slater, 2006). Although the term person-centred care (PCC) is widely used, the concept is elusive and lacks a consensus understanding (Allerby et al., 2022; Edvardsson et al., 2008; Håkansson et al., 2019). This is particularly true in mental health settings, where there is a recognized lack of conceptual understanding of what characterizes PCC (McKay et al., 2021). A lack of consensus understanding of PCC can make it difficult to measure care outcomes and implement the approach in practice (Burgers et al., 2021).

The concept of PCC can be traced back to American humanistic psychologist Carl Rogers' work from the 1940s (Thórarinsdóttir & Kristjánsson, 2014). Rogers developed the nondirective approach to psychotherapy, which places the person at the centre of their care (Kirschenbaum & Jourdan, 2005). PCC focuses on the person's individual needs and goals by recognising and respecting the whole person—beyond just their illness or condition (Cloninger & Cloninger, 2011). PCC has since become a concept used internationally. Healthcare systems across the globe are transitioning towards a more PCC approach (Santana et al., 2018). Mental health literature from Australia, Sweden, the United Kingdom, and the United States all use the concept of PCC (Gabrielsson et al., 2015). Even though there is a global use of the concept, mental health literature on person-centred care is sparse in the Canadian context.

Many mental health services may purport to implement PCC, yet often lack a comprehensive understanding of the concept. Delivering PCC in these settings involves significant tensions, such as balancing client safety with respecting autonomy in treatment decisions (Gask & Coventry, 2012; McKay et al., 2021). These tensions are particularly evident in the use of involuntary or coercive procedures, which pose substantial challenges to fully

realising PCC in practice (McKay et al., 2021). Despite this, Allerby et al. (2022) found that such procedures were not always perceived as barriers to PCC, even though historically, coercive approaches have contributed to the disempowerment and devaluation of persons receiving care (Barker, 2001). Implementing PCC in mental health settings, especially those involving coercion, is therefore essential to improving care quality, though it requires a fundamental transformation of mental health services (Gabrielsson et al., 2015).

One objective of the *Advancing the Mental Health Strategy for Canada: A Framework for Action (2017-2022)* by the Mental Health Commission of Canada (2016) prioritizes access to PCC to improve the availability of quality mental health services. However, the objective fails to offer an explanation of what PCC is and how to implement it. There is an assumption that healthcare practitioners are knowledgeable about PCC and understand how to implement it, particularly in disciplines where PCC is embedded in standards of practice, such as Nursing (Registered Nurses' Association of Ontario, 2015), Pharmacy (Alberta College of Pharmacy, 2025), and Recreation Therapy (Canadian Therapeutic Recreation Association, 2023). However, Allerby and colleagues' (2022) study found that practitioners had difficulty defining PCC, even after years of attempting to implement it. With a lack of understanding, Schwind and colleagues (2014) found that mental health healthcare practitioners do not have time or space to determine if their practice is person-centred.

Canada has a unique structure and organization of health services, including mental health services (Jenkins et al., 2022). Health care delivery is primarily the responsibility of provincial and territorial governments, resulting in some variation across regions (Jenkins et al., 2022). This uniqueness offers strengths and challenges to persons seeking care. One challenge is that Canadian mental health care has been labelled as a "patchwork" of services and programs

with a lack of interconnection and integration (Jenkins et al., 2022). In a comparison between Australia and Canada, the mental health settings significantly differ concerning a person's autonomy in refusing treatment (Gray et al., 2010). For example, in some Canadian provinces, involuntary patients have the right to refuse treatment (Gray et al., 2010), suggesting that although there are similarities between developed countries, differences in mental health services exist. Differences also extend to the purpose of the involuntary admission process between the two countries (Gray et al., 2010). The right to refuse treatment for involuntary patients may be seen as a strength of the Canadian mental health system. However, the Alberta Government recently introduced legislation under the *Compassionate Intervention Act* that could undermine the right to refuse involuntary treatment—a practice considered high-risk and lacking high-quality evidence to support or refute its effectiveness (Ritchie, 2025, June 3). Thus, these differences and the uniqueness of the Canadian mental health system offer a need to focus on the further exploration of only Canadian literature.

There is value in exploring the actual and possible uses of concepts that create meaning for healthcare practitioners and consumers of mental health services. Breaking down a concept into its elements can assist in determining the internal structures of the concept (Walker & Avant, 2011). We form these concepts by learning the uses of words and by seeing what we understand of words (Wilson, 1963). The use and understanding of words act both as guides to forming concepts and as tests of concepts when formed. To analyze a concept is to present different uses of the word in different real-life contexts (Wilson, 1963).

A concept analysis is an intellectual deep dive into how literature connects language to meaning or doing (Schiller, 2018). It is a systematic and rigorous process that allows researchers to explore the basic elements of a concept, including its function and structure (Schiller, 2018).

“Concepts provide the ability to categorize, organize, label, discuss, and, consequently, to study phenomena of interest in the discipline” (Rodgers et al., 2018, p. 456). Each concept is categorized into key attributes for enhanced understanding, distinguishing it from similar or related concepts.

A concept analysis aims to clarify a poorly understood concept and establish it as a worthwhile phenomenon to be addressed effectively through practice (Schiller, 2018). This concept analysis focuses on person-centred care to recognize a person’s individuality—a meaningful life beyond just functioning, and see the person as active in their care. This analysis of PCC is contextualized in Canadian mental health settings. Adding context when examining a concept can deepen the understanding of the everyday routines, language, interrelationships, and discourses of healthcare practitioners who use the concept (Jakimowicz & Perry, 2015).

The purpose of this paper is to clarify the concept of PCC for a more comprehensive understanding in the context of Canadian mental health settings. Without a shared understanding of PCC, efforts to implement it may be inconsistent, especially in coercive and involuntary settings. A clearer conceptualization can help healthcare practitioners align with standards of practice, prioritize PCC approaches and policies, and better recognize the personhood of those in care. Therefore, this concept analysis has direct implications for clinical practice, education, and policy.

METHODS

This paper used the modified Wilson Method concept analysis by Walker and Avant (2011), an eight-step, iterative process. The first four steps are: select a concept, determine the aims, identify all uses of the concept, and determine the defining attributes. The fifth step

includes identifying a model case, which often outlines a clinical situation demonstrating each defining attribute. The sixth step is to identify a borderline case to help clarify the prerequisite defined attributes. The seventh step is to identify antecedents (something that comes before) and consequences of the concept. The final step is to define empirical referents—ways to recognize or measure the attributes.

Step 1: Select a Concept

Researchers are encouraged to select a topic of interest that is relevant to their professional practice or field (Schiller, 2018). I have selected to focus on person-centred care in this paper because, despite being referenced in various Canadian healthcare standards (Registered Nurses' Association of Ontario, 2015; Alberta College of Pharmacy, 2025), particularly within the field of recreation therapy (Canadian Therapeutic Recreation Association, 2023), it remains ambiguously defined in the context of Canadian mental health literature.

Step 2: Determine the Aims

A comprehensive review of peer-reviewed mental health articles can provide an optimal understanding of PCC. For the second step of the concept analysis, Schiller (2018) suggests a deeper reflection on the overall purpose of the analysis. Burgers and colleagues (2021) discussed the difficulty of assessing PCC due to the heterogeneity of definitions, interventions, and outcomes. This analysis aims to clarify the concept of PCC, delineate its attributes, and identify ways it is measured. By doing so, this analysis seeks to contribute to mental health theory by providing a more unified conceptual framework for PCC, and to clinical practice by identifying measurable components that can guide implementation, evaluation, and improvement of person-centred approaches in mental health care.

Step 3: Uses of the Concept

Researchers are encouraged to consider all uses of the concept (Walker & Avant, 2011). During the initial search process, the term *patient*-centred care surfaced as a variation and, at times, was considered a synonym for PCC. However, after further exploration of the two terms, it became apparent the difference between patient and person was significant. PCC broadens the perspective of patient-centred care by aiming to live a meaningful life beyond focusing solely on functional well-being (Burgers et al., 2021; Håkansson et al., 2019). PCC recognizes the person and their active role beyond the "patient" status (Coulombe et al., 2016). Person-centredness requires a shift in how healthcare practitioners see the people they work with. Person-centredness recognizes a person's individuality and reduces the authoritative relationship that may result from seeing the person as a patient (Slater, 2006). Thus, only the concept of PCC was explored for this analysis.

An extensive search was conducted to identify PCC in Canadian mental health settings from the following databases: APA PsycINFO (OvidSP), Psychiatry Online (APA), PubMed (U.S. National Library of Medicine), Academic Search Complete (EBSCO), CINAHL Plus (EBSCO), and ProQuest Nursing & Allied Health Premium (ProQuest). The literature search was limited to studies published between 2000 and 2024. A further search for sources was conducted using Google Scholar and reference lists of relevant papers. Inclusion criteria for the search included peer-reviewed sources written in English. PCC in settings other than mental health services and articles outside Canada were excluded. Truncation was used to search for multiple derivatives of root words (see Table 1).

Table 1 Search results.

#1	Canad*
#2	Mental health OR mental illness OR mental disorder OR psychiatric illness
#3	#1 and #2
#4	Person-Cent*
#5	#3 and #4

FINDINGS

The extensive search and selection process for relevant articles resulted in 17 peer-reviewed articles in the concept analysis (Figure 1). Of the 17 articles, 11 were empirical research with quantitative, qualitative, and mixed-methods designs (see Appendix 1). Six empirical research articles targeted the experiences of persons with mental disorders (e.g., depression), while the remaining five explored the experiences of practitioners. The most common practitioner profession in the empirical research articles was nursing. The non-empirical articles accounted for six of the 17 relevant articles on PCC (see Appendix 2). These articles included discussion, commentary, scoping review, open forum, and descriptive. Full-text articles were excluded if they did not originate from Canada, did not address person-centred care, or were not conducted within mental health settings.

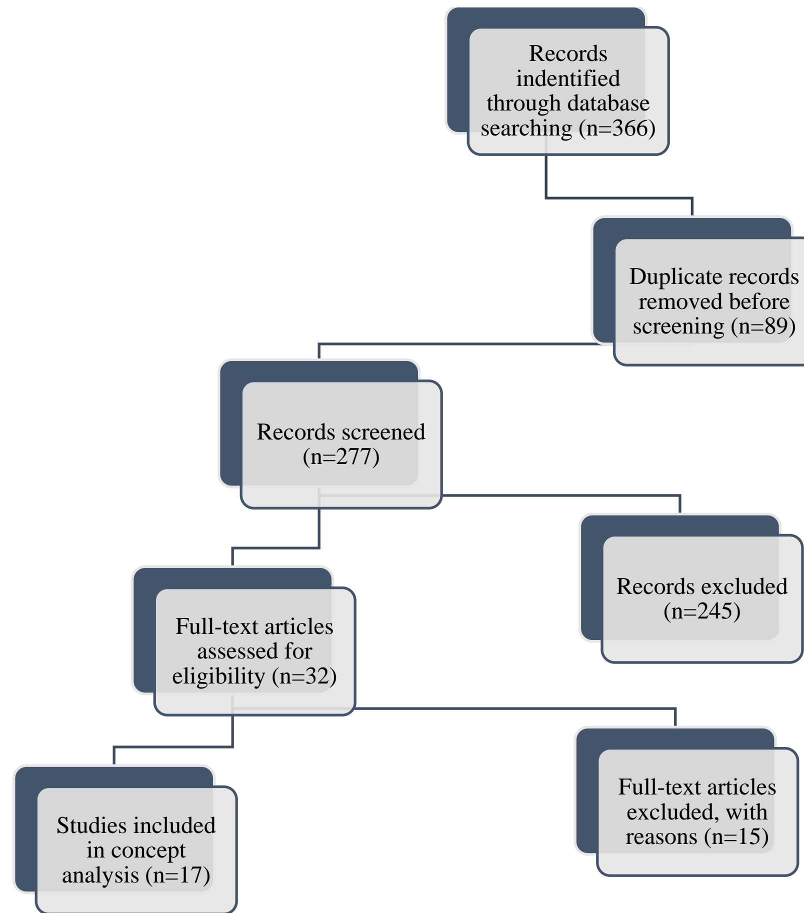

Figure 1 PRISMA data search and selection process.

Step 4: Defining Attributes

Discovering a concept's defining attributes is what Walker and Avant (2011) describe as the heart of concept analysis. This process involves scanning the literature to identify the most frequently used characteristics (i.e., words or phrases) on PCC. All keywords or phrases are gathered and combined based on the exact same or functionally equivalent uses (Schiller, 2018). I identified the initial 12 characteristics found in the 17 articles, which were numbered and organized using Microsoft Excel. Following the guidelines of Walker and Avant (2005), these characteristics were then reduced to the smallest number that still adequately differentiate the

concept from another similar or related one. This reduction process involved transforming the combined characteristics into defining attributes, by naming the occurrence of a specific phenomenon (Walker & Avant, 2005). As a result, I initially identified six defining attributes. Through collaborative review and discussion among my supervisor and committee members, this number was reduced to five. In accordance with guidelines recommending the smallest possible set of attributes, we determined that two of the original attributes were functionally equivalent and therefore combined them. The final five defining attributes reflect the most commonly associated characteristics of PCC in the analyzed literature. These attributes form the foundation for a clearer understanding of the concept and serve as a basis for future theoretical or empirical work.

Based on this analysis, the following attributes of PCC in Canadian mental health settings include (a) Care tailored to the person, (b) Active engagement, (c) Clear communication and active listening, (d) Holistic perspective, and (e) Empathy and compassion. The following section explores each of these attributes in detail.

Care Tailored to the Person

Care tailored to the person begins with taking time to know who the person is as an individual (Schwind et al., 2014; Stuart, 2017; Suen, 2016) and assessing their strengths, preferences, and needs (Kopalo, 2017; Martin et al., 2009; Oades et al., 2009). Knowing who the person is and what care works best for them is the focus of this attribute. Each person has different goals, strengths, and capacities (Schwind et al., 2014), which can conflict with the practitioner’s suggested care treatment (Stergiopoulos et al., 2024). A key characteristic of care tailored to the person includes respecting the wishes and preferences of persons in care (Lindsay & Schwind, 2015; McKay et al., 2021), even if they conflict with the practitioner’s suggestions

or preferences. Finally, after assessing and respecting the person's wishes, care plans need to remain flexible based on the strengths, goals, and stage of recovery that the person is in (Thomson et al., 2019).

Active Engagement

The person in care must be an active part of the care process. Stuart (2017) suggests that the person is not a "passive recipient of care" but actively engaged in the care process. Thus, the person in care sets the direction of the care and therapy (Josefowitz & Myran, 2005). Having an active role in care involves shared decision-making related to care (Stergiopoulos et al., 2024) and collaborative involvement in care planning and rehabilitation (Thomson et al., 2019). A partnership exists between the mental health practitioners and the person in care working towards a common goal (Coulombe et al., 2016; Schwind et al., 2014). This partnership is based on a collaborative (Kolapo, 2017; Oades et al., 2009) and therapeutic relationship (Josefowitz & Myran, 2005) built on trust and safety in mental health settings (Suen, 2016). One of the partnership's focuses is preventing further deconditioning of people in care (Lindsay & Schwind, 2015). Having a voice and choice in the care plan is particularly important for the person in care in restrictive environments such as mental health settings (Thomson et al., 2019). The person in care has an active role in steering the direction towards their own recovery.

Clear Communication and Active Listening

Another characteristic of PCC involves using accessible language when mental health practitioners are communicating with people in care (O'Neill et al., 2024). Communication needs to be clear about the situation or circumstances involved in the care process; for example, helping the person in care comprehend difficult to understand aspects of the medical chart

(McKay et al., 2021). Listening was listed in several articles (Corbiere et al., 2012; Guilcher et al., 2016; O'Neill et al., 2024; Stergiopoulos et al., 2024; Suen, 2016; Thomson et al., 2019) as an important characteristic of providing PCC. Listening is an active and ongoing process between the mental health practitioner and the person in care (Corbiere et al., 2012; O'Neill et al., 2024; Thomson et al., 2019). Active listening was described as an opportunity for people to talk, which had a high degree of value for those seeking care (Guilcher et al., 2016). Feeling heard is part of the therapeutic process (O'Neill et al., 2024) and leads to efficient and effective coordination of care (Suen, 2016). The creation of this partnership is dependent upon the development of interpersonal competencies of the mental health practitioner (Stuart, 2017), such as being present and being genuine with what is real to the person in care (Josefowitz & Myran, 2005). When using a person-centred approach, listening is encouraged in one-to-one interactions in a private setting (Thomson et al., 2019), free of distractions and interruptions (Lindsay & Schwind, 2015). Communication between the practitioner and the person in care is based on respect rather than being presumptive, suspicious, or judgmental (Guilcher et al., 2016).

Holistic Perspective

Care focuses on the whole person rather than on individual mental health symptoms (Coulombe et al., 2016). While mental health symptoms are a significant part of mental health care, there is also a need to consider the totality of a person (Lindsay & Schwind, 2015; Martin et al., 2009; Stuart, 2017; Thomson et al., 2019). This holistic perspective of care provides a more comprehensive review of a person's needs, including mental, emotional, spiritual, and social needs (Stuart, 2017). It considers a person's education, employment, and housing needs (Guilcher et al., 2016). A practitioner's consideration of a person's strengths rather than deficits aligns with a person-centred approach (Lewis & Hasking, 2021). This holistic perspective

enables mental health practitioners to look beyond providing care that is only focused on the mental disorder symptoms to the totality of needs of people seeking care.

Empathy and Compassion

Mental health practitioners' ability to empathize with people seeking care is central to the provision of PCC. Empathy involves understanding the central issues of the person (Josefowitz & Myran, 2005). Having empathy for someone means attempting to understand them and their world (Thomson et al., 2019). Along with empathy, PCC involves compassion for those seeking care (Guilcher et al., 2016; Lindsay & Schwind, 2015). Seeking support for a mental disorder can be a vulnerable experience for many persons; therefore, compassionate and empathetic interactions with practitioners are critical for person-centred engagement (Guilcher et al., 2016).

Step 5: Model Case

The model case, which is fictionally constructed by the authors, is created after determining the defining attributes of a concept and serves as a paradigmatic example (Walker & Avant, 2005). The following fictional model case features Noah, an individual seeking mental health support, and exemplifies the five attributes of PCC in a clinical situation.

Noah voluntarily admitted himself to a psychiatry unit because of his inability to attend to his personal care needs. After a discussion with the psychiatry unit team, he also wanted to improve his ability to make friends in the community. Noah's team listened to his new and ongoing needs and began putting together a plan of action. After determining the additional goal, the team gathered resources to support him. While talking and listening to Noah, the team noted that he felt the stigma of living with schizophrenia challenged his ability to have close friends. To ensure the team understood what happened, they spoke with Noah about how devalued he felt

in his previous relationships with friends. To address this concern, Noah's team discussed opportunities to empower him to develop close friendships by encouraging him to join community leisure events. They then learned that Noah loves to run, watch sports, and spend time with animals. Thus, Noah and the team developed a plan for Noah to start volunteering at the humane society and join a local running group. The plan includes growing Noah's support network so that when he struggles to attend to his personal care, he can reach out to them for support and resources. Noah and his team feel comfortable with the plan to address his current needs. This case study demonstrates how Noah's care was tailored to his needs, how he was actively engaged in the process, listened to, how the team was empathetic to him, and how the care was holistic.

Step 6: Borderline Case

Schiller (2018) recommends that a borderline case be considered along with the model case. A borderline case contains between one and the second highest number of attributes (Schiller, 2018); thus, this paper will contain between one and four attributes. By not having all five attributes, a clinical case example can highlight the differences in care from a comprehensive PCC understanding. In the following fictionally constructed borderline case, we explore how Jamie's care differs from Noah's care (the model case).

Jamie is a patient in a mental health unit because her neighbour called the police to conduct a wellness check due to her erratic behaviours at home. The emergency physician at the local hospital admitted Jamie involuntarily to the mental health unit. Jamie is in her mid-forties, lives alone, is passionate about hiking, and volunteers at a local art museum. The mental health team sat down with Jamie to discuss her concerns. Jamie discussed two main concerns—she feels lonely and wants more friends, and her neighbour is spying on her. Jamie discussed how

she spends every night alone, which she finds to be difficult for her. The team listens to Jamie and her concerns; however, they decide to focus on Jamie's mental functioning by increasing her anti-psychotic medication. After a week of observation, the team discharged Jamie from the unit to her home. Jamie became stressed and anxious at home regarding her concerns with her neighbours, and she feels lonely every night. Jamie feels only some of her needs were met and that the team did not consider other needs she discussed with them. This case study demonstrated how Jaime was provided care and listened to, but that only some of her needs were met by the team, and a failure to see her care from a holistic perspective.

Step 7.1: Antecedents

Antecedents are events that must occur or be in place before PCC can exist (Schiller, 2018; Walker & Avant, 2011). A defining attribute cannot be an antecedent, but identifying any antecedents can help refine the defining attributes (Walker & Avant, 2011). Of the 17 articles analyzed in this study, nine addressed antecedents.

Practitioners who are interested in PCC are encouraged to undergo adequate education and training (Thomson et al., 2019), especially concerning culturally sensitive topics such as stigma (Guilcher et al., 2016). Practitioners' ability to be self-aware (Lindsay & Schwind, 2015; Schwind et al., 2014), having time to develop a rapport with the person in care (Schwind et al., 2014; Suen, 2016), and having the space and environment that promotes interconnectedness (Corbiere et al., 2012) are all antecedents to PCC. Lastly, having a nonjudgmental care space was listed in many articles (Josefowitz & Myran, 2005; Lewis & Hasking, 2021; Stergiopoulos et al., 2024) as a prerequisite for PCC in mental health settings. The antecedents from this analysis include areas that are the mental health agency's responsibility, and others include the practitioner's responsibility for continued professional development.

Step 7.2: Consequences

Consequences are the possible outcomes of PCC or events that may transpire due to the concept's existence (Schiller, 2018). The consequences of PCC for the person in care include general outcomes (e.g., quality of care) and specific outcomes (e.g., validation). Consequences emerged as a topic in seven of the 17 articles reviewed.

First and most significantly, improving the quality of care was listed in several articles (Barbic et al., 2018; Guilcher et al., 2016; Martin et al., 2009; McKay et al., 2021) as a consequence of implementing PCC. Outcomes of PCC related to the person in care include sustained symptom reduction, a return to functioning (Barbic et al., 2018), and the prevention of any further deconditioning (Lindsay & Schwind, 2015). Other consequences of PCC include the person in care's experiences being better validated (Lewis & Hasking, 2021) and the enhancement of coping strategies for the person in care (Thomson et al., 2019). Finally, a consequence of PCC for mental health care practitioners includes increased confidence and job satisfaction (Lewis & Hasking, 2021). In summary, the literature overwhelmingly highlights the positive and desirable outcomes associated with PCC. Notably, none of the reviewed studies reported any negative aspects or criticisms of PCC, emphasizing a strong consensus regarding its benefits.

Step 8: Empirical Referents

The final step of this concept analysis is determining the existing empirical referents, which are indicators of the defining attributes that can be recognized or measured (Schiller, 2018). Unfortunately, only four of the 17 analyzed articles had existing empirical referents. All four articles had indicators of the defining attributes from the healthcare practitioner perspective;

two from nursing (Lindsay & Schwind, 2015; Schwind et al., 2014), one from peer workers (O'Neill et al., 2024), and one from mental health staff (Thomson et al., 2019). None of the analyzed articles had existing empirical referents from the perspective of the person in care. The concept analysis highlights a significant gap in the PCC literature, which largely centres on practitioner actions and offers limited insight into the role or perspective of the person in care. However, all the defining attributes can be recognized or measured through the perspective of the person in care and perhaps their family members. The person's satisfaction with their care would be a strong indicator for the defining attributes in this study. For example, the person in care would be able to recognize and articulate their satisfaction with their engagement in the care process. Josefowitz and Myran (2005) discuss having frequent check-ins with the person in care regarding their understanding of the care process. The care process needs to be collaborative, where the person in care is a full partner in decision-making and planning (Thomson et al., 2019). The person's satisfaction with their care is a good indicator of the identified defining attributes of PCC.

Indicators for clear communication were discussed in the analyzed articles. O'Neill and colleagues (2024) mention that practitioners who maintain neutrality when listening and use accessible language are viewed as more approachable and friendly. The practitioner's ability to avoid medical jargon when communicating with the person in care would be another indicator of clear communication. Lindsay and Schwind (2015) provide a communication example for mental health practitioners to implement, "Person-centred care is staying really quiet, letting them [persons in care] breathe, walk, feel; don't interpret for them but offer options" (p. 8). This example indicates the ability to recognize how a practitioner engages in active listening as part of person-centred care.

Aside from the person's satisfaction with their care, practitioners are encouraged to engage in reflective practice (Lindsay & Schwind, 2015) to increase their self-awareness of their involvement in the defining attributes. For example, a practitioner reflecting on their level of understanding of the person in care's world (i.e., empathy) would be part of their self-awareness practice.

DISCUSSION

This paper analyzed the concept of PCC in the context of Canadian mental health settings, contributing to the understanding of the complex challenges in using an approach to care in environments that can often be or become coercive. Using a concept analysis, this paper focused on a term's actual and possible uses (Walker & Avant, 2011). Many familiar attributes were found between this analysis and others, such as respecting the person (Jakimowicz & Perry, 2015; Morgan & Yoder, 2012), empowering individuals (Morgan & Yoder, 2012; Slater, 2006), and holistic care (Morgan & Yoder, 2012). Although familiar attributes were revealed, this paper highlights the significance of separating and distinguishing certain attributes for greater importance, such as distinguishing clear communication and active listening as a separate, stand-alone attribute. A practitioner's ability to prioritize talking with persons in care over other tasks and work suggests a shift in the care process (Allerby et al., 2022). Listening was also highlighted in the differences between the team's approach to care in the model and borderline cases presented in this paper. Noah's team made time to talk to him about his concerns, even if they changed during his stay in the hospital. In contrast, some of Jamie's needs were overlooked, which left her feeling stressed and anxious after being discharged.

Slater (2006) suggests using a consistent definition of PCC, especially in interdisciplinary healthcare settings such as mental health. The defining attributes identified in

this analysis could contribute to creating a definition of PCC for Canadian mental health settings. A consistent definition could enhance the communication of mental health services across Canada and, by doing so, contribute to PCC, as identified in the findings. Creating a definition from the findings could also guide the construction of person-centred research instruments or interview guides. The instruments and guides incorporating all defining attributes from this study have yet to be developed.

This comprehensive review of PCC literature in Canadian mental health settings can have implications for practice. Enacting PCC can improve care, but requires transforming current inpatient psychiatry practices (Gabrielsson et al., 2015). Gask and Coventry (2012) discuss the lack of time to implement PCC in practice. The attributes of being actively engaged and listening suggest a shift in care focus to prioritize time in mental health settings. To implement PCC, time is required from the practitioner's practice to engage meaningfully with the person in care. Prioritizing time could be part of the transformation of mental health care practices discussed by Gabrielsson and colleagues (2015).

Allerby and colleagues (2022) discuss enhancing PCC in involuntary settings by providing patients with choices—for example, who is present during forced injections or which room to use. Providing choice should be part of the mental health agency's PCC procedures. However, new person-centred procedures were at times disregarded by psychiatrists (Allerby et al., 2022), which can lead to inconsistencies in care and tensions between staff members. This analysis revealed a lack of antecedents from the mental health agency's perspective. Research is needed to review how organizational policies, initiatives, guidelines, and legislation impact the implementation of PCC in Canadian mental health settings.

Given the lack of empirical referents in the literature from this concept analysis, further exploration of how the defining attributes are assessed and measured would improve our understanding of PCC. Implementing formal and informal satisfaction measures for persons in care would highlight several defining attributes of PCC, as identified in this analysis. To ensure a focus on PCC, persons in care should be involved in these satisfaction measures' design, language, and layout.

Limitations

This concept analysis explicitly focused on the uniqueness of Canadian scholarly literature to explore the countries' approach to PCC in mental health settings. This required a purposeful exclusion of PCC literature from other nations (e.g., Sweden and America). This study focused exclusively on PCC within mental health settings, which may limit the generalizability of the findings to other healthcare contexts. PCC may be shaped by different structural and interpersonal dynamics in settings such as acute or primary care, and future research is needed to examine how these findings translate across these environments. I acknowledge that by only looking at *person*-centred care, I excluded comparable concepts such as patient-centred care and client-centred care. The focus of this study was on the holistic term of PCC. Finally, this analysis required peer-reviewed scholarly articles for review. Thus, white and grey literature was not included.

CONCLUSION

Through this concept analysis, key attributes of PCC in Canadian mental health settings were identified: (a) Care tailored to the person, (b) Active engagement, (c) Clear communication and active listening, (d) Holistic perspective, and (e) Empathy and compassion. These attributes

help clarify the concept of PCC and provide a framework for recognizing and supporting its application in mental health practice.

Having mental health practitioners recognize the personhood of the people they work with expands their understanding of how care is perceived and provided to that person (Slater, 2006). Using consistent language, attributes, and a definition of PCC will help guide mental health practitioners in exploring what matters to each person they work with.

However, this analysis also revealed gaps in the literature related to the structural and systemic factors that influence the implementation of PCC, such as organizational policies and regulatory body standards. These factors can significantly shape the extent to which PCC is supported or hindered in practice and should be the focus of future research.

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CHAPTER 3: THE IMPACT OF PATIENT PRIVILEGE POLICIES ON RECREATION THERAPY PRACTICE IN MENTAL HEALTH CARE

ABSTRACT

Background: Patient privileges in Canadian mental health care settings are intended to support patient autonomy and reintegration, but their discretionary application and use as behavioural incentives can conflict with person-centred care (PCC) principles.

Aim: This study explored how institutional practices surrounding patient privileges influence the delivery of PCC by recreation therapy (RT) professionals in mental health settings.

Methods: An institutional ethnography was conducted in three mental health sites in Alberta, Canada. Investigative methods included in-depth interviews with 18 RT professionals and textual analysis.

Findings: This study found that the implementation of the *Observation, Privileges, and Passes Policy* significantly shaped how RT professionals delivered PCC, with variations in implementation across sites influencing patient autonomy, privilege assignment, and attendance in RT programs. The findings highlighted how institutional structures and interdisciplinary dynamics either constrained or supported RT professionals' capacity to balance safety concerns with collaborative PCC.

Keywords: Institutional Ethnography, Mental Health, Off-Unit Privileges, Person-Centred Care, Therapeutic Recreation

INTRODUCTION

Canadian research consistently highlights systemic barriers within mental health care, underscoring the uniquely complex and fragmented nature of the country's service network compared to other nations (Wang et al., 2024). A central contributor to this complexity is Canada's decentralized approach to health governance, where each of the ten provinces and three territories enacts and administers its own health legislation. This structure has resulted in 13 distinct mental health acts across the country (O'Reilly & Gray, 2014). A common provision across these acts is the legal requirement that patients be informed of their rights upon admission—a safeguard intended to promote patient autonomy and procedural clarity within mental health care (O'Reilly & Gray, 2014). For instance, Alberta's Mental Health Act, under Section 9.01, mandates that patients be provided with detailed treatment plans that specify both the nature of the treatment and the conditions under which patient privileges may be granted (Government of Alberta, 2020; Alberta Health, 2025). These privileges refer to a patient's ability to leave the unit and access hospital grounds, either with or without the accompaniment of a healthcare staff member (Alberta Health Services, 2021). Interestingly, there is a lack of consistency in the terminology used to describe these privileges, with some jurisdictions referring to them as *liberties* (Charles, 2007). This distinction is significant: privileges suggest that a patient has earned certain freedoms, while liberties are viewed as inherent rights that individuals retain while receiving care (Charles, 2007).

Privileges are often introduced as a means of balancing patient autonomy with the need to manage behaviours that might be deemed dangerous (McKay et al., 2021). The gradual easing of restrictions, such as granting off-unit privileges, plays a crucial role in preparing patients admitted to mental health care settings for eventual reintegration into the community (Stübner et

al., 2006). However, this process is not always straightforward. In some instances, the granting of off-unit privileges can be seen as a negotiation between healthcare staff and patients, based on the latter's behaviour (Cleary et al., 2012). Importantly, off-unit privileges can be revoked at the discretion of nursing staff or other members of the treatment team, with any suspension subject to further investigation by the attending physician (Charles, 2007).

Notably, the denial of off-unit privileges, particularly when enforced by staff as a form of rule adherence, has been linked to increased tensions and incidents of restraint (Flannery, 2005). Staff restrictions on patient behaviours, such as denying off-unit privileges, are often perceived as punitive by patients, which can lead to frustration and even aggression toward staff. In fact, many patient-to-staff assaults have been found to precede mistakes in the communication or implementation of privilege policies (Flannery, 2005).

Given the complexities surrounding privileges, it is essential to recognize the therapeutic role of recreation therapy (RT) in mental health settings, where the ability to leave the unit, even if just within the facility grounds, can be integral to patient care. The Canadian Therapeutic Recreation Association defines RT as a healthcare profession that uses leisure, recreation, and play to help individuals achieve the highest level of independence and quality of life (Canadian Therapeutic Recreation Association, 2021). An RT professional tailors interventions based on individual strengths and values, using leisure activities as therapeutic modalities to foster meaningful and purposeful outcomes (Canadian Therapeutic Recreation Association, 2021). This individualized, strengths-based approach is aligned with the principles of person-centred care (PCC), a foundational philosophy within RT practice. PCC emphasizes treating individuals as whole persons by considering their unique goals, preferences, and experiences, rather than focusing solely on their medical conditions (Cloninger & Cloninger, 2011). While privileges are

meant to encourage patient autonomy and progress, the blanket application of restrictive policies—such as a lack of shared decision-making or a failure to address the specific needs of patients—can undermine advancements in the PCC approach in healthcare (Coulter & Richards, 2020). Together, these challenges highlight the tension between institutional control and individualized care, suggesting that aligning language and policy with the principles of PCC is essential to truly empower patients and uphold their autonomy.

The connection between PCC and the RT profession is longstanding. RT practice has traditionally emphasized placing the person at the centre of their care (Kunstler & Stavola Daly, 2010). The person-centred approach aligns closely with RT's humanistic foundations and is further supported by principles of positive psychology (Austin, 2018; Hebblethwaite, 2013). A central tenet of PCC is identifying the unique needs and goals of each person (Cloninger & Cloninger, 2011), which then guides the development of individualized RT treatment plans (Anderson & Heyne, 2012; Kunstler & Stavola Daly, 2010; Stumbo & Folkerth, 2018). Through this approach, RT professionals support and empower individuals to take an active role in shaping their care, fostering autonomy and meaningful engagement (Anderson & Heyne, 2012). This alignment between PCC and RT reinforces the profession's vital role in advancing individualized, respectful care that prioritizes patient empowerment and well-being. The focus on individualized care emphasizes the need to reconsider how privileges are granted, ensuring that these policies align with PCC principles.

Notably, there is a gap in the existing literature regarding the institutional practices surrounding patient privileges in mental health settings and their impact on the delivery of PCC by RT professionals. This gap is particularly surprising given that RT professionals are often directly involved in facilitating patient activities off the unit, such as outings, RT programs, and

other off-unit interventions. Despite the integral role RT professionals play in these activities, their experiences and perspectives on the effects of patient privileges remain underexplored in current research. Thus, the aim of this study is to explore how the institutional practices associated with patient privileges influence the delivery of PCC by RT professionals in mental health settings.

METHODS

This qualitative study forms part of a broader research project using Institutional Ethnography (IE) as a method of inquiry to explore how the work of RT professionals is socially organized in mental health care services and how this impacts their provision of PCC. Smith (2006) explains that IE brings together Marx's materialist approach and Garfinkel's ethnomethodology, enriched by insights from feminist consciousness-raising practices. She argues that history begins with actual individuals and their coordination, including textual coordination. IE is based on the idea that analyzing everyday experiences can reveal important knowledge (Smith, 2005). Rather than concentrating on individuals themselves (such as RT professionals), IE investigates the broader social and institutional structures that influence their work and daily routines within institutions (such as mental health care settings) (Smith, 2005). However, Smith (2005) argued that institutions are not merely physical spaces—such as hospitals or government agencies—but are composed of interconnected social relations structured through discourse, texts, and systems of authority.

Smith (2005) described social relations as distinct from how we typically perceive human relationships. Rather than simple interactions, social relations are more complex and refer to the ways people engage in coordinated activities within specific organizational contexts (Campbell & Gregor, 2008). In IE research, the focus is on the intentional coordination of people's

everyday activities (Caspar, 2014). Ruling relations, on the other hand, are social relations that are shaped by those in power and often exist outside the immediate local context (Rankin, 2017a). These ruling relations are embedded in everyday work, sometimes unbeknownst to the workers (e.g., RT professionals). An IE approach can uncover these ruling relations, making them visible, even though they are often hidden (Rankin, 2017b).

Smith developed IE as an alternative approach to studying human experiences, emphasizing the importance of analyzing real-world interactions rather than imposing predefined theoretical constructs. This approach supports the researcher in constructing findings directly from the data through close and iterative engagement, rather than applying a pre-existing theoretical perspective (Rankin, 2017a). By doing so, IE explicates the tensions and complexities of individuals' lived experiences without forcing them into a theoretical framework (Rankin, 2017a; Winton, 2019). Health research can benefit from an IE approach by examining the congruence (or lack thereof) of the internal components in an institution (Caspar, 2014). This examination can further our understanding of the organized tasks, formal structure, ways people relate to each other, policies, procedures, and congruency in healthcare settings (Caspar, 2014). The aim is not only to document what RT professionals do, but to uncover *why* they do it in certain ways, and *how* their practices are organized by external policies, texts, and structures. Traditional qualitative methods might explore experiences or perceptions, but IE provides a systematic way to trace those experiences back to institutional processes and ruling relations that often go unquestioned.

In IE research, data typically includes participant interviews and institutional texts. Texts are commonly referred to as replicable material forms of work, for example, paper, images, electronic forms, and other communications (Smith, 2006). These texts can influence the daily

work practices done by RT professionals. For example, RT professionals use an attendance record to monitor patient participation in their programs. This institutional text lists the patients who attend each specific RT program on a given day, helping RT professionals track engagement and program utilization over time.

Setting

This study focused on participants employed in mental health care settings in Alberta, Canada. Three sites were chosen in consultation with the provincial RT director, who identified facilities with well-established RT programs and services. The selection criteria for each site included the following:

- A minimum of 10 RT professionals employed at the time of selection,
- Programs and services operating under the same regional health authority, and
- Inpatient mental health services with a capacity of more than 75 beds.

Smaller facilities were excluded due to their limited number of clients, programs, and services. Of the three selected sites, two were located in rural areas of Alberta, while the third was in an urban setting.

Sample

This study utilized purposeful selection of participants and sites, a commonly used strategy in qualitative research that prioritizes relevance over randomness (Creswell & Creswell, 2018). Purposeful selection enables the researcher to gain in-depth understanding of the research problem by intentionally selecting individuals who meet specific inclusion criteria (Creswell & Creswell, 2018). In this study, this approach was used to identify participants with specific

characteristics and sites with particular features that could meaningfully contribute to the exploration of the research problematic. To be eligible for participation, individuals had to be employed full-time, part-time, or on a casual basis; work in a mental health setting; hold a job title such as recreation therapist, recreation therapy assistant, or a recreation therapy aide; and be English-speaking.

Recruitment primarily took place through email distribution of welcome letters, which site managers shared with potential participants. Those interested in the study contacted me via email to request more information and complete the informed consent process. Additionally, I conducted one visit per site to host an informational session, providing further details and answering any participant questions. During these visits, some individuals requested one-on-one meetings with me to inquire about specific aspects of the study, such as the expected time commitment.

According to the provincial RT director, a total of 71 RT professionals—including full-time, part-time, and casual roles—were employed across the three selected sites. Of these, 18 RT professionals chose to participate. Among the participants, three held the title of recreation therapy assistant, while 15 were designated as recreation therapists. All participants provided voluntary written consent before taking part in the study. Those who opted not to participate cited time constraints as their primary reason. As a token of appreciation, participants received a gift card honorarium. Ethics approval for this study was granted by the University of Alberta Research Ethics Board (REB ID Pro00127334).

In-Depth Interviews

This study involved conducting in-depth interviews with RT professionals, all of which were audio recorded with the participants' informed consent. Each interview lasted 60–90 minutes and was transcribed verbatim with assistance from Otter AI transcription software. According to Smith (2005), it is more effective to discuss participants' daily experiences rather than following a rigid interview script. Using a scripted approach can introduce a power imbalance, steering the conversation towards the researcher's agenda rather than allowing participants to share their own reflections (Smith, 2006). Reflecting this perspective, I opted for a flexible set of preplanned questions to promote a more open and participant-led conversation, rather than adhering to a fixed interview guide. Interviews began with broad, open-ended questions such as "Can you describe a typical workday in as much detail as possible?" "What makes a good day?" "What does a challenging day look like?" and "How would you describe your experience doing this work?" I sought to ensure accurate understanding throughout the interview by rephrasing questions and seeking clarification when necessary (Campbell & Gregor, 2008).

Texts

Text data collection included obtaining blank copies of replicable texts, documents, and forms identified in the interviews that are used in the care practices in the everyday work of RT professionals. Texts can coordinate, or attempt to coordinate, the actions of participants in their work (Caspar, 2014). Requested blank copies of texts did not include patient or client information, respecting the confidentiality and privacy of those seeking mental health services. The guiding question that assisted in the identification of meaningful texts was, "What are the texts that influence the work of RT professionals in their daily work?" The collection of texts occurred during and after the interview process and included examples such as RT attendance

records, RT information documents, and RT specific program plans. Consistent with the principles of IE, data collection continued until sufficient information was gathered to trace the nuances of the daily practices of RT professionals within the mental health care framework (Townsend, 1996).

Data Analysis

Smith (2005) explained that the aim of analysis in IE is to explore how work is organized within a social context rather than identifying recurring patterns or themes. Therefore, data analysis in IE is not a formulaic or fixed process. Importantly, IE does not focus on explaining individual behaviours or attitudes but seeks to uncover the underlying social processes that people participate in, which they both sustain and transform through their actions (Caspar et al., 2016). Understanding socially organized work involves connecting smaller social experiences, which can reveal broader power structures within an organization (DeVault & McCoy, 2002).

The focus of the analysis in this study was to gain a deeper understanding of how the everyday practices of RT professionals in mental health settings both shape, and are shaped by, the patients' privilege levels. Using an inductive approach, I identified key institutional texts and practices and explored how they related to one another and shaped or organized the work of the RT professionals. For the purpose of this study, I also engaged in collaborative discussions with my supervisor to refine the data analysis, continuously reflecting on the process and validating the emerging findings and their interconnections (Morse et al., 2002).

The data sources included interview transcripts, institutional texts, and reflexive field notes created after site visits and interviews. Interviews were conducted over a seven-month period from 2023 to 2024. Microsoft Word® was used to organize and categorize the interview

data, textual content, and field notes. To ensure the study's rigour, I kept detailed reflexive field notes after each interview, as suggested by Creswell (2013).

FINDINGS

The findings of this study highlight that the *Observation, Privileges, and Passes Policy* (Alberta Health Services, 2016) is a central institutional text that significantly shapes how RT professionals deliver care in mental health settings. This policy is implemented agency-wide and applies to all sites within the provincial agency. While the policy is designed to balance patient safety with therapeutic engagement (Alberta Health Services, 2016, p. 1), its implementation varies across sites, resulting in distinct practices that influence patient and professional autonomy, privilege assignment, and RT program attendance. The policy outlines structured levels of observation, privileges, and passes assigned collaboratively by physicians and the interdisciplinary care team based on relevant assessments, risk evaluations, and clinical judgment—though it does not define or specify the nature of these assessments or evaluations.

Observation levels range from constant monitoring to checks at intervals of 15, 30, 60, or 120 minutes. Privileges, which determine a patient's ability to leave the unit, are tiered into three categories: no privileges, accompanied (with staff) privileges, and unaccompanied privileges. These are intended to support therapeutic engagement in the least restrictive setting and are adjusted through team collaboration, although the policy does not detail how this collaboration is to be carried out. Passes extend privileges by allowing patients to leave the facility grounds, again with or without accompaniment, and are similarly framed as part of therapeutic care.

The findings highlight how the work of RT professionals is influenced by the implementation of the policy in everyday decision-making duties. This influence is evident in

how professionals assign privileges with attention to safety and patient autonomy, how privileges impact the assessment process in RT, and how policies regulate attendance in RT programs. As shown in Table 2, the site characteristics and institutional structures are compared to highlight their key differences.

Table 2 Site Characteristics and Institutional Structures.

	Site 1	Site 2	Site 3
Characteristics			
Setting	Rural	Rural	Urban
Type of Clients	Adults	Adults	Adults & Youth
Services Offered	Inpatient and Outpatient	Inpatient and Outpatient	Inpatient and Outpatient
Clinical Practice Lead	No	No	Yes
Institutional Structures			
Assigning privileges	Through a safety assessment, by the physician, RT professional input was minimal.	Immediate unaccompanied privileges to all.	Through a safety assessment, by the physician, with input from RT professionals.
Assessment process	Assessment driven primarily by off-unit privilege protocols, resulting in delayed and compliance-focused engagement.	Assessment shaped by mandatory vs. voluntary programming structures, with mandatory-attendance units conducting minimal intake assessment.	Assessment supported by formal tools and interdisciplinary collaboration, enabling comprehensive, person-centred planning.
Attendance in RT program	Attendance regulated through a strict incentive and surveillance system, where participation is tracked publicly and directly tied to privilege access.	Attendance governed by mandatory programming on two units, with privileges contingent on meeting daily attendance quotas and penalties for missed programs.	Attendance shaped by a choice-driven, autonomy-focused model, with participation optional and privileges not dependent on attending RT programs.

Assigning Privileges: Implications on Safety and Patient Autonomy

In mental health settings, the assignment of patient privileges plays a critical role in balancing safety and patient autonomy. This section examines how the assignment of patient privileges differs across the three sites and the implications of these processes for RT professionals. Physicians typically hold formal authority over privilege assignments. As Study Participant 11 explained, privileges are contingent upon a physician's assessment of safety and risk factors: "Keeping them safe from being in the community where they might access substances or elopement or things like that." However, RT professionals are often tasked with implementing or navigating these decisions in practice, particularly during therapeutic programming or community outings. Drawing on participants' accounts, this section explores how institutional structures and team dynamics shape the tension between supporting patient independence and ensuring safety, and how RT professionals navigate their roles within these frameworks.

At Site 2, patients are granted unaccompanied privileges immediately upon admission, leaving RT professionals with no opportunity to assess or determine a patient's readiness for participation in RT programs. RT professionals did not raise concerns about their exclusion from these decisions during interviews, highlighting a possible normalization of this dynamic within the site. This predetermined assignment of privileges distinguishes Site 2 from the other sites, where initial privilege levels may be more contingent on ongoing assessment. At Site 2, the early allocation of privileges allows patients some autonomy right from the start, enabling them to leave their unit and move about the facility, albeit restricted to the building's interior. This protocol contrasts with practices at Sites 1 and 3, where the assignment of privileges are typically

earned or adjusted based on individual assessments, though these assessments are not consistently done in consultation with the interdisciplinary care team.

A significant finding in this study pertains to the negotiation of patient autonomy and safety when assigning unaccompanied privileges. While these privileges can allow patients greater freedom and autonomy, some RT professionals expressed concerns about trusting patients' ability to handle this increased autonomy, especially when they felt it was assigned prematurely or without adequate consideration of patient behaviour. At Site 1, Study Participant 5 described how they often used professional judgment to assess whether a patient was ready for unaccompanied privileges, even when the privileges were already granted. They noted:

> Sometimes we feel like maybe [unaccompanied privileges] a bit quick. So, we also use our best judgment and say, 'Okay, I don't feel comfortable taking them right now. Just based on reading the notes, seeing how they act on the unit, maybe not the best to take them for a walk.'

Given that RT professionals frequently escort patients off the unit for RT programs, community outings, and access to outdoor spaces, their role in assessing readiness for unaccompanied privileges is pivotal. Despite this, RT professionals described the assignment of privileges is typically determined by the psychiatrist during their morning appointments and recorded in the medical chart, often without prior consultation with the broader care team. At Site 1, Study Participant 4 explained this process: "Oh, their privileges have changed," referencing the moment of discovering updates in the chart following the psychiatrist's visit. This privilege assignment approach reflects a unidirectional communication dynamic that undermines the collaborative potential of interdisciplinary care teams.

This workflow illustrates the top-down nature of privilege assignment at Site 1 and highlights a structural disjuncture. RT professionals, whose close and continuous interactions with patients position them to provide nuanced assessments of readiness, often find their clinical

judgment sidelined in formal decision-making processes. As a result, while physicians hold the institutional authority to assign privileges, RT professionals are responsible for enacting or withholding them in practice, especially when safety concerns arise. This finding underscores how hierarchical structures within mental health care settings can create tensions between institutional procedures and direct care experience.

Another prominent challenge identified was the balancing of patient autonomy with staff safety. RT professionals reported instances where they felt physicians assigned unaccompanied privileges without fully considering the safety of the staff members who would be interacting with the patient. As Study Participant 3 explained, in these cases, RT professionals felt the need to advocate for their own safety by reporting safety concerns to the charge nurse and requesting adjustments to patient privileges. They shared:

> Usually, if something happens, then I would explain what happened to the charge nurse because the doctors usually aren't there all day, every day. And then it would be, "Yeah, we can pull their privileges." It's usually with an explanation. Usually, the team is supportive if something major happens and I've explained what's happened and why it's been a safety issue or an issue in general. Then, you can pull privileges for 24 hours, and it gets re-evaluated by the doctor or nursing staff.

This account demonstrates how RT professionals must navigate institutional hierarchies by advocating for safety through informal channels. The reliance on the charge nurse for adjustments to privileges further exposes the structural dynamics at Site 1, where the authority to assign or revoke privileges is centralized in the physician's role. RT professionals, therefore, are left to navigate safety concerns with limited formal authority, often relying on nursing leadership when physicians are unavailable.

Fortunately, many RT professionals reported more collaborative practices at other sites. For example, at Site 3, RT professionals emphasized the importance of team discussions in

assigning patient privileges, which fostered greater patient autonomy. For instance, Study Participant 14 explained:

> For example, I have a fellow right now. He goes to the community rec centre twice a week and on weekends. So, he's got privileges to do that. So, there's a number of folks depending on their stability, how they've been doing and programming, their ability levels, their independence or cognitive capacity, it's discussed as a team and a doctor makes the decision that yes, this person is definitely eligible for privileges. So that's a team decision, also a safety decision.

This illustrates a more collaborative decision-making process, where the RT professionals' insights are central to assigning a patient's readiness for increased autonomy. Additionally, Study Participant 14 shared how regular team meetings fostered a shared commitment to patient autonomy:

> We talked about the policies weekly, if they're affecting our practice. The doctors were on board. We were all in agreement, frontline staff, that we need to increase some privileges and get some more autonomy for our folks. And that was super important. So yeah, we were always talking about it consistently, I would say week after week after week, and we kept pushing and pushing and pushing.

This collaborative approach contrasts with the top-down decision-making at Site 1, emphasizing the importance of involving RT professionals earlier in the process of assigning privileges, rather than merely reacting to changes made by physicians.

In conclusion, the contrasting practices across the three sites highlight how institutional structures and decision-making models shape the extent to which privilege assignment aligns with principles of PCC. The experiences at Sites 1 and 3 demonstrate the varying impacts of institutional structures and decision-making processes on RT professionals' ability to support patient autonomy while ensuring safety. While Site 2's predefined approach offers early autonomy, Site 3's collaborative approach more fully integrates RT professionals' insights, achieving a balance between autonomy and safety that better reflects the *Observation, Privileges,*

and Passes Policy. Conversely, the top-down decision-making at Site 1 creates tensions, limiting RT professionals' contributions to privilege assignments and increasing the challenges in balancing autonomy and safety. Collectively, the findings emphasize the importance of interdisciplinary collaboration and professional judgment into privilege assignment processes, not simply for consistency across sites, but to better realize the principles of PPC that the *Observation, Privileges, and Passes Policy* aims to uphold.

Privileges Impacting the Assessment Process in RT

The assessment process is foundational to RT practice. According to best practice standards, assessments should identify each patient's unique strengths, needs, and values to facilitate purposeful and meaningful outcomes (Canadian Therapeutic Recreation Association, 2021). However, across the three sites in this study, institutional processes and mandates often disrupted this practice standard. Rather than functioning as a tool to tailor care to individual needs, RT assessments were frequently shaped by institutional priorities, particularly those tied to patient privilege levels and programming mandates.

At Site 1, assessment practices were closely aligned with institutional protocols surrounding off-unit privileges. Rather than guiding therapeutic engagement, privilege levels functioned as a gatekeeping mechanism. RT professionals began their shifts by reviewing patient charts to identify who held off-unit privileges—a process more reflective of risk management than clinical assessment. As Study Participant 4 explained, "So I usually start off my morning going through the charts, the people that have off-unit privileges and highlighting those that don't, just to make sure that I don't take anyone off the unit that's not supposed to." While it is reasonable to expect that determining privilege levels could be part of the assessment process, in practice, the emphasis appeared to be on protocol compliance rather than tailoring therapeutic

needs or goals. This suggests that institutional safety structures may have shaped how the assessment was enacted, potentially at the expense of individualized therapeutic planning.

The use of privilege levels as a determining factor meant that assessment and engagement often only began after institutional clearance had been granted, regardless of the patient's interests or readiness. Study Participant 5 stated, "I usually try to wait until they go to off-unit privileges before I approach them." This approach illustrates how staff decisions were frequently contingent on the patient's privilege levels, rather than on individual needs. In this context, assessment and engagement were initiated only once a patient's privileges changed to permit off-unit access. This suggests a deferral of care that was less about clinical judgment and more about alignment with institutional protocols.

When assessments did occur, they primarily involved a standardized *Leisure Screen*—essentially a checklist of recreation activities already available at the site. This approach reduces the assessment to a basic inventory of leisure preferences, overlooking the broader scope of the RT assessment. In contrast, comprehensive RT assessments identify each patient's unique strengths, needs, and values to facilitate purposeful and meaningful outcomes (Canadian Therapeutic Recreation Association, 2021). Thus, the *Leisure Screen* emphasized program alignment over personalization, reducing the assessment to an institutional formality. Rather than tailoring interventions to individual goals, the process funnelled patients into existing programming, shifting the focus from therapeutic engagement to diversional participation.

In contrast, Site 2 exhibited more variability between units, driven by whether patient participation was voluntary or mandatory. Some units required mandatory participation in the treatment programs, while others allowed patients to choose whether or not to engage in specific programs based on their individual needs. On voluntary units, RT professionals demonstrated

efforts to incorporate individualized assessments through chart reviews, informal interactions, and collaboration in interdisciplinary care planning. For instance, Study Participant 11 described engaging in multiple forms of information gathering to better understand patient needs on their voluntary unit, "Doing client face to face [interactions], assessment screens, things like that."

However, on units with mandatory participation, assessment practices were notably limited or bypassed altogether. Study Participant 10 described the intake process: "I give the patients a small intake assessment, just to get to know a little bit about their background. But as long as they are referred to programs and referred to recreation, then they just start." For this intake assessment, Study Participant 10 mentioned that items like the patient's physical limitations or impairments or allergies are important items for them to be aware of before their mandatory participation. Here, the assessment prioritized medical risk factors over patient interests or therapeutic goals. The logic of liability and compliance took precedence over PCC.

Mandatory participation in RT programming further diminished the role of assessment. All patients were automatically assigned to pre-determined RT programming, regardless of interest. As Study Participant 10 explained:

> So, my role in my unit it's not like, "let's meet and do an assessment and see what you're gonna go in." Everybody is mandatory in recreation in my unit. So, it's not an option. But once they come to the unit, their psychiatrist, who does their admission, just writes an order that they are to attend programming. And everybody goes into programming. So, it's not like, "let's see what you would like to do." It's, "this is what everybody does."

The institutional mandate effectively silenced the patient's voice and negated the possibility of individualized planning, revealing how rigid structures can obstruct the therapeutic intent of assessment.

Unlike the previous two sites, Site 3 exemplified an assessment process that aligned more closely with RT standards and PCC principles. RT professionals at this site used standardized

tools such as the *Therapeutic Recreation Assessment & Intervention Focus* and the *Initial Recreation Therapy Interview* documents. These texts enabled a more comprehensive understanding of the patient's needs, interests, and goals. Study Participant 16 highlighted a collaborative and goal-oriented approach: "We can try to ensure that we're facilitating activities that are of that client's interest or something that could potentially help that client post-discharge." While off-unit privileges still influenced engagement decisions, these were made collectively within interdisciplinary care teams. As Study Participant 16 noted, "It's discussed as a team, and a doctor makes the decision that yes, this person is definitely eligible for off-unit privileges." This shared decision-making structure allowed RT professionals to integrate clinical judgment and institutional protocols while still centring patient goals. This approach connects to the RT practice and institutional standards, suggesting that RT professionals can implement PCC practices within the assessment process.

The three sites revealed stark contrasts in how institutional ruling relations shaped RT assessment practices. At Site 1, privilege levels dictated engagement, reducing assessment to a compliance task. At Site 2, in units with mandatory participation, assessment was minimal and procedural, overshadowed by blanket programming mandates. In contrast, Site 3 demonstrated how structured assessment tools and interdisciplinary collaboration could uphold both institutional requirements and professional standards. These findings illustrate that when institutional structures override professional autonomy, the potential for person-centred assessment is severely constrained. However, when RT professionals are empowered with the tools and collaborative structures to conduct comprehensive assessments, the process aligns more closely with therapeutic goals and the core values of the RT profession.

Regulating RT Attendance

This final finding examines how RT programs are structured and operationalized across the three sites, focusing on the role of institutional texts and attendance policies in shaping patient participation and access to privileges. This section highlights significant variations in how RT professionals regulate patient attendance—ranging from rigid, compliance-based models tied to incentive systems, to more flexible, person-centred approaches that emphasize autonomy.

At Sites 1 and 2, the institutional texts created to introduce newly admitted patients to the RT programs provide important insight into how the work of RT professionals is organized and coordinated. These texts, entitled the *RT Introductory Document* at Site 1 and the *RT Information Sheet* at Site 2, serve as institutional texts that structure and regulate the relationship between patient participation in RT programs and the gaining, losing, and using of privileges. At Site 1, for instance, this text explicitly connects participation in RT programs to a system of rewards, stating, “The recreation team runs the program on an incentive system to increase motivation. The more programs you attend and participate in, the more rewards you receive.” These rewards include off-unit privileges, such as access to the cafeteria, snacks, and community outings. Also, the introductory documents inform the patients that their attendance will be recorded and closely monitored by the RT professionals. At Site 1, patients are informed, via the document, that their attendance record will be publicly displayed on this unit. It states, “There is a big incentive board on the unit with everyone’s name on it, after you complete a program, we put a check mark by your name.” Moreover, this text specifies that patients must attend at least one RT program per day in order to receive privileges, underscoring the direct link between attendance and privilege use.

At Site 2, the link between RT program attendance and privileges is even more pronounced. For two of the three units, attendance is mandatory, with patients required to attend

three daytime RT programs and at least one evening program each day. These units are organized based on specific diagnoses (e.g., concurrent disorder), and are designed to address more acute stages of recovery. Failure to meet these attendance requirements results in a direct loss of privileges, ranging from a 24-hour to a three-day removal. Whereas, on the third unit (chronic, long-term), privileges do not rely on the patient's attendance in RT programs. This contrast highlights a divergence in how the *Observation, Privileges, and Passes Policy* is operationalized: while the mandatory units enforce participation through a more coercive, attendance-based model, the voluntary unit adopts a more flexible, autonomy-oriented approach that aligns more closely with the principles of PCC.

In contrast, Site 3 does not have an introductory document outlining the relationship between RT attendance and privilege distribution. Instead, RT professionals at Site 3 emphasize patient autonomy, stating that participation is not a requirement for receiving privileges. As Study Participant 16 pointed out, even if patients do not attend these programs, they are still "gifted privileges" such as the ability to go for coffee or take a walk. This approach fosters patient autonomy, allowing individuals to choose whether or not to participate in RT programs without affecting their access to privileges.

This variance in practices across units highlights the role of institutional texts and guidelines in shaping how RT professionals, patients, and even physicians interpret and enforce rules about privileges and RT program participation. It also calls attention to the institutional governance mechanisms that frame the work of RT professionals as a tool for monitoring patient behaviour rather than focusing on therapeutic outcomes.

At Sites 1 and 2, mandatory attendance is a core feature of the RT programs, particularly in the daytime. For example, at Site 2, two units have pre-planned and prescribed daytime

programs, leaving patients with little to no input regarding which activities they participate in. Despite this lack of choice, attendance is strictly enforced, and patients must attend, regardless of whether they feel the activities are beneficial. As Study Participant 10 noted, patients often struggle with the mandatory nature of these programs, especially when they are still adjusting to recovery:

> The program really emphasizes the daily need for leisure lifestyle. Which I would say, at first, sometimes they don't like the rules, "why do I have to go?" But they're new to recovery. And so that's why some of them do bump up a little bit. Like, "Why do we have to do this?" It does really help foster that need for daily, healthy, and positive leisure.

At these sites, patients also earn points for attending RT programs, which are tied to their privilege levels. The goal behind this reward system is to encourage socialization and active engagement in leisure activities, as patients with mental health and addiction challenges are often prone to isolation during their recovery. Study Participant 8 explained:

> I believe the reasoning is because mental health and addictions, [patients] tend to isolate, when they first get admitted or even throughout the recovery. They do a lot of isolating. I'm sure it would be difficult for anyone to come right out of the gates and be out of their rooms and participating in everything and socializing with clients. So that point system reasoning is just to get them out of their rooms, get them socializing, and get them to do more active leisure or at least being off the unit.

While the intent behind the mandatory attendance and points system is to foster engagement, it can inadvertently prioritize institutional goals—such as patient attendance—over individualized care. This structure can constrain the patient's ability to make choices about their recovery journey, potentially diminishing the therapeutic value of the RT programs. If patients are attending activities only to meet institutional requirements or earn privileges, rather than because the programs align with their needs, the impact of the therapy may be less meaningful. For instance, a patient experiencing high levels of anxiety or overstimulation may be compelled to attend a group program despite expressing a need for solitude or one-on-one support. In such

cases, mandatory participation could exacerbate distress, reduce trust in staff, and reinforce feelings of disempowerment, ultimately undermining therapeutic goals rather than supporting them.

In contrast, Site 3 adopts a more flexible and choice-driven approach to RT, offering patients a range of options through a centralized programming structure. Patients at Site 3 can choose from a variety of RT programs offered both on-unit and in shared spaces across the facility. This approach not only provides a broader spectrum of activities but also allows patients to select programs based on their interests and preferences. Site 3 offers two distinct weekly RT calendars: one dedicated to on-unit programs and another featuring off-unit, centralized options. The centralized programs are collaboratively facilitated by all RT professionals at Site 3, with each typically leading one or two per week. By offering these choices, Site 3 embraces a PCC model, emphasizing patient autonomy and individual preference. Study Participant 16 expressed the value of this approach, stating:

> I find the biggest thing is just allowing them the option to choose and do things that they actually enjoy. By forcing them to do anything is not, in my opinion, going to do any benefit to the patient. And if anything, it's going to continue to enforce that power dynamic that I absolutely dread. I find the benefit of being an [RT professional] and working within the [RT] department is that that power dynamic isn't there.

The emphasis on patient choice at Site 3 reflects core values of respect and autonomy, creating an environment where patients are empowered to make decisions that align with their personal recovery needs. This shift from a one-size-fits-all approach to one that is more tailored to individual interests allows for greater engagement and, potentially, a more meaningful therapeutic experience.

At Site 1 and Site 2, RT professionals use a detailed tracking system to monitor attendance, which is an institutionalized practice that supports the incentive structures described

in the introductory documents. For instance, at Site 1, patient attendance is publicly displayed on a unit-wide board, reinforcing the idea that patient behaviour is under constant surveillance. At Site 2, attendance is meticulously recorded on paper and then transferred to an electronic system, with an added stipulation that patients must remain in the RT program for at least 30 minutes to receive points for attendance. This focus on minimum attendance standards rather than engagement or participation reflects a compliance-based framework, rather than a therapeutic one. Study Participant 8 noted, “They just need to be in the space,” which exemplifies a system where meeting attendance thresholds becomes a form of passive compliance rather than active engagement with the therapeutic process.

This raises a critical point: At both Sites 1 and 2, attendance in RT programs is explicitly tied to the maintenance of privileges, yet there is little emphasis on the quality of participation or whether patients meet any therapeutic goals through their attendance. While mandatory attendance structures may ensure that patients are physically present in the programs, they do not guarantee meaningful engagement or advancement in recovery goals. This reliance on attendance as the sole measure of participation reflects a tension within institutional practices, where patient compliance—rather than therapeutic outcomes—appears to be the central focus.

At Site 3, by contrast, the link between RT attendance and privilege allocation is less rigid. RT professionals still document attendance, but it does not directly influence the granting or withholding of privileges. Instead, privilege distribution is based more on clinical assessments of safety and behaviour. For example, Study Participant 16 describes instances where patients might lose privileges due to safety concerns or failure to demonstrate respect, regardless of whether they attend RT programs. This shift away from a strict attendance-based system at Site 3

offers a more flexible, individualized approach to privilege allocation, contrasting with the rigid structures seen at Sites 1 and 2.

Overall, the findings reveal a clear divide between institutionally driven and person-centred approaches to RT programming. Sites 1 and 2 employed rigid attendance policies and incentive structures that prioritize patient compliance and behavioural monitoring over individualized therapeutic engagement. Attendance and participation is closely tracked and directly linked to patients' access to off-unit privileges, often limiting personal choice. In contrast, Site 3 adopts a more flexible model that values patient autonomy, offering greater choice in programming and disconnecting attendance from privilege allocation. By comparing these practices, we can see how institutional arrangements not only regulate patient behaviour but also influence the type of care patients receive, suggesting that the process greatly influences the RT professional's work.

DISCUSSION

The findings of this study highlight the pivotal role that institutional texts, such as the *Observation, Privileges, and Passes Policy*, play in shaping the delivery of care by RT professionals in mental health settings. One of the most striking findings of this study is the variation in how the same privilege policy is applied differently across sites, which directly impacts patient autonomy and participation in RT programs. At Site 2, where unaccompanied privileges are assigned upon admission, patients are granted some autonomy early in their treatment. In contrast, at Site 1, although RT professionals recognize the value of promoting patient autonomy, they voice concerns about the potential risks of granting unaccompanied privileges too soon or without their input. The findings in this study aligns with existing

literature that emphasizes the importance of balancing patient autonomy and safety in mental health care, particularly through the granting of privileges (McKay et al., 2021; Stübner et al., 2006).

While Sites 1 and 2 maintain a structured, mandatory attendance model aimed at reducing isolation and fostering engagement, these policies may limit patient autonomy and may not fully align with individual recovery needs. The reward system used at these sites attempts to motivate participation but often prioritizes institutional goals over individualized care. On the other hand, Site 3 offers a more person-centred approach by prioritizing patient autonomy and providing a variety of choices that respect individual preferences. This contrast underscores the ongoing tension between institutional frameworks that aim to ensure patient engagement and the need for more flexible, individualized care that honours patient choice.

My findings elucidate the complexity of privileging and its effects on patient autonomy is consistent with previous research that has noted the negotiation involved in granting off-unit privileges (Cleary et al., 2012). At Sites 1 and 3, where privileges are adjusted based on clinical judgment and team discussions, RT professionals should play a role in assessing patient readiness. However, as seen in Site 1, the hierarchical structure often sidelines RT professionals in formal decision-making processes, leading to tensions between institutional procedures and the hands-on experiences of direct care staff. These findings are consistent with the work of Charles (2007) and Flannery (2005), who noted that inconsistent application of privilege policies could lead to increased frustration and tension between patients and staff. The lack of consistency in applying privilege policies, as seen in Site 1, can foster a punitive environment that affects not only patient satisfaction but also staff safety and engagement.

While the foundational philosophy of RT is grounded in PCC (Austin, 2018; Hebblethwaite, 2013), the realities of practice within institutional settings can challenge this ideal. Although RT emphasizes individualized, strength-based care that promotes client autonomy (Anderson & Heyne, 2012), institutional structures and organizational priorities often hinder the implementation of these core principles. In particular, mandatory programming at Site 1 effectively undermined the purpose of RT assessments. RT assessments are intended to inform the development of personalized treatment plans (Anderson & Heyne, 2012; Kunstler & Stavola Daly, 2010; Stumbo & Folkerth, 2018); however, at Site 1, assessments were instead used to direct patients into pre-existing group activities, shifting the focus of care from therapeutic to diversional. The findings highlight how assessment practices are shaped, constrained, or redirected by broader institutional ruling relations, particularly those governing patient privileges. This analysis underscores the critical tensions between professional values and organizational demands, illustrating how systemic factors can either constrain or support the delivery of person-centred RT—or even the provision of RT services altogether.

Moreover, the emphasis on privilege-based reward systems, as observed at Sites 1 and 2, reflects concerns raised in the literature regarding the role of privileges as both a tool for therapeutic engagement and a potential source of conflict. This study found that at Sites 1 and 2, privileges were directly tied to participation in RT programs, reinforcing a compliance-based framework rather than one that focuses on individualized therapeutic goals. This structure appears to alter the purpose of RT by requiring patients to engage in programming, deviating from the profession's humanist roots (Austin, 2018; Hebblethwaite, 2013). The mandatory attendance systems at these sites echo Coulter and Richards' (2020) critique of rigid structures that undermine PCC. By contrast, Site 3's more flexible and person-centred approach to

privilege allocation, where participation is not mandated for receiving privileges, exemplifies an RT program structure that better supports patient autonomy and fosters a therapeutic environment.

RT professionals' unique position within mental health settings allows them to make crucial assessments about patient readiness for privileges and their engagement in therapeutic activities. The study reveals that the experiences of RT professionals, particularly in their navigation of privilege assignments and advocacy for patient safety, are essential to understanding the broader implications of privilege policies on patient care. The results highlight the importance of including RT professionals in the decision-making processes surrounding patient autonomy and privilege assignment, as their direct involvement is key to fostering meaningful engagement in therapeutic activities and promoting patient recovery.

The findings of this study emphasize the need for a more nuanced approach to privilege policies in mental health settings, one that balances institutional goals with individualized patient care. When privileges are granted primarily as rewards for attendance and participation, systems risk reinforcing compliance-focused behaviors rather than supporting genuine recovery. The active participation of RT professionals in decision-making processes is essential to this balance, as their unique position allows them to advocate for patient autonomy and ensure that privilege policies align with the therapeutic goals of RT. This study calls for a re-evaluation of current institutional frameworks, particularly those that enforce rigid compliance-based systems, in favour of more flexible, person-centred approaches that respect patient preferences and foster engagement. Further comparative research is needed to explore how privilege policies are implemented across diverse mental health settings and how these approaches affect both patient outcomes and staff dynamics.

Limitations

This study has several limitations. First, participants were self-selected, introducing potential bias, as those with stronger opinions, more interest in the topic, or greater availability may have been more inclined to participate. Individuals who declined often cited time constraints, suggesting the sample may overrepresent those with more flexible schedules. Second, the research was conducted at three specific sites in Alberta, Canada (two rural, one urban), limiting the generalizability of findings to other regions or countries with different mental health care systems. Finally, data collection occurred over a relatively short period (seven months), restricting the study's ability to capture long-term trends, evolving professional challenges, or changes in institutional practices within dynamic mental health care environments.

CONCLUSION

This study emphasizes the significant influence of institutional privilege policies on the delivery of RT in mental health settings, revealing the tension between institutional control and patient autonomy. The findings highlight considerable variation in how privilege systems are applied across sites, shaping patient participation and therapeutic engagement in diverse ways. Structured, compliance-based models may hinder PCC, while more flexible approaches better support individualized recovery. RT professionals occupy a critical role in mediating these tensions yet are often excluded from key decision-making processes. To better align privilege policies with therapeutic intent, institutions should consider approaches that draw on the clinical expertise of RT professionals and are guided by principles of patient autonomy, individualized care, and professional collaboration.

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CHAPTER 4: EXPLORING MANAGEMENT STRUCTURES AND STAFFING PRACTICES IN RECREATION THERAPY: CHALLENGES AND INSIGHTS FROM MENTAL HEALTH SETTINGS

ABSTRACT

Background: Mental health professionals face significant challenges related to managerial support and staffing issues. However, no research exists on the staffing practices of recreation therapy (RT) professionals working in mental health settings.

Aim: This study explores the institutional factors influencing managerial support and staffing practices among RT professionals working in mental health settings.

Methods: The study draws on data from 18 in-depth interviews, part of a larger institutional ethnographic study, which explored the social organization of care across three purposively selected mental health sites in Western Canada.

Findings: Institutional structure and staffing practices play a crucial role in shaping both the work experience of RT professionals and the quality of care provided to clients. Success depends on strong leadership, well-defined roles, and consistent staffing practices. This study highlights the importance for mental health organizations to reassess management structures and staffing practices to enhance job satisfaction and potentially reduce burnout among RT professionals.

Keywords: Burnout, Coverage, Job Satisfaction, Mental Health Care, Therapeutic Recreation

BACKGROUND

Managerial support is critical to mental health professionals' retention and professional growth. A lack of managerial support for mental health professionals often results in frustration, resentment, and mistrust, leading individuals to feel dismissed when raising concerns (Thompson et al., 2024). Conversely, when professionals receive effective managerial support, they are less likely to consider leaving their positions, which can improve retention (Moloney et al., 2020; Yan et al., 2024). Managerial support also plays a vital role in mitigating burnout by helping professionals set boundaries and maintain both their own safety and that of their clients (Tragantzopoulou et al., 2024). In supportive environments, professionals feel empowered to take risks, implement innovative ideas, and learn from experience, thereby enhancing job satisfaction and commitment to their teams (Moloney et al., 2020; Fleury et al., 2018). The demanding nature of mental health work consistently undermines job satisfaction, which, in turn, affects staff retention and the quality of service delivery (Adams et al., 2021; Maslach & Leiter, 2016; Tragantzopoulou et al., 2024; Yang & Hayes, 2020). Excessive workloads and chronic understaffing further exacerbate these problems (Adams et al., 2021; Ma et al., 2022).

Staffing challenges further complicate mental health service delivery. Such challenges include staffing shortages, understaffing, and reduced staff-to-client ratios. Inadequate staffing increases workloads and diminishes job satisfaction for mental health professionals by creating unsustainable working conditions (Yan et al., 2024). Staffing shortages, or being "short-staffed," arise when workforce capacity cannot meet service demands, leading to unmanageable client caseloads (Last et al., 2024). These circumstances contribute to overwhelming work environments for mental health professionals (Last et al., 2024). Additionally, understaffed settings often require professionals to assume multiple roles during a single shift, which

contributes to fatigue and burnout (Thompson et al., 2024). These conditions have been linked to increased client injury and missed essential care (Thompson et al., 2024). Staffing ratios also play a critical role in determining the quality of mental health care. Boden et al. (2019) emphasized that staff-to-client ratios are more predictive of care quality than other operational factors such as staff productivity or client wait times. Thus, increasing the number of mental health professionals relative to clients may have a significant impact on service quality (Boden et al., 2019).

Despite these well-documented challenges, little research has examined staffing practices and job satisfaction among recreation therapy (RT) professionals working in mental health settings. RT professionals use recreation, leisure, and play as treatment modalities to create meaningful interventions based on individual strengths and values (Canadian Therapeutic Recreation Association, 2021). In mental health contexts, RT services help alleviate symptoms of depression, anxiety, and stress by enhancing self-confidence, social skills, and independence (Alberta Health Services, 2025). RT professionals also contribute to mental health recovery through peer support, social inclusion, and personalized care—elements essential to reintegration into community life (Stumbo et al., 2015).

In Canada, RT is an unregulated health profession, which means employers independently determine staffing needs (Alberta Therapeutic Recreation Association, 2025). This decentralized approach can contribute to inconsistent or suboptimal staffing practices across agencies. Given the evidence linking managerial support and effective staffing practices to job satisfaction and quality of care among other mental health professionals, the absence of research specific to RT professionals represents a notable gap. This study addresses that gap by examining institutional factors influencing managerial structures and staffing practices for RT

professionals in mental health settings. Findings highlight the need for mental health organizations to reassess managerial structures and staffing coverage in order to enhance job satisfaction and care quality among the RT profession.

METHODS

This qualitative study forms part of a larger institutional ethnographic research project designed to examine how the work of RT professionals is socially organized within mental health services. Within Institutional Ethnography (IE), discussing everyday experiences serves as a way to uncover knowledge (Smith, 2005). IE begins with an investigation into the experiences of individuals directly involved in institutional settings (e.g., mental health care settings). However, rather than focusing on the individuals themselves (e.g., RT professionals), IE emphasizes the social processes that shape their daily activities within the institution (Smith, 2005). IE was chosen as the method of inquiry because it offers a practical and effective way to analyze the institution. According to Smith (2005), institutions extend beyond physical entities like hospitals or government offices; they are formed through networks of social relations, shaped and maintained by discourse, texts, and authoritative structures.IE avoids imposing an a priori theoretical framework, ensuring that findings emerge organically from the concrete data (Rankin, 2017). In doing so, IE explicates the tensions rooted in people's actions and experiences without resorting to a theoretical interpretation of their lived realities (Rankin, 2017; Winton, 2019).

Setting

This study included participants working in mental health settings in one Western Canadian province. Three sites were selected based on the following criteria:

- Employed over 10 RT professionals at the time of the selection process,
- Offered programs and services under the same health authority,
- Provided outpatient (i.e., community) and inpatient services, and
- The site's inpatient mental health care services had >75 beds.

Smaller sites were excluded due to the low number of clients served and the limited number of programs and services offered. Sites 1 and 2 were located in rural areas of Western Canada, while Site 3 was situated in an urban area.

Sample

This study employed purposeful selection of both participants and locations, a widely recognized method in qualitative research that emphasizes the importance of relevance rather than chance (Creswell & Creswell, 2018). By deliberately choosing individuals who satisfy predetermined inclusion criteria, purposeful selection allows for a deeper insight into the research issue (Creswell & Creswell, 2018). In this case, the method was applied to select participants and sites that were suitable to provide distinct perspectives on the research topic. To participate in the study, individuals had to work full-time, part-time or casual in mental health services, speak English, and have the title recreation therapist, recreation therapy assistant or recreation therapy aide. Therapists are typically assigned to a single mental health unit (e.g., inpatient adult unit) at each site, with all clients admitted to that unit being part of the therapist's caseload. Assistants are usually assigned to a therapist's caseload, but some assistants are shared between units to support RT programs when needed. For instance, some assistants implement RT programs to cover for therapists or other assistants who are absent. Therapists are generally responsible for the comprehensive application of professional standards of practice, whereas

assistants are primarily focused on program implementation, client observation, and reporting findings (Canadian Therapeutic Recreation Association, 2023).

Most recruitment occurred with an email distribution of welcome letters by the managers at each site. Participants emailed me to inquire about the study and to complete the informed consent document. I conducted one site visit per site to meet with potential participants during a study information session to further explain the study and answer questions. During the site visit, some potential participants requested individual meetings with me to ask questions about the study, such as questions about the length of time required to participate.

The provincial RT director stated that 71 RT professionals were employed at the three sites, including full-time, part-time, and casual employees. Eighteen RT professionals participated in this study: three working exclusively in the community and fifteen in inpatient mental health units. Fifteen participants held the title of recreation therapist, and three held the title of recreation therapy assistant. Each participant provided written voluntary consent to participate in this study. Participants were provided with a gift card honorarium for participating in this study. Ethics approval for this study was obtained from the University of Alberta Ethics Research Board, REB ID Pro00127334.

Data Collection and Analysis

In IE research, data analysis does not follow a prescriptive approach. According to Smith (2005), the purpose of the analysis in IE is to explicate how work is socially organized rather than to seek patterns or themes. Therefore, the primary goal of IE is not to explain individuals or their attitudes, but to uncover the social processes in which people are involved, and which they both reproduce and change through their participation (Caspar et al., 2016).

The data consisted of interview transcripts and reflexive field notes generated after site visits and after each interview. Interviews were conducted over a seven-month period from 2023 to 2024. All interviews were audio recorded and transcribed verbatim with assistance from Otter AI transcription software. Interviews ranged from 60 to 90 minutes. Smith (2005) suggests talking to study participants about their daily work rather than having scripted interviews. Having a script can create a power imbalance during the conversation in favour of the researcher's goals instead of allowing room for the study participants to reflect on their experiences (Smith, 2006). For this study, having some preplanned questions was preferred rather than a scripted interview guide. Interviews started with general questions such as "Describe a regular workday, with as much detail as you can," "What does a good day look like?" What does a bad day look like?" and "What's it like to do this work?" I verified my understanding of the information during the interviews by reframing the questions and clarifying the responses as needed (Campbell & Gregor, 2008). To ensure rigour, I relied on the writing of reflexive field notes following each interview (Creswell, 2013). Following the recommended IE methods, data collection continued until enough information was gathered to document the everyday practices of RT professionals within the institutional framework of mental health facilities (Townsend, 1996).

Microsoft Word® was utilized to organize the interview data and reflexive field notes. I derived salient categories of meaning and the relationships between them through an inductive reasoning process similar to the constant comparative method outlined by Glaser et al. (1967). This involved continuously comparing data segments to one another to identify patterns, refine emerging categories, and explore how these categories related to each other throughout the analysis. For this paper, I engaged in collaborative discussions with my supervisor to analyze the

collected data, reflecting on the analysis process, and actively refining and confirming the findings and their relationships (Morse et al., 2002).

FINDINGS

By examining the experiences of RT professionals working in mental health settings, I found that managerial structures and staffing practices, particularly the provision of coverage, significantly impacted their job satisfaction. At Sites 1 and 2, RT staffing practices created stress and increased work demands, contributing to a negative work environment and lower job satisfaction. By comparison, RT professionals at Site 3 benefited from greater institutional managerial support and more resources for staffing coverage, which contributed to higher job satisfaction.

Three key findings elucidated the impact of managerial structures and staffing practices on RT professionals' job satisfaction: (1) The Importance of Managerial Awareness and Support, (2) The Impact of Managerial Support on Staffing Coverage Practices in RT Services, and (3) The Impact of Staffing Practices on Short-Staffing and Understaffing in RT Services.

The Importance of Managerial Awareness and Support

The different managerial structures influence support, awareness, and daily operations of RT professionals across all three sites. The lack of formal RT leadership and managerial understanding of RT services at Sites 1 and 2 differs from the more formal leadership structure at Site 3, and this difference appears to be associated with variations in RT professionals' reported job satisfaction, collaboration, and perceptions of service sustainability.

At Sites 1 and 2, RT professionals reported directly to unit managers who also oversaw other disciplines, such as nursing. While these other disciplines often had designated clinical

leads or charge nurses to support their staffing practices, RT professionals did not have a formal equivalent role at these two sites. Additionally, most unit managers came from non-RT backgrounds, with nursing being the most common.

RT professionals at both sites described that their unit managers were largely uninvolved in their day-to-day work. At Site 2, Study Participant 8 described the minimal involvement of their manager:

> *Interviewer*: Okay, and what role does [your manager] have in your day-to-day working activities and duties?
>
> *Study Participant 8*: I would say close to nothing. I don't think they've really affected recreation too much. But in terms of my programming and everything, they don't handle any of it. The only thing that [they] would really be for me is someone to ask questions about benefits and pay.

Similarly, many RT professionals at Site 1 reported a lack of managerial awareness of their professional scope. As Study Participant 3 stated, "To be honest, I don't even know if my manager really grasps the scope of what a recreation therapist does." This perceived lack of awareness and understanding of their work contributed to a relational distance between managers and RT professionals. Without knowledgeable and involved managers, it becomes difficult for RT professionals to receive the support they need. This finding also suggests that the work of RT professionals may not be valued, as the relational distance limits managers' awareness of the outcomes of RT services.

At Site 2, the absence of a designated RT clinical lead further compounded these issues, as this role typically provides support and oversight for staffing practices. As a result, one RT professional, Study Participant 10, assumed this role informally, stating, "Somebody has to do the schedules," indicating that staffing coordination fell to them by necessity. This lack of structured support extended beyond staff scheduling. Study Participant 8 remarked: "I'm

technically supposed to go to the manager because they're my official, on-paper manager. But we usually just go to [Study Participant 10]." In the absence of managerial support, RT professionals relied on Study Participant 10's unofficial leadership role to maintain departmental operations. This informal leadership structure reflects a strong commitment by the RT professionals at Site 2 to preserve service delivery and emphasizes the need for greater institutional guidance and recognition. Without managerial support, RT professionals were left to assume tasks outside their job descriptions, such as scheduling and team coordination, to ensure continuity and quality of service delivery.

In comparison to Sites 1 and 2, RT professionals at Site 3 reported to an allied health manager who collaborated closely with an RT clinical lead. The allied health manager had an occupational therapy background, and the RT clinical lead was a recreation therapist at this site. This managerial structure separated RT supervision from unit-level management, leaving RT practice oversight to professionals with greater RT knowledge. Study Participant 15 explained: "We're supporting members of the unit, but not directly reporting to those [unit] managers." Thus, the unit managers worked with the RT professionals to support client care but did not oversee their practice, including staffing practices.

The presence of an RT clinical lead seemed to create more equitable workload distribution and facilitated creativity and innovation in practice. As Study Participant 14 shared:

> All the allied health are under the same structures, which is really nice because we can do planning together, we brainstorm together. I would say there's more support for initiatives, and we're not having to work on things off the side of our desks or shared workloads, so I think it makes things a lot better, personally. There's less pressure, and you don't feel like you're the only one doing things or working on things, which is quite nice.

The greater managerial awareness of the RT profession, combined with the allied health leadership structure, appeared to create a formal workflow process that improved operations at Site 3. RT professionals could spend more time on work that was part of their job description, as opposed to the unofficial RT leader at Site 2, who often engaged in work outside of their job description. The managerial structure at Site 3 included monthly team meetings led by the RT clinical lead, which provided more support and team collaboration. These meetings provided space to share concerns, brainstorm collectively, and identify educational opportunities. By comparison, at Site 1, the lack of managerial awareness and support not only created relational distance between managers and RT professionals but also signalled a broader undervaluing of RT work and its impact.

The Impact of Managerial Support on Staffing Coverage Practices in RT Services

RT professionals generally described staffing coverage practices as essential to ensuring the consistent delivery of group programs, which are integral to scheduled mental health services. Maintaining this continuity in RT group programming was a central concern across all sites. Staffing coverage practices included staff scheduling, organizing coverage assignments, and coordinating communication between staff and management.

At Site 1, limited access to casual staff meant RT professionals primarily relied on their colleagues to provide coverage, often pulling them away from their regular duties and reducing time spent on direct client care. In contrast, Site 2 had a larger pool of casual RT professionals available, and Site 3 had both casual staff and an RT clinical lead who could provide coverage when needed.

RT professionals at Sites 1 and 2 were responsible for managing their own staffing coverage practices with minimal institutional or managerial support. This expectation to self-organize coverage in the case of staffing absence created stress, as noted by Study Participant 2: “We try to find coverage as much as possible for our groups. That’s why it can be a little stressful.” This administrative responsibility, particularly at Sites 1 and 2, was associated with negative emotions during work and was perceived as an additional responsibility not reflected in the formal job description. Moreover, the RT professionals’ attempts to maintain consistency of RT group programming exacerbated these feelings of stress, as they wished to continue to provide client care when absent.

At Site 1, RT staffing coverage was once managed by the unit manager. However, this responsibility has shifted to the RT professionals without corresponding changes to their job roles or support structures. Study Participant 1 highlighted the impact of this change:

> Our previous manager would put in shift requests for us to get casual coverage. And now this manager wants us to do the scheduling [coverage], and that’s not at all in our job description. And I’ve been kind of fighting, saying, “That’s actually in a clinical lead’s job description, and we don’t have one here.” I physically do not have the time in the day to go out and look for a casual to come in and cover my vacation.

The reasons for this change in staffing coverage responsibility from management to RT professionals were not detailed in the interviews. Additionally, the absence of an RT clinical lead at Site 1 further compounded this issue. Study Participant 1 emphasized, “We’re the only discipline here that we don’t have a clinical lead... It’s very hard to find any time to do anything extra.” This lack of managerial support contributed to RT professionals feeling that the extra time and energy increased workplace stress, particularly when planning their scheduled time off. This additional responsibility increased workplace stress, which negatively impacted the RT professional’s job satisfaction.

At Site 2, RT professionals also managed their own staffing coverage, independent of the institution's standardized process. Study Participant 10 contrasted the process for RT coverage with other disciplines:

> We operate very independent of the rest of the centre. [Other disciplines] operate on a system called Makeshift, and they have one schedule for the entire centre. So, it's an online app, and when somebody puts in a vacation request, anybody interested in applying for that shift can put in their name. Or if somebody calls in sick, the scheduler will look for people. Our department has never been a part of that since it started.

The staffing coverage practices RT professionals used at Site 2 were always separate from the standardized institutional process, primarily because the RT program extends into the evening, which is staffed almost exclusively with casual staff. Study Participant 10 described the reason for potential difficulties in adding RT staffing coverage practices to the institutional practices:

> Just because we operate exclusively almost with casual staff. And it would be a nightmare for a scheduler to try and fill these shifts like all the other departments. [Other disciplines] run on the 7.75-hour workday, where we have people come in for three hours or five hours. They don't know what our needs are, and they can't really put it out there. So, it's just always kind of been the way it is, we've always done our own thing.

Since the RT department's scheduling differs from other disciplines' typical staffing practices, the responsibility for coverage falls on the RT professionals. This includes securing coverage and assigning casual staff to units. This staffing practice highlights the potential lack of managerial awareness of the unique needs of the RT professional's coverage. Thus, this potential lack of awareness seems to limit the support from managers, suggesting that the RT professionals manage their own coverage, separate from institutional practices. Study Participant 11 further described the separate RT staffing coverage practices at Site 2, "We're an island of our own, and we're pretty independent. We manage our own casual staff, and we do our own call-ins amongst ourselves."

To coordinate these efforts, RT professionals relied on a social media platform to communicate with casual staff, offering better access than the internal IT system. Study Participant 8 noted, “[Casual staff] will be able to see something even though they won’t be in for five days.” Hence, they can receive information about available shifts as needed through the social media platform since they are not working consistent days each week and would not have access to the internal institutional communication system. This practice further demonstrates the staffing coverage needs of the RT department not being met by the institution. This workaround highlighted ongoing institutional gaps and emphasized RT professionals’ proactive efforts to ensure program continuity.

Site 3 benefited from a formal managerial structure with a designated RT clinical lead who coordinated staffing coverage and oversaw daily operations. The RT clinical lead, Study Participant 15, stated, “Part of my role is to ensure that coverage is happening for the many different programs that are happening on site, should someone be away.” This centralized responsibility allowed RT professionals to focus on clinical duties without the added administrative responsibility of finding their own coverage. Staffing coverage needs were primarily communicated and managed through an internal email list, maintained by the RT clinical lead. Study Participant 18 described the staffing coverage practice at Site 3:

> *Study Participant 18*: If we’re not on site that day, we’ll send an email out to our RT team. If somebody calls in sick or vacation, then that’s when we’ll connect usually by email as to who’s going to cover that program.
>
> *Interviewer*: And who runs or manages that group list?
>
> *Study Participant 18*: We have a [clinical] lead for our site.

The presence of an RT clinical lead at Site 3 allowed dedicated time and support for staffing coverage practices, which seemed to improve the workplace experience for RT professionals. Study Participant 14 described this positive change:

> It's very peaceful now, we don't have to worry about all these things that we used to do off the side of our desk. Now, there are dedicated people to organize that and give support where we need it. That's been very, very helpful.

Across sites, the presence or absence of managerial support, particularly through a designated clinical lead, shaped how RT staffing coverage practices were organized. At Sites 1 and 2, the lack of formal support structures required RT professionals to independently manage coverage using informal methods, contributing to stress and negatively impacting job satisfaction. In comparison, Site 3's formal managerial structure alleviated additional administrative responsibilities and supported more consistent program delivery. These findings highlight the importance of formal managerial structures and institutional support for RT staffing coverage practices to contribute to job satisfaction.

The Impact of Staffing Practices on Short-Staffing and Understaffing in RT Services

Ensuring staffing coverage for RT programs during sick leave or vacation is not always feasible across all sites, particularly at Site 1. At this site, program cancellation is considered a last resort; however, it remains a necessary option when coverage cannot be arranged. Study Participant 2 shared the stress they experience when coverage is not available (i.e., being short-staffed) and how it prompted them to speak with their unit manager. They stated:

> I did have that conversation with my manager. And [they] were like, "We need to be able to cancel programs, we should be able to." My manager understands that if we need to cancel, then that's what we need to do.

This manager emphasized that program cancellation should be viewed as an acceptable solution when coverage is limited. A minimal casual pool compounded this challenge. As a result, program cancellations occur, compromising the quality of care for mental health clients who

benefit from consistent RT programming. This finding suggests a stronger need for managerial support for improved staffing coverage strategies that prioritize continuity in client care.

Further strain arises when RT professionals are expected to cover multiple units due to staff absences. Study Participant 1 expressed the toll this takes, “And I would honestly say being short is a bad day, like we’ve been short now. And I have to cover two units… It’s exhausting.” RT professionals also noted that when staff are stretched thin, meaningful daily interactions with clients become limited. This can lead to program cancellations and reduced quality of care. Study Participant 4 captured this challenge:

> Like, if we only have two people here, then that kind of makes it difficult because there are three units. But it always sucks when you can’t do a lot for the patients during the day or when you have to cancel programs because of short staffing.

These staffing issues are not solely due to short-term staffing gaps but also reflect broader institutional challenges. At Site 2, a significant concern is the institution’s failure to support permanent RT positions. This is an example of understaffing. Instead, there is a reliance on casual staff, which can contribute to instability and hinder retention. Study Participant 10 elaborated:

> So, we’ve brought up on numerous occasions to different managers the need for a permanent part-time [RT] aide instead of constantly filling with casuals. We can retain somebody if they’re in a position but if they just get casual, half shift hours, they eventually look for other work. So, we’ve brought up the need for a permanent part-time [RT] aide, which we’re just always told, “that won’t happen.”

While management appears aware of this reliance on casual staffing, they have not allocated the necessary resources to create permanent roles, which limits service consistency and increases the administrative responsibilities (i.e., coverage) on existing RT professionals at Site 2.

Many RT professionals emphasized the importance of maintaining care, even in the face of understaffing. For instance, Study Participant 2 explained that Fridays are particularly challenging because of understaffing at Site 1:

> Let's use Fridays as an example. So, I have a .8 [not full-time] therapy assistant. So [they are] not here on Fridays. So that is the day where I would do kind of both jobs. I would do what the therapy assistant does during the free time, squeezing some assessments, run a group, do gym. Sometimes it's crazy because you're the only one. And if you have a lot of requests, like taking people down to get clothes and doing the extra recreation, that can be a heavy day.

This illustrates how RT professionals often absorb additional staffing responsibilities to keep programs running, even at the cost of other duties. It also suggests that RT professionals assume responsibility for higher staff-to-client ratios on days that they are understaffed. These added pressures may negatively impact job satisfaction and increase the risk of burnout. Yet, these efforts reflect the RT professionals' strong professional commitment to sustaining client care.

At Site 1, staffing shortages contributed to an increase in program cancellations, demanding workloads, and reduced client engagement. These outcomes contributed to diminished quality of care and lower job satisfaction among RT professionals. At Site 2, RT professionals faced challenges due to a shortage of staffing positions that could support the RT services more effectively.

At Site 3, the RT clinical lead plays a central role in managing coverage needs. Their familiarity with RT programs allows for more responsive and informed scheduling: "I have a pretty good idea of the schedules and the programs that are happening here. And so, then it's a matter of trying to find coverage" (Study Participant 15). Importantly, the RT clinical lead maintains a small client caseload and can act as a float staff member when needed, "And then, at

certain times, I often will cover if I can’t find somebody” (Study Participant 15). This flexible leadership structure helps ensure coverage and highlights the recognized importance of maintaining RT services in supporting client progress and treatment outcomes.

Despite these advantages, Site 3 is not immune to staffing challenges. Certain periods of the year, such as the summer months, were particularly difficult, as described by Study Participant 15:

> There was a period of time this summer, early summer, where we had some vacancies and that created some gaps in services and programming. And so, I was in between hiring recreation therapists and doing a lot of program coverage and unit support, as much as I could, given that I was one person.

Although Site 3 seemed to have more managerial support than Sites 1 and 2, the RT professionals still experienced staffing concerns. However, the RT clinical lead’s coverage flexibility and professional knowledge support a more proactive and effective approach to managing these gaps.

DISCUSSION

The findings from this study highlight several critical aspects of staffing practices, management structures, and their impact on the work experience and performance of RT professionals across different sites. One prominent finding is the significant variation in staffing practices at Site 2, which have developed in response to the site’s unique scheduling needs. The reliance on casual staff and short evening shifts necessitates an adaptive staffing practice that operates outside the traditional institutional framework. This autonomy allows RT professionals at Site 2 to have flexibility in managing their staffing schedules, which is essential for meeting the needs of clients. However, this independence also means RT professionals rely heavily on

informal communication methods, such as social media, to coordinate coverage. While this may provide short-term flexibility, it could lead to long-term challenges in excessive workloads and work demands. Over time, these pressures can reduce the time available to complete essential tasks, ultimately increasing the risk of staff intending to leave the workplace (Adams et al., 2021).

In addition, the staffing practices at Sites 1 and 2 face significant challenges due to a lack of managerial awareness and support. Unit managers seem to lack a thorough understanding of the scope of RT services, which results in RT professionals managing tasks outside of their defined roles, such as coordinating schedules and ensuring adequate staffing coverage. These added responsibilities can contribute to burnout and fatigue among mental health professionals (Thompson et al., 2024). The absence of managerial support in these settings exacerbates the challenges, leaving RT professionals to shoulder additional responsibilities without appropriate recognition. This highlights the importance of clear communication and managerial involvement in ensuring that RT professionals are properly supported and their roles are well-defined within the institutional structure.

At Site 3, a more structured approach to RT staffing practices seems to be more evident, with RT professionals reporting to an allied health manager and a formal RT clinical lead overseeing staffing coverage. This institutional structure not only ensures consistent coverage of RT programs but also reduces the additional administrative responsibilities on RT professionals. The support provided by clinical leadership at Site 3 fostered a more collaborative environment where RT professionals felt less pressure and more empowered to engage in creative and meaningful work. Similarly, Wozencroft et al. (2024) found that RT professionals in collaborative workplace environments reported higher job satisfaction. While the structure at Site

3 appears to have a positive impact on job satisfaction and professional support, its applicability to other sites may depend on factors such as staffing levels and organizational capacity. Rather than assuming this model can be directly replicated, further attention to structural features, including the role of interdisciplinary leadership and the potential for unit managers to provide meaningful support, may be key to enhancing RT staffing practices. These findings are similar to how mental health professionals' job satisfaction improves with the presence of supportive management supervision (Fleury et al., 2018; Moloney et al., 2020; Tragantzopoulou et al., 2024).

One of the most significant challenges identified at Site 1 was the impact of staffing shortages. The shortage of RT professionals can result in the cancellation of programs and an increased workload for the remaining staff. This can reduce client interaction, compromise the quality of care, and diminish job satisfaction among RT professionals. This observation is consistent with Ma et al.'s (2022) findings in nursing. The increased pressure to take on multiple roles to cover for understaffed shifts often leads to fatigue and decreased morale, highlighting the importance of addressing staffing coverage gaps. Importantly, these conditions have direct implications for the implementation of person-centred care (PCC), which requires RT professionals to have sufficient time to engage meaningfully with clients. Because PCC begins with taking time to understand the individual, staffing shortages restrict professionals' ability to build the rapport necessary for PCC to be effectively achieved (Schwind et al., 2014; Suen, 2016). The reliance on casual staff, particularly at Site 2, creates instability and further complicates efforts to retain skilled workers. The lack of long-term continuity in staffing may affect the quality of care provided to clients and diminish the overall effectiveness of RT

programs, which are intended to promote client progress toward individualized therapeutic goals, increase engagement, and support overall well-being.

These findings suggest that the institutional managerial structures and staffing practices directly influence the work experience of RT professionals and the quality of care provided to clients. Effective leadership, clear role delineation, and stable staffing practices are crucial for ensuring job satisfaction and minimizing the negative effects of staffing shortages. The differences found across the sites emphasize the need for a tailored approach to RT professionals that takes into account the unique challenges and needs of each setting while prioritizing professional awareness, support, and consistency in care delivery.

Limitations

As with all studies, this study has limitations. One, interviews at Site 1 occurred during the summer months, and scheduled vacations may have impacted the RT professionals' focus on staffing coverage practices. Many RT professionals discussed that the summer months are when most staff take their vacations during the year. However, I believe it is important to capture a realistic perspective of the RT professional's working experience, and vacations are part of the typical aspects of annual work in mental health care settings. Another limitation is that this study is based on only 18 interviews, which may not provide a comprehensive understanding of RT staffing practices across broader mental health settings. This is compounded by the fact that this study was conducted at only three sites in Western Canada, which may limit the generalizability of the findings to other regions.

CONCLUSION

This study addresses the gap in research regarding how institutional factors influence staffing practices for RT professionals working in mental health settings. Findings from this study highlight that institutional managerial structures and staffing practices significantly impact both the work experience of RT professionals and the quality of client care. Key factors for greater job satisfaction include effective leadership, clear role definitions, and stable staffing practices. The variation across different sites emphasizes the importance of customizing staffing practices to address specific challenges while maintaining professional awareness, support, and consistency in care. In conclusion, this study underscores the need for mental health organizations to address staffing practices to improve job satisfaction and may perhaps mitigate burnout among RT professionals.

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CHAPTER 5: SUMMARY AND SYNTHESIS

In this final chapter, I summarize and synthesize the key findings from chapters 2 through 4 to further explore the central aim of the study: to examine how institutional structures empower or hinder RT professionals in delivering PCC. Thus, I return to the study's two research questions: (1) How is the work of RT professionals socially organized in mental health services? and (2) How does the social organization of RT work support, enable, or impede PCC?

In chapters 2, 3, and 4, I examined different dimensions of these questions. In chapter 2, I presented a concept analysis that described five defining attributes of PCC. In chapter 3, using institutional ethnography (IE), I investigated how the institutional practices surrounding patient privileges shaped RT professionals' ability to deliver PCC. In chapter 4, also using IE, I explored how institutional factors influenced staffing practices among RT professionals working in mental health settings.

In the following section, I briefly summarize each manuscript (chapters 2-4). Building on the summaries of chapters 3 and 4, I synthesize the findings to offer new insights that align with the defining attributes outlined in chapter 2. Finally, I reflect on the implications of this study for mental health services, highlighting the contributions of my research to the field, and propose directions for policy and practice.

Summaries and Synthesis of Findings

Chapter 2, *Person-Centred Care in Canadian Mental Health Settings: A Concept Analysis*, aimed to clarify the understanding of PCC within Canadian mental health care. Using the modified Wilson Method concept analysis (Walker & Avant, 2011), I identified five defining

attributes of PCC: (a) Care tailored to the person, (b) Active engagement, (c) Clear communication and active listening, (d) Holistic perspective, and (e) Empathy and compassion. These defining attributes further clarify the understanding of PCC in mental health care and offer a foundation for developing a consistent and operational definition.

Chapter 3, *The Impact of Patient Privilege Policies on Recreation Therapy Practice in Mental Health Care*, aimed to explore how institutional practices surrounding patient privileges influence the delivery of PCC by RT professionals. I identified that the implementation of the *Observation, Privileges, and Passes Policy* played a key role in shaping how RT professionals delivered PCC. Differences in how the policy was implemented across sites affected patient autonomy, the assignment of privileges, and participation in RT programs.

I discovered that, although the policy was intended to balance patient safety with therapeutic engagement, in practice it was often used to prioritize control and compliance over collaboration. This shift had a significant impact on the ability of RT professionals to tailor care to the person. In particular, in settings where program attendance was mandatory or tied to institutional consequences, both patient and professional autonomy were compromised. Under these conditions, care became more about enforcing participation than understanding the person, which limited opportunities for personalized assessment and reduced the patient's active role in their care.

However, there were also examples of RT professionals who resisted these coercive dynamics. Some offered patients choices within the boundaries of the policy, using professional judgment to align care more closely with the defining attributes of PCC. In these cases, RT professionals conducted more robust assessments and developed deeper understandings of each

patient's needs, values, and goals. These instances demonstrated that even within rigid institutional structures, there is room for therapeutic flexibility and advocacy.

Still, these were exceptions to the overall findings. Even though the system was sometimes effective in addressing behaviours such as social withdrawal, it did so through a lens of compliance rather than individualized understanding. These findings reveal a greater pattern: institutional systems that claim to support holistic PCC often revert to standardized, symptom-focused approaches in practice. In this context, the patient privileges process became a structural barrier to PCC, limiting the RT professionals' capacity to deliver relational, responsive, and person-focused care.

Chapter 4, *Exploring Management Structures and Staffing Practices in Recreation Therapy: Challenges and Insights from Mental Health Settings*, aimed to explore the institutional factors influencing managerial support and staffing practices among RT professionals. I identified that managerial support and staffing practices played a crucial role in shaping both the work experience of RT professionals and the quality of care provided to clients. These findings highlight that greater success relies on strong leadership, clearly defined roles, and consistent staffing practices.

Work environments characterized by staffing shortages and heavy workloads constrained the capacity of RT professionals to prioritize direct patient care. Competing demands and a lack of protected time resulted in individualized assessment and planning being rushed or completed inconsistently, undermining opportunities to engage with patients in understanding their care needs. When staffing practices protected time for clinical work and supporting individualized assessment, RT professionals were better able to deliver care that reflected each person's unique

goals, preferences, and needs. These findings highlight that staffing practices are not only operational concerns but core determinants of the delivery of PCC.

In addition to patient-staff interactions, I uncovered an underexplored aspect of PCC in mental health care: staff-to-staff communication. While PCC frameworks typically emphasize direct communication with patients, the findings show that clear and consistent communication among staff is equally essential for supporting PCC. RT professionals developed informal communication systems, reflecting their commitment to patients and to the integrity of their services. These findings suggest that clear and consistent staff-to-staff communication is critical for delivering PCC in mental health settings.

Another significant finding was that gaps in institutional support compelled RT professionals to assume additional responsibilities, such as informal leadership and coordination roles. In the absence of formal guidance, they assumed these responsibilities that extended beyond their clinical duties. While these actions reflected deep dedication and professional integrity, they also exposed a broader issue: institutions are downloading leadership responsibilities onto staff without providing the necessary resources. This pattern contributed to the RT professionals’ emotional fatigue and increased the risk of burnout.

Despite these challenges, I was struck by the compassion that RT professionals brought to their work. Direct patient interaction was among the most meaningful and fulfilling facets of their roles. Many described their best work days as those spent primarily in therapeutic engagement. These reflections demonstrate that the emotional resilience and empathy of RT professionals are key drivers of care quality, even when institutional conditions are less than ideal.

The research findings on patient privileges, managerial structures, and staffing practices highlight a central insight: PCC is not sustained by intention alone—it requires institutional structures that support clinical time, communication, leadership, client collaboration and autonomy, and staff well-being. Without these supports, PCC risks remaining an aspirational ideal rather than a practical reality. The emotional labour and informal leadership provided by RT professionals hold together systems that, in many cases, fail to support them in return.

Implications for Mental Health Services

This study highlights a fundamental tension in mental health care between institutional practices and the delivery of PCC. Although the language of individualized, recovery-oriented care is widely adopted, the observations tell a different story. Institutional structures, such as rigid risk protocols, mandatory programming, and uneven workload distribution, frequently undermine the very principles they claim to uphold.

I identified that the delivery of individualized care is not simply a matter of the RT professionals' intent, but rather a matter of systemic design. Instead, their capacity to offer PCC is closely tied to the availability of institutional supports. Adequate staffing, protected time for assessment, and leadership that encourages flexibility and patient-led programming are not luxuries—they are essential prerequisites. Without these institutional supports, even the most committed RT professionals are constrained by systems that reward standardization over responsiveness.

While PCC discourse emphasizes patient-staff communication, this study revealed that staff-to-staff communication is equally vital. In resource-constrained settings, internal coordination—encompassing a shared understanding of roles, coverage planning, and workload

clarity—directly impacts the continuity of care. When team communication breaks down, the continuity and reliability of therapeutic delivery are compromised, ultimately undermining the principles of PCC.

Finally, despite aspirations to support holistic wellness, this research identified care practices as predominantly symptom-driven and compliance-focused. Engagement strategies, such as point systems, incentivize adherence to institutional norms rather than responsiveness to individual needs. When programs overlook critical factors such as emotional readiness, social context, or personal meaning, they reinforce institutional priorities rather than promoting recovery.

Original Contributions of the Study

This study offers original insights by detailing how institutional practices related to patient privileges, such as mandatory attendance and incentive systems, undermine core PCC attributes, including care tailored to the person and active engagement. By analyzing practices across multiple mental health care sites, I highlight how differences in institutional support related to staffing practices (e.g., leadership roles and time allocation) influence the delivery of PCC. This comparative approach demonstrates that meaningful PCC is achievable, but only when institutional structures align with its principles.

A novel contribution of this study is the finding that physical presence in therapeutic spaces does not equate to meaningful engagement. Although institutional settings often rely on surface-level metrics of participation, this research highlights the need for more meaningful approaches that genuinely centre the patient in their care planning. I also identified that while PCC frameworks typically focus on the staff-patient dynamic, this study expands the

conversation by highlighting how staff-to-staff communication and leadership coordination are essential to upholding PCC values in mental health practice.

By examining how superficial institutional mechanisms (e.g., point systems, mandatory attendance) are used to simulate holistic engagement, I showed that well-meaning structures can distort holistic principles when implemented without person-centred flexibility. This study highlights the challenge that RT professionals go beyond their formal roles to maintain care quality, filling institutional shortfalls with personal effort. This emotional labour, often undertaken without institutional support, represents a significant yet under-recognized burden that contributes to staff burnout.

Directions for Policy and Practice

Creating conditions for meaningful engagement in care requires more than attendance mandates or rigid program structures. Policies and practices can support PCC most effectively by aligning with patient goals, fostering collaboration, and embedding flexibility, empathy, and trust throughout the system.

Program attendance policies may benefit from review to ensure they reflect patient input and clinical assessment, rather than enforcing participation based solely on physical presence. Redefining engagement to emphasize meaningful involvement aligned with patient-identified goals can foster more authentic participation. Incentive systems that recognize progress toward individualized recovery goals, rather than attendance alone, can better align motivation with therapeutic relevance and personal meaning. Care planning and decisions around autonomy (such as off-unit privileges) may be more effective when patients are active collaborators in the process, rather than passive recipients of team decisions. Embedding shared decision-making

into standard practice can enhance trust and transparency, ultimately leading to improved patient outcomes. Programs could also explore more flexible, choice-based models of participation that respect emotional readiness and autonomy. Social engagement may be more sustainable when it reflects individual pacing rather than rigid incentive structures.

Training efforts might emphasize relational approaches over transactional ones, encouraging staff to view engagement as a co-created process grounded in trust, empowerment, and mutual respect. Clear internal communication processes also play a key role in maintaining therapeutic continuity. Consistent staffing coverage and leadership support (as demonstrated by the RT clinical lead at Site 3) can enhance service delivery and protect the therapeutic environment. To uphold these practices, accountability could be embedded through regular reflective supervision, clear role expectations, and performance evaluation frameworks that prioritize relational competencies and team communication.

This study observed wide variation in how the *Observation, Privileges, and Passes Policy* was implemented across sites. This raises important questions about the clarity and flexibility of the policy itself. If policy language allows for broad interpretation, or fails to sufficiently prioritize relational and participatory approaches, it may inadvertently enable practices that conflict with PCC. Revisiting the policy to align more explicitly with PCC principles could support more consistent and equitable implementation.

Finally, institutional policies that centre on a responsive care culture, for both patients and staff, can support resiliency. This includes recognizing the breadth of RT contributions, creating channels for staff feedback and accountability, and offering appropriate wellness

supports. Moving from an expectation of empathy to a structure that enables it is essential to delivering PCC.

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APPENDIX 1: PRIMARY STUDIES TABLE

Table 2 Primary studies about person-centred care in Canadian mental health settings.

Citation	Sample/Setting	Methods	Aim	Findings
Schwind et al. (2014)	14 Nurses and nursing students	Arts-informed narrative inquiry. Four 3-hour group meetings and an individual follow-up phone call.	To explore how nursing students and nurses construct and enact person-centred care in mental health education and practice.	This study reveals how nursing knowledge is constructed, assumptions challenged, and new practices emerge. Nurses and nursing students talked about enabling patient preferences, language used, self-reflecting on person-centred care, and resistance faced by coworkers. Significance of this study is primarily for nursing education and practice.
Coulombe et al. (2016)	149 people from Canada (91.9%) and France community organizations recovering from anxiety, depression, or bipolar disorders.	Quantitative questionnaires. Latent profile analysis.	To identify mental health recovery profiles, describe key characteristics of participants, and examine the associations between profiles.	Latent profile analysis revealed three profiles: Floundering (rarely used self-management, moderate/severe symptoms, & lowest positive mental health), Flourishing (frequent use of self-empowerment, least severe symptoms, & highest positive mental health), and Struggling (active in self-management strategies focuses on symptom reduction and health lifestyles).
Barbic et al. (2018)	228 adults receiving community mental health outpatient services in the Greater Toronto Area.	Quantitative research design (descriptive and correlational analyses).	By using recovery-oriented Patient Reported Outcome (PRO) measures, describe the personal recovery needs of community-dwelling Canadians with mental illness.	The information gathered in this study provides preliminary evidence towards how PRO's can be used to understand the recovery needs of Canadians. The study used the CHIME framework as a theoretical guide to organize data from individual items for trends. The results of this study provide evidence to support ways to gather person-centred recovery data from community-dwelling people with mental illness using PRO's.
Martin et al. (2009)	963 persons were assessed with the RAI-MH and 1505 persons were assessed with the interRAI CMH in various psychiatric facilities and community mental health agencies in Ontario.	Quantitative, descriptive analysis, chi-square analyses.	To evaluate the validity of the Mental Health Assessment Protocols (MHAPs) using staff ratings of appropriateness of the MHAPs for specific individuals.	The study found that the MHAPs are valid measures of current or potential issues with care, in multiple domains. MHAPs assist practitioners in identifying a variety of day-to-day issues of the person in care. The use of these assessment instruments in mental health settings is linked to enhance continuity of care of mental health services.
Thomson et al. (2019)	Six acute psychiatric nurses working in a large urban Canadian prairie city.	Hermeneutic phenomenology, van Manen's method of phenomenology.	To explore psychiatric nurses' experiences in providing nursing interventions to adult clients in acute care settings.	Clients require tailored care plans to their strengths, goals, and needs throughout their recovery. Themes were presented from the findings: developing and delivering PCC plans; determining goals; fostering empathy, support, and hope; listening to one-to-one interactions; providing person-centered teaching; and enhancing coping strategies. Person-centered care involved putting the client first to develop and deliver PCC plans. The

				PCC plans were built on the client's goals and hopes for the future.
Corbiere et al. (2012)	222 stakeholders were used for the analysis based on their experiential, organizational, or clinical knowledge.	Questionnaire with a Likert scale and open-ended questions. For this paper, thematic analysis was used for one open-ended question: *tell us briefly what you do to reduce prejudice and stigma toward people with a diagnosis of mental disorder.*	To provide a more comprehensive perspective on the of potential strategies to fight stigma toward people with mental disorders.	15 categories of strategies to fight stigma were identified. These categories consisted of 6 themes: education, contact, protestation, person centered, working on recovery and social inclusion, and reflexive consciousness. The results from this study highlight the concept of disclosure of mental disorders as a key factor in stigmatization.
Guilcher et al. (2016)	30 adult men with problem gambling experience and housing instability in Toronto, Canada. 83% of the sample presented with a mental disorder.	Grounded Theory, semi-structured interviews. Community-based participatory approach.	To explore men's experiences with health and social services—in particular, those with problem gambling and housing instability.	The overarching theme of this study was the concept of person-centred engagement. This concept includes: empowerment and autonomy; empathy, compassion and sincerity; respectful communication; and tailored and holistic life plans.
Lindsay & Schwind (2015)	Four nurses in three group meetings in person and two independent sessions with online resources.	Arts-informed narrative inquiry.	Through self-reflective practice, explore how participants use the concept of person-centred care in their relationships with patients, other practitioners and the organisation.	The narratives from the participants related to the experiences of practicing person-centred care in the context of a relationship-based care approach. The findings reaffirmed values and practices of the participants in learning more about what it means to provide person-centred care within the context of mental health practice.
Stergiopoulos et al. (2024)	30 adults living with mental illness and 25 adult family members. Conducted in Ontario, Canada.	Qualitative semi-structured interviews, using a persona-scenario exercise.	To explore the views of persons with mental illness and family members on MAiD MI-SUMC implementation and care practices.	Six themes emerged: (1) Raising MAiD MI-SUMC awareness; (2)Sensitive introduction of MAiD MI-SUMC in goals of care discussions; (3) Asking for MAiD MI-SUMC: a person-focused response; (4) A comprehensive circle of MAiD MI-SUMC care; (5) A holistic, person-centered assessment process; and (6) Need for support in the aftermath of the decision.
O'Neill et al. (2024)	Seven Peer Workers at two urban hospitals in Toronto, Canada.	Concurrent mixed methods. Patient interaction survey and semi-structured interviews.	To outline the role of Peer Workers in care of a marginalized populations in the emergency department. To characterize the impact of Peer Workers on patient care. To describe how the role of a Peer Worker impacts the individual, both	Five themes emerged: (1) Establishing empathy and building trust between the patient and their care team through self-disclosure; (2) Facilitating a person-centered approach to patient care through trauma-informed listening and accessible language; (3) Support for patient preferences on harm reduction; (4) Peer Worker role facilitating self-acceptance and self-defined recovery; and (5) Importance of supports and resources to help Peer Workers navigate the emotional intensity of the emergency department.

			personally and professionally.	
Suen (2016)	One older (over 55) Chinese immigrant with depression living in the Ontario, Canada.	Arts-informed narrative inquiry.	To understand the experiences of the participant with depression and the sources of mental health support they use.	This study found the value of using a person-centered approach to providing mental health care to older Chinese immigrants with depression. The study also found the importance of creating a culturally safe environment, as the participant's narrative illustrated complexities of his culture when it comes to a mental disorder such as depression.

APPENDIX 2: OTHER PEER-REVIEWED LITERATURE TABLE

Table 3 Other peer-reviewed literature about person-centred care in Canadian mental health settings

Citation	Article Type	Aim	Conclusion
Stuart (2017)	Commentary paper	A brief discussion on how traditional organizational practices stigmatize people and suggest a move to recovery paradigm, including person-centred care.	The principles of the recovery movement in the mental health system and person-centred care suggest creating a health care environment that ensures that persons and their family members receive the care that meets their needs, delivered in ways that are affirming and recover-oriented rather than disempowering and stigmatizing.
Oades, Crowe, & Nguyen (2009)	Discussion paper	To describe the transformation of an inpatient mental health unit in Ontario, Canada, through the implementation of a coaching framework, known as the Collaborative Recovery Model (CRM).	This paper described how the principles and practices of coaching psychology, positive psychology, and positive leadership could be combined with an emerging movement in mental health service provision. Using these principles, mental health staff are leading change in the organization.
Kolapo (2017)	Discussion paper	Transforming the delivery of mental health services in Canada by utilizing the culturally competent commissioning as a framework. Synonymous with cultural competence is "person-centred care".	Culturally competent commissioning and provision of care is recommended as capable of addressing quality issues and the problematic variation in services available. Recommendations include: a. Achieving cultural competence in mental health services b. Responding to diverse mental health needs in primary and secondary care c. Providing culturally competent compassionate care d. Developing a culturally competent workforce e. Identifying good practice f. Evaluating cultural competence
Josefowitz and Myran (2005)	Descriptive paper	This paper considers the definitions of the three core conditions of person-centred care and examines ways in which CBT interventions can be informed by these conditions.	Within the structure of CBT, therapists can empathically attend to clients' experience and provide a safe, non-judgemental environment where clients can identify and explore their thoughts, affect, and behaviours. This paper examines the three core conditions developed by Carl Rogers and his followers: acceptance and unconditional positive regard; empathy, ability to understand the client's world and communicate this understanding to the client; and genuineness or congruence, being present and real in interactions.
McKay et al. (2021)	Scoping review and framework development.	To report on how person-centred care is provided in coercive mental health care settings and its outcomes.	Providing opportunities to facilitate more person-centred approaches is important, especially in coercive mental health care settings as it may improve mental health care. The conceptual framework, RAISe, is presented to potentially bridge the gap of person-centred care in coercive mental health care settings.
Lewis & Hasking (2021)	Open Forum	To present a person-centered framework to further understand self-injury.	A person-centered framework can empower people who self-injure themselves, to increase dialogue, and lead to more effective service provision. Thus, increasing well-being outcomes.

APPENDIX 3: INTRODUCTION LETTER

4401 University Drive
Lethbridge, Alberta, Canada
T1K 3M4

Phone 403.329.2699
Fax 403.329.2668

http://www.uleth.ca/hlsc

May 31st, 2023

Introduction Letter

Study Title: The Provision of Person-Centred Care in Mental Health Care Settings through Recreation Therapy Professionals

Student Researcher: Devan McNeill, phone – (403)332-4456, email – devan.mcneill@uleth.ca

Devan McNeill is a doctoral (PhD) student at the University of Lethbridge in the Population Studies in Health program. He is doing a study to learn how to create working environments that help recreation therapy professionals provide the best possible care to persons with mental health disorders. To accomplish this, Devan will be speaking to recreation therapy professionals to learn more about what it is like to work at your facility. He will be interviewing the recreation therapy professionals using Zoom. Devan will also complete one site visit to interview the lead recreation therapy professional and collect some common texts (e.g., assessment forms and policies). All texts collected will be blank—containing no client information for confidentiality purposes.

You are being sent this letter because you are identified as a potential recreation therapy professional who would benefit from participating in this study. Devan would like to ask you some questions about your day-to-day work responsibilities, duties, and interactions. The interview will be recorded using Zoom and secured using the data storage and security at the University of Lethbridge. Transcripts of the interviews will be completed and sent to you if requested.

I believe this research can provide a new perspective and deepen our understanding of person-centred care—thus improving services for persons accessing mental health services in Alberta. My proposed research will use institutional ethnography as the method of inquiry to explore the institutions and systems of care in mental health services.

Participation in all aspects of the study is completely voluntary. You will be asked to complete the Informed Consent document before participating in this study. If you decide to participate, you will receive a $30 CDN gift card to a grocery store for your time. However, you may withdraw from the study at any time for any reason. If you withdraw, all information from you will be destroyed, and you will be allowed to keep your gift card.

You can ask questions about this study at any time. If you have any questions or would like to learn more about the study please do not hesitate to contact Devan McNeill at (403)332-4456.

Devan's doctoral thesis committee includes the following:

> Supervisor: Dr. Sienna Caspar, PhD, CTRS, Faculty of Health Sciences
>
> Committee Members: Dr. Lisa Howard, PhD, RN, Faculty of Health Sciences, and Dr. James Sanders, PhD, Faculty of Health Sciences

Thank you for your time and consideration.

Sincerely,

Devan McNeill, PhD Candidate
University of Lethbridge, School of Graduate Studies

APPENDIX 4: RECRUITMENT LETTER

Hello:

I hope this email finds you well.

I would like to invite you to participate in a research study entitled "The Provision of Person-Centred Care in Mental Health Care Settings through Recreation Therapy Professionals." The purpose of this research is to investigate how institutions contribute to empowering or hindering recreation therapy professionals in providing person-centred care to clients. To date, limited research explores this topic from a Canadian perspective.

In order to participate in this research, you must meet the following criteria:

- Working full-time or part-time in mental health care,
- Work as a recreation therapist (including lead, professional practice lead, etc.), recreation therapy assistant, or recreation therapy aide,
- Communicate in English, and
- Willing to participate in this study voluntarily.

This study involves speaking to you (i.e., interviewing you) about your experiences working in mental health care settings. I will be using Zoom to conduct the interviews. A minimum of one 60-90 minute interview, with as many as 2-3 follow-up interviews, may be requested as needed. The expected time for each participant is 2-4 hours (depending on the number of follow-up interviews). The entire study will take place between two to four months. I will work with you to create a time that works best for you to participate in this study.

I will also complete one site visit to interview the lead recreation therapy professional in-person and collect some common texts (e.g., assessments, care plans, evaluations, etc.). All texts collected will be blank—containing no client information for confidentiality purposes.

This study is completely voluntary, and you may choose not to answer any question or withdraw at any time, without consequence. All information will remain confidential, and your name will not be used in any reporting.

This research study has been reviewed for ethical acceptability and approved by the University of Alberta's and the University of Lethbridge's Research Ethics Boards (REB ID Pro00127334).

If you would like to participate in this study or have any questions, please feel free to reach out.

Thank you,

Devan McNeill
devan.mcneill@uleth.ca
403-332-4456

APPENDIX 5: PARTICIPATION CONSENT FORM

Title of Study: The Provision of Person-Centred Care in Mental Health Care Settings through Recreation Therapy Professionals

Principle Investigator: Dr. Sienna Caspar (403-329-2724)

Student Co-Investigator: Devan McNeill (403-332-4456)

Why am I being asked to take part in this research study? You are invited to participate in this research study project. You are being asked to be in this study because you are a recreation therapy professional working in a mental health setting for Alberta Health Services. The purpose of this study is to learn how to create working environments that help recreation therapy professionals provide the best possible care to persons with mental health disorders. To accomplish this, Devan (researcher coordinator) will be speaking to you to learn more about what it is like to work at your facility.

This form contains information about the study. Before you read it, a member of the study team will explain the study to you in detail. You are free to ask questions about anything you do not understand. You will be given a copy of this form for your records.

What is the reason for doing the study? This study aims to investigate how institutions contribute to empowering or hindering recreation therapy professionals in providing person-centred care. Exploring this topic aims to improve mental health services for persons with mental disorders in Alberta. This research study will explore how institutions are supporting and enabling their recreation therapy professional employees to implement person-centred care into their daily care practices. This research focuses on exploring person-centred care within Canadian mental health services, which is a first.

What will I be asked to do? Devan will be using Zoom to conduct the interviews. A minimum of one 60-90 minute interview, with as many as 2-3 follow-up interviews, may be requested as needed. The expected time for each participant is 2-4 hours (depending on the number of follow-up interviews). You are not required to turn on your camera while using Zoom.

Devan will also complete one site visit to interview the lead recreation therapy professional in-person and collect some common texts (e.g., assessments, care plans, evaluations, etc.). All texts collected will be blank—containing no client information for confidentiality purposes.

How long will I be in this study? The study will be between two to four months at your facility. Devan will organize and schedule an interview and possible follow-up interviews based on your schedule. Participation will take a total of about 2-4 hours of your time, and each interview will be 60-90 minutes.

What are the risks or discomforts? There are no anticipated risks or discomforts related to this research. It is not possible to know all of the risks that may happen in a study, but the researchers have taken all reasonable safeguards to minimize any known risks to a study participant. For the site visit, Devan will abide by any COVID-19 requirements (e.g., wearing a mask, sanitizing hands, social distancing, etc.) for each facility.

What are the benefits to me? Some participants may benefit from participating in this study because they will have someone to listen to their perceptions, experiences, and stories about work and life in a mental health care setting. Some participants may reflect on their experiences of providing person-centred care in practice, which could be beneficial to their everyday work experiences. Some participants might feel that they are contributing to research on a topic that is important to them. It is possible that participants will get no benefit from taking part in this study.

Do I have to take part in the study? Being in this study is your choice. If you decide to be in the study, you can change your mind and stop being in the study at any time, and it will in no way affect your employment. Participation in all aspects of the study is completely voluntary. You do not have to answer any questions you don't feel comfortable answering during the interviews.

You can withdraw from the study at any time. This includes before, during, and after the interviews. You can inform Devan of your decision via email or phone, or during a meeting/interview. Devan will then follow up with you to inform you about what will happen to the information collected (if any).

Will I be paid to be in the research? Participants will receive a gift card to a grocery store for participating in the study. All participants who participate are eligible whether they complete the entire study or not. The value of the gift card will be $30.00 CDN. The gift card can be mailed to them or offered as a virtual card emailed to them. If the participant withdraws from the study, they will still receive reimbursement if they wish to still receive it.

Will my information be kept private? During the study, we will be collecting data about you. We will do everything we can to make sure that this data is kept private. No data relating to this study that includes your name will be released outside of the researcher's office or published by the researchers.

Steps will be taken to protect your anonymity and identity. While the interviews will be video and audio recorded, the files will be destroyed once they have been transcribed. The transcribed interviews will NOT contain any mention of your name, and any identifying information from the interview will be removed. Pseudonyms will be used when presenting and disseminating the data. Only Devan and his PhD supervisor (Dr. Sienna Caspar, sworn to confidentiality) will have access to the interviews. All information will be destroyed after five years time.

The results from this study will be presented in writing in academic journals read by recreation therapy professionals and mental health professionals to help them better understand the experiences of person-centred care. The results may also be presented in-person or virtually to groups of recreation therapy professionals or mental health professionals. At no time will your name or any identifying information be revealed. If you wish to receive a copy of the results from this study, you may contact Devan McNeill at devan.mcneill@uleth.ca.

What if I have questions? If you have any questions about the research now or later, please contact Devan McNeill at 403-332-4456 or at devan.mcneill@uleth.ca. If you have any questions regarding your rights as a research participant, you may contact the University of Alberta Research Ethics Office at reoffice@ualberta.ca. This office has no affiliation with the study investigators. The proposed research project has been reviewed for ethical acceptability and

approved by the University of Lethbridge Human Participant Research Committee (REB ID Pro00127334).

How do I indicate my agreement to be in this study?

By signing below, you understand:

- That you have read the above information and have had anything that you do not understand explained to you to your satisfaction
- That you will be taking part in a research study
- That you may freely leave the research study at any time
- That you do not waive your legal rights by being in the study
- That the legal and professional obligations of the investigators and involved institutions are not changed by your taking part in this study.

SIGNATURE OF STUDY PARTICIPANT

____

Name of Participant

______________________________ ____________________

Signature of Participant Date

SIGNATURE OF PERSON OBTAINING CONSENT

______________________________ ____________________

Name of Person Obtaining Consent Contact Number

______________________________ ____________________

Signature Date

SIGNATURE OF THE WITNESS

____

Name of Witness

______________________________ ____________________

Signature of Witness Date

A copy of this consent form has been given to you to keep for your records and reference.

APPENDIX 6: INTERVIEW GUIDE

General comments: “Really” “Tell me about that” “In what way” “How.”
Get concrete examples, not abstract ones.

1. Describe a regular workday, with as much detail as you can. Begin with leaving your house.
2. How do you decide who does what on your unit? Between you and the other staff who works with you?
3. Would you say there is good teamwork here?
    a. Do you feel comfortable asking for help when you need it?
    b. Do you have access to help when you need it?
4. What’s it like to do this work?
5. What does a good day look like?
6. What does a bad day look like?
7. How would you describe the communication in this facility?
8. Tell me about written communication: how do these documents influence your work?
    a. How are they used?
    b. What are they for?
    c. Do they meet your needs?
    d. Did you have input in creating them?
9. Are there any other documents/forms you regularly refer to?
10. When a client is admitted, how do you learn how to provide them care?
    a. Where do you get information that will be useful to you?
11. Is the information you receive in the report useful to you?
    a. In what way?
    b. What would you change, if anything?
12. Please describe how you empower the clients you work with.
    a. What does this look like in practice?
    b. Is there anything that hinders you from empowering clients? If so, what? How?
13. What is your approach to providing autonomy to clients you work with?
    a. How does this work at this facility?
    b. Is there anything that hinders you from providing autonomy? If so, what? How?
14. How do you share your knowledge about the clients with other recreation therapy professionals?
15. How do you share your knowledge about the clients with other staff?
    a. Talk to me about staff meetings/rounds.