

**TRACING THE TENSIONS, CONSTRUCTIONS, AND SOCIAL RELATIONS
SURROUNDING COMMUNITY INTEGRATION PRACTICE FOR
INDIVIDUALS WITH SEVERE MENTAL ILLNESS:
A FOCUS ON ASSERTIVE COMMUNITY TREATMENT.**

By

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ABSTRACT

Assertive Community Treatment (ACT) is considered the primary service-delivery vehicle for integrating individuals with severe mental illness into the community. Research on the model suggests that it has been helpful in aiding service users to achieve basic levels of integration including stabilized housing and maintaining financial and social security (Bond, Drake, Mueser & Latimer, 2001; Mueser, Bond, & Drake, 2001). However, critics of the model emphasize its limited success in enabling higher-order aspects of integration such as mainstream employment, recreation and socialization (Estroff, 1981; Gomory, 1998, 2001, 2002a, 2002b). These are fundamental criticisms given the significant investment in the model by policy makers. The rationale for the failure to promote higher-order integration typically rests on two central assumptions: a) service users are incapable of realizing full integration; and b) practitioners lack the training, skills, and philosophical base required to foster full integration. By focusing on the personal and professional characteristics of practitioners and service users, these views serve to obscure organizing structures operating at organizational, systemic, and social levels that encourage common ways of thinking about and carrying out community integration practice.

The concern of this thesis is to explicate the impact of these organizing structures on the everyday practices engaged in by individual practitioners. In particular this thesis focuses on how practice becomes shaped by external structures that overrule both personal and professional values and intentions. The current study used the method of institutional ethnography to examine the impact of organizing structures of ACT in shaping how community integration practice is conceptualized, carried out, and

accounted for on an everyday basis. The study findings are threefold. First, they suggest that organizing structures foster goals associated with protection as opposed to empowerment. Second, they reveal that organizing structures advance an individual-level focus over a social-level focus, prohibiting the community capacity building and environmental change necessary for fostering social autonomy and empowerment. Third, they show that organizing structures encourage practices discordant with integration, resulting in contradictory and therefore inconsistent attempts to facilitate higher-order aspects of integration. The power of these organizing structures is such that the personal and professional intentions of providers to facilitate broad community integration are consistently overruled within the context of everyday practice. The results of this study highlight the powerful role played by organizing structures in shaping community integration practice and provide an important theoretical model for planning, implementing, and evaluating models of service delivery for individuals with severe mental illness.

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Dad, your courage and strength inspire.

"In every conceivable manner, the family is link to our past, bridge to our future."

Alex Haley

“At the beginning of this century, Freud laid the foundations, within psychiatry, of a human study of man. To Freud and his colleagues this was not a study of man as object, whose worth is gauged by his social usefulness, and whose conduct is manipulated by his fellow man for the alleged good of society. On the contrary, it was a study of man as subject, a sentient being whose self-concept was never to be subordinated to his social image, and whose conduct was to be governed, not by benevolent therapists but by his own ego” Szaz, 1991, p.78

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CHAPTER 1: INTRODUCTION

1.1 The Problematic: Shifting Community Integration Practice

My interest in conducting this study evolved from a personal experience I encountered when first working as a case manager¹ on an Assertive Community Treatment Team (ACT)². The purpose of the ACT model is to provide integrated treatment, rehabilitation and support services³ to individuals with severe mental illness⁴ for the purpose of integrating them into the broader community (Stein & Santos, 1998). One day, a service user to whom I was providing support was spotted riding a bicycle erratically along a busy downtown street. The spotting was relayed to the team by one of the team members during a team meeting (team meetings generally consisted of case managers reviewing clinical concerns with the team psychiatrist). The incident was discussed amongst staff and was unanimously determined to be unsafe behaviour that could possibly lead to serious harm or injury. Ideas regarding whether and how the team should attend to the matter, however, were far from unanimous.

As the individual's case manager, my suggestion was to teach the person the rules of bicycle safety. My rationale was that providing him with the relevant knowledge and skills would increase his capacity to maintain this form of travel in a safe manner. My clinical opinion was influenced largely by the principles of Psychosocial Rehabilitation (PSR). PSR is a philosophical and practice approach to service delivery that espouses

¹ This was a maternity leave position that I filled for a period of six months.

² This service was not designated as an ACT team at the time of this experience (1994) but had received ACT designation by the time of this study (2003).

³ Support services are defined as practical help and support by Stein and Santos (1998).

⁴ The term severe mental illness has been used within both diagnostic and Ontario Ministry of Health and Long-Term Care documents to refer to individuals who have been diagnosed with schizophrenia or major affective disorder and who have a chronic history of receiving inpatient services.

“assuring that the person with a psychiatric disability can perform those physical, emotional, social, and intellectual skills needed to live, learn, and work in the community with the least amount of support necessary from agents of the helping professions” (Anthony, 1979 cited in Liberman, 1992, p. 1). The team psychiatrist proposed an alternate suggestion, to take away the bicycle. Her argument appeared to be based on a concern that teaching bicycle skills would not guarantee the safety of the individual. Further, she argued that the individual did not possess the ability to learn or consistently apply new skills due to symptoms associated with schizophrenia. The following day the bicycle was placed in a locked wardroom by the program director. When I asked for the key to retrieve the bicycle, I was told that the key had been misplaced. Eventually, I believed I had no choice but to surrender my stance.

I found this experience both frustrating and confusing. I had believed my position was in keeping with PSR principles, which I had come to consider primary to the provision of case management services⁵ within the ACT model. At the time, the experience left me wondering whether I was right to place a priority on PSR principles in this situation. I wondered if I had misinterpreted the everyday enactment of these principles. Were the principles of PSR relevant only if there was no possibility for harm? Many years later, looking back on the incident with the knowledge and experience generated from a decade of work and academic endeavors, I came to develop a new set of questions. For instance, I wondered about the extent to which the decision-making process had been impacted by the hierarchical integration of multiple disciplines and

viewpoints. I wondered as well about the impact of decision-making processes on the ability of practitioners to enact everyday activities consistent with philosophical ideologies meant to shift practice in new directions.

While reading the literature in search of a topic for my PhD thesis, I came across the writings of Dorothy Smith (1987, 1990, 1996, 2006). Her application of the method of institutional ethnography helped me to understand the conflict I had experienced as a predictable and orchestrated event. In her work, Smith describes the personal questioning in which I engaged (e.g., wondering how my actions and inactions were reflective of a PSR philosophy) as an example of bifurcated consciousness. Smith explains bifurcated consciousness as a split in one's consciousness. Often individuals may possess a subtle awareness that daily activities are in conflict with personal and professional intentions. This awareness, however, is often subsumed by a more pronounced awareness of the correct way to carry out everyday activities (thus, my instinct to question myself rather than the system when the bicycle was locked in a ward room). Smith goes on to suggest that the materials that comprise organizing structures⁶, such as job descriptions, policy and procedure manuals, pay distribution, designated roles and responsibilities, professional registration requirements, and service guidelines, organize everyday activities in ways that are often more powerful than the personal and professional intentions of individual practitioners. Consequently, the pressure to conform to external

⁵ I believed that a PSR approach was integral to my role largely because a demonstration of knowledge of PSR principles and their application to case management activities constituted a significant portion of the job interview.

⁶ Organizing structures are comprised of objectified structures with goals, activities and obligations and include the various administrative materials used to govern the activities of individuals socially (e.g., legislation), systemically (e.g., mental health policy), and organizationally (e.g., program guidelines). These structures are shaped by dominant ideological and knowledge influences and in turn shape the everyday activities of individuals.

expectations can render certain personal and professional values, ideas and desires as abnormal, valueless and even illegitimate. Ultimately, the concepts raised by Smith helped me to think about my experience as a conflict between the values and assumptions that I had been exposed to through my training and personal beliefs and the way my everyday work was shaped by broader organizing structures.

1.2 Current Study

The current study examines how the community integration practice of ACT practitioners becomes shaped by organizing structures that exist at organizational, systemic and social levels. Institutional ethnography (the method used in the current study) locates the research problematic in the tensions experienced in everyday practice. The purpose of this study is informed by the problematic outlined above. Attempts are made to reveal how organizing structures come to shape the everyday practice of ACT practitioners in ways that appear to be at odds with the current philosophies associated with community integration, including PSR and other more recent philosophical advances.

The ACT model is the most prominent vehicle developed for the purpose of directly integrating individuals with severe mental illness into the community. Stein and Santos (1998) state that, “no psychosocial intervention has influenced current community mental health care more than ACT” (p.3). Similarly, in Canada, the Ontario Ministry of Health and Long-Term Care has endorsed ACT as the service delivery model of choice for individuals with severe mental illness (Health Systems Research Unit, Clarke Institute of Psychiatry, 1998). In the late 1990s, the Ontario Ministry of Health and Long-Term

Care invested significant funding towards the establishment of 65 ACT teams throughout the province of Ontario⁷.

It can be argued that ACT is currently considered to be the primary vehicle for supporting the community integration of individuals with severe mental illness both provincially and nationally. ACT is at the forefront of the Mental Health Reform movement for this population and research on its effectiveness has been widely disseminated. Reviews of randomized controlled trials, however, indicate that the model is effective in reducing time spent in hospital and improving housing stability and symptomatology, but demonstrate insignificant effect in areas of social, educational and vocational functioning (Mueser, Bond & Drake, 2001; Mueser, Bond, Drake & Resnick, 1998). Thus, a basic level of integration (health and housing stability) is promoted but higher-order aspects of integration that focus on relationship building as well as social, political, and economic influence are neglected. The discrepancy between basic-level and higher-order integration is worrying given current understandings of the impact of integration on the physical and social wellbeing of marginalized groups (Berman & Phillips, 2000). Likewise, given the significant investment in the ACT model, a failure to facilitate broad integration could hold important implications for future funding and support. The lack of findings in areas of higher-order integration also has implications for service practitioners and service users who are drawn to the ACT model for its emphasis on community integration.

⁷ This number is approximate and is based on personal correspondence with key informants in the field. It is difficult to attain a specific number given that there has been a mixture of fully and partially funded teams since 1998.

Two explanations have typically been offered for the limited success of the model in facilitating broad community integration. The most common explanation rests on an assumption that individuals with severe mental illness are incapable of realizing high levels of integration (Carling, 1995). This explanation is problematic in that the potential for community integration is linked solely to the personal characteristics of service users and fails to acknowledge social and systemic factors. The alternate view holds that ACT practitioners must receive more training in community integration philosophy and practice in order to better facilitate integration for service users (Bond, Salyers, Rollins, Rapp & Zippel, 2004). This view is also problematic in that it places the onus for community integration success upon service practitioners and again neglects to recognize the impact of organizing structures in shaping the everyday integration activities of practitioners. By focusing on the personal and professional characteristics of practitioners and service users, these views serve to obscure organizing structures that are operating at organizational, systemic, and social levels, which encourage common ways of thinking about and carrying out community integration practice.

Organizational theorists, on the other hand, have contributed extensively to an understanding of individual behaviour as a product of organizing structures. According to organizational theory, organizing structures play an integral part in shaping the day-to-day activities of both service users and service practitioners (Meyer & Rowan, 1997; Scott, 2000). Organizational structures comprise the ideas, opinions, and morals that formulate “social facts” as well as the material conditions that regulate daily activity to correspond with social values. The current study argues that individual level explanations alone do not sufficiently account for the relatively basic integration that has

been achieved thus far for individuals with severe mental illness and that structural explanations must also be at play. Without uncovering these structural-level explanations the knowledge base surrounding community integration for this population will not be adequate and may lead to ill informed strategies for improving integration. The objective of the current study, then, is to provide greater understanding of the impact of organizing structures in shaping how the integration practice engaged in by practitioners is conceptualized, carried out, and accounted for on an everyday basis. By employing the method of institutional ethnography, this study focuses on the everyday work practices of practitioners. The study is particularly concerned with tracing those issues and concerns raised in the problematic at the start of this dissertation to overarching organizing structures. Although the method of institutional ethnography could certainly be used to explicate how organizing structures affect the ways in which service users conceptualize, enact and account for their own integration, this is not the focus of this study. The implications of this study lie in the potential for removing structural barriers to the integration work carried out both by ACT practitioners and community mental health practitioners generally. This form of inquiry offers tremendous possibility for identifying ways of attaining higher order integration for individuals with severe mental illness. The overall goal of the study is both to create an awareness amongst ACT practitioners of the powerful influence of organizing structures over day-to-day practice decisions, and to inform policy and practice efforts aimed at enhancing the community integration practice of ACT practitioners.

1.3 Organization of Thesis

Chapter 2 of this thesis explores the values and assumptions that influence the investigator's orientation to the study of community integration. Chapter 3 provides an

overview of the background literature pertinent to the study. Studies are reviewed that contribute an understanding of community integration theory, approaches to service delivery in community mental health, the ACT model, and organizational analysis. Chapter 4 presents the methodology of institutional ethnography and its application to the current study. Chapters 5 through 8 comprise the analysis portion of the thesis. Each chapter represents a stage in the iterative analysis process. Each begins with a statement of purpose that includes an overview of the techniques employed in conducting the analysis specific to that section. Because the explicit intention of an institutional ethnography is to begin with a problematic in everyday experience, the first stage (Chapter 5) is an analysis of the tensions that occur when the intentions of practitioners are systematically overruled by organizing structures. The second stage (Chapter 6) analyzes the organizational structures and related ideological assumptions reflected in key texts, and the potential implications for community integration practice. An examination of how these organizational structures shape the social relations of practitioners with service users, other practitioners, and members of the community forms the basis of the third stage of analysis (Chapter 7). Finally, the fourth stage (Chapter 8) explores ways in which practitioners attempt to overcome the influence of powerful organizing structures. Chapter 9 provides a final synthesis and model of the data, identifying broad organizational structures that shape community integration practice. Chapter 10 offers a discussion of the study findings in relation to other schools of thought and explores the implications for new directions in community integration practice.

CHAPTER 2: VALUES AND ASSUMPTIONS

2.1 Chapter Overview

The ontological (what is the nature of reality) and epistemological (how do we come to know the world) stance of the investigator necessarily influences the paradigmatic framework to which the investigator is drawn and in turn, impacts the nature of data collection and analysis (Higgs, 2001). Consequently, much has been written regarding the importance of explicating the personal values and assumptions of the investigator (Schram, 2003; Denzin & Lincoln, 2005). To this end, the current chapter offers an in-depth exploration of the personal experiences of the investigator that have influenced the ontological and epistemological perspectives of this work.

2.2 Personal Experience

Long after my experience as an ACT case manager, I had the opportunity to work as a research coordinator at Queen's University. Part of my role was to work with individuals with mental illness who had been hired as research assistants for a project. These individuals were responsible for administering a battery of self-report questionnaires to examine the characteristics of others who received ACT services. The position constituted a "regular job"⁸ for 12 individuals with mental illness and 6 graduate students over a three-year period. Within my role as research coordinator, I was given

⁸ Research Assistants were considered to be "casual employees" of Queen's University. Training and supervision were provided in the same manner as for any traditionally trained research assistant (i.e., university graduate student). See Eastabrook, Krupa and Horgan (2003) for a more detailed description.

the task of creating a flexible and supportive employment atmosphere for the research assistants.

My perspective on the importance of social and work roles for individuals with mental illness was greatly influenced by this experience. Through observations, experiences and dialogue with my colleagues, I came to see the impact of responsible social and work roles on self-esteem, trust and health. It is important to note that several of my colleagues held diagnoses that would, in medical terminology, fall under the category of severe mental illness. One of my colleagues, in fact, was a current recipient of ACT services.

My role as a research coordinator challenged me to find ways around barriers that often prevent individuals with mental illness from accessing valued resources such as regular employment. One employment barrier that we needed to overcome was how to pay the research assistants a fair wage and not jeopardize the security of their disability pension. Some research assistants withdrew from the disability supplement during the time of employment in the hopes of re-applying once the job ended. Others chose to receive the Ontario Disability Support Program (ODSP) benefits and be paid only the maximum allowable top-up⁹. This was a choice left up to the individuals as they differed in their circumstances and preferences. Some research assistants took longer than others to complete the interviews and associated paperwork. To minimize the pressure on research assistants to conduct interviews within a particular time frame, a set price was established per interview. Interviewers were also guaranteed that their jobs would be held if they had to leave for an indefinite period of time due to illness. To accommodate

illness related leave, twice the number of research assistants were hired and trained to ensure a seamless continuation of project activities. Unlike offering women maternity leave, these accommodations are not traditionally offered in the workplace, but were just as possible to arrange.

The story of one individual stands out in particular. During his initial job interview, he did not appear to be attending to the material that was presented, and his answers were not always consistent with the questions posed. Due to concerns that my supervisors and I had regarding his ability to attend to the training material, we initially did not offer him a position. A few months later however, we decided to undergo a second round of hiring and the individual re-applied. During the interview he still did not appear to be attending to the material. This time, though, we hired him. Our decision was based largely upon his determined pursuit of the position. I did the training session with him, still feeling somewhat worried about his ability to independently carry out activities associated with the job¹⁰. To begin, I allocated him only one interview. He returned two days later having completed the interview successfully and was extremely excited about his new job. I was surprised and pleased, but still somewhat hesitant. Cautiously, I continued to provide him with more interviews. As time went by he appeared to become more focused on conversations, he demonstrated greater affect and seemed happier. This man turned out to be one of our best interviewers. He conducted the most interviews of any of the research assistants and often spoke about what the

⁹ Individuals receiving ODSP are allowed a maximum top up of \$160.00 per month, after which funds are deducted commensurate with monthly earnings.

¹⁰ Research assistants were to contact and set up an appointment with research participants on their own. They were responsible for obtaining informed consent and conducting the interview (2 separate sessions) in

position meant to him. At one point he told me that until he acquired the position he had not had a phone. He hadn't needed one, he explained, until he became employed and knew that someone would actually be calling him. Around the same time as he acquired a phone he also became engaged in a romantic relationship and began doing odd jobs for his neighbours. Throughout this time, this individual's medication regimen remained constant¹¹. However, his entire manner changed. According to him the reason behind the change was the acquisition of responsible, normal, social and work roles within society; he was a Queen's employee, a research assistant, a romantic partner and a handyman.

During the course of his 3- year tenure with our project, this individual did become ill and was voluntarily admitted to a psychiatric hospital for a period of 3 months. I struggled with the potential role that I, and the project, had played in this occurrence. What role had the position and related expectations played in his return to hospital? The idea that high levels of stress can bring about a recurrence of psychiatric symptoms is a strongly held belief amongst mental health workers in the field. Members of the ACT team, from which this individual received services, were quick to make a connection between his newly acquired social and work roles and his return to hospital. Again, I began to question my own previously held beliefs regarding the connection between participation in meaningful social roles and wellness. Had the level of responsibility and related stressors led directly to his re-hospitalization? Would he have remained out of hospital had he not become involved in these various opportunities, or

a place of the participant's choosing. They were also responsible for paying participants an honourarium of \$10.00 and providing a receipt upon completion of the interview.

was he better off for having had the opportunities to engage in meaningful life roles during the time in which he was well?

2.3 Relating Personal Experience to Community Integration Theory

One of the most profound aspects of this individual's journey was his transformation from someone who appeared extremely disoriented and uncertain of himself, to an aware, outgoing, and motivated individual. I am convinced that the factor most integral to this transition was the act of participation in normalized social and work roles that carried with them expectations of responsibility. To this day he has remained integrated in society through his participation in a normal romantic relationship and mainstream employment¹².

My personal reflections on this experience have led me to believe that illness and wellness are entwined in a complex dance within each of us, that participation in life often involves stress, that stress can exacerbate illness, and that living with no stress is not necessarily a path to wellness. My experiences working as a colleague with individuals with mental illness have shaped the values and assumptions I possess regarding the issue of community integration. I believe that integration is fostered not only by having opportunities to live and function outside of a psychiatric hospital, but also by the opportunity to truly integrate with other members of society. It is integral as well that the roles which individuals with mental illness play within mainstream society

¹¹ That is, he did not start on any new psychotropic medications, which can often lead to dramatic changes in functioning.

¹² Four years after the completion of the Queen's project, I came across this individual at a local store. He was still in a romantic relationship with the same partner and was working in a permanent mainstream employment position.

foster independence, responsibility and equality. Ultimately, I believe that opportunities for community integration must not be denied to particular groups of individuals on the basis that these opportunities may be stressful or because there are times in which they may be unable to participate due to illness.

CHAPTER 3: LITERATURE REVIEW

3.1 Chapter Overview

This chapter provides an overview of the background literature pertinent to the current study. Studies are reviewed that contribute to an understanding of community integration theory, approaches to service delivery in community mental health, the ACT model, and organizational theory. The current study is ultimately concerned with examining how ideology (broad social assumptions) becomes embedded into the organizing structures of our institutions. The objective is to trace the material conditions which organize and legitimize daily activity so that common practices (of individuals and collectives) occur across sites independent of the values and assumptions held by individual actors. In particular, this study focuses on the influence of ideology and structures on community integration practices of ACT practitioners.

3.2 Community Integration Theory

The concept of community integration for individuals with disabilities, including those with mental illness, is integrally linked with the human rights movement. The human rights movement advocates for the rights of minority groups to fully participate in the activities, processes, and rights conferred upon members of mainstream society (Ignatieff, 2000). Human rights advocates specifically define community integration as the right to equal physical, social and political participation (Ignatieff, 2000). The movement makes an important distinction between rights provided by the state and basic human rights. From a human rights perspective all individuals possess basic rights such as the right to dignity, equality, and respect. They argue that governments (through the

establishment of legislation) often recognize and protect the basic human rights of particular groups but not those of others. Minority groups can be excluded from certain state rights on the basis of perceived physical, social or political differences (i.e., individuals with physical and mental disabilities, offenders, members of cultural minorities) (Ignatieff, 2000). Consequently, these groups become marginalized from mainstream society, further widening the physical, social and political divide between minority and mainstream groups. The rights movement stresses the belief that mainstream society is responsible for developing legislative and social policies that distribute rights across all groups to encourage equal participation (Ignatieff, 2000).

Within the mental health literature, there has recently been an emphasis placed on the need to re-establish the rules that dictate how, when, and for what purpose individuals with mental illness participate in mainstream society. Both practitioners and the system as a whole are encouraged to be more consistent with a human rights-based conceptualization of community integration. For example, Carter and Markham (2001) assert that:

Addressing disability from the civil rights and social model perspectives is consistent with the public health approach of achieving improved health through organized efforts of society. Many [mentally] disabled people are systematically excluded from aspects of life known to promote good health, such as education, employment, leisure and exercise. But the disabling effects of society are not usually included in public debates (p. 179).

Likewise, Beck et al (1997, p. 3) define integration as, “the extent to which citizens are able to participate in the social and economic life of their communities under conditions which enhance their well-being and individual potential.” Integration is also seen as a more complex and multi-faceted phenomena than it was in the past. McMillan & Chavis (1986), for example, stress the importance of the relationship that exists between the

individual and society. The authors suggest that elements such as membership, influence, integration, fulfillment of needs and shared emotional connection form important measures of perceived personal integration.

The concept of integration encompasses the sub-concepts of inclusion and exclusion. Berman and Phillips (2000) argue that what is present in a society which serves to limit inclusion axiomatically promotes exclusion. The authors further contend that social capital, defined as the collective economic and social strength of a community, is reliant upon the inclusion of all groups comprising a society. Within this context, the opportunities for inclusion extended to individuals with mental illness and other marginalized groups become an issue of the overall health of a population. Berman and Phillips (2000) offer a continuum of social quality containing four key elements: social-economic security, social inclusion, social cohesion, and empowerment. These elements of integration are interactive and include interdependent determinants of citizen well-being, which serve as indicators of social quality. Achievement of high social quality is determined by the extent to which members of society are able to participate in and contribute to the overall production of a society. Social economic security, the first level of the model proposed by Berman and Phillips (2000), refers to protection against poverty, unemployment, and ill health. Social inclusion, a higher-order level of community integration, refers to access to social goods, education, and economic productivity. A third layer of integration, social cohesion, refers to shared rights and responsibilities between those with and without mental illness; and finally, empowerment refers to social, cultural, political, and economic influences. The model can be conceptualized as possessing two levels of integration: primary (or basic) integration and

higher-order integration. Social economic security and social inclusion refer primarily to physical integration and rely largely upon access to valued resources such as shelter, food, and productivity. This association links these particular layers of integration to a primary or basic level of integration. Social cohesion and empowerment, on the other hand, rely on the interconnection between marginalized and mainstream groups and hence require the mutual convergence of all members of society. The reliance on mutual interaction with other members of society links social cohesion and empowerment with higher-order levels of integration. No doubt a society must provide a strong foundation for primary or basic-level integration before higher-order integration can be achieved. However, higher-order integration does not naturally spring forth from a foundation of basic-level integration. Concerted effort must be placed on developing opportunities for interconnection between marginalized and mainstream groups.

3.3 Approaches to Service Delivery in Community Mental Health

Over the past half-century, four key approaches have guided mental health services and supports. These approaches can be defined as the institutional-medical approach, guided by a biomedical ideology¹³; the community treatment rehabilitation approach, guided by a psychosocial rehabilitation (PSR) ideology; the recovery approach, guided by a recovery ideology; and the empowerment-community integration approach, guided by a community development ideology.

The institutional-medical approach was the dominant service delivery direction within the mental health field up until the commencement of de-institutionalization

¹³ Ideology refers to the values and assumptions that underlie a particular service delivery approach.

(Carling, 1995; Nelson, Lord, Ochocka, 2001). The approach was based on an assumption that individuals were in need of symptom abatement, which in turn indicated a need for treatment-oriented services. Mental health programs guided by this approach were usually located within institutional environments and were organized in accordance with the goal of decreasing psychiatric symptoms. The approach promoted the assumption that mental health staff possessed expert knowledge and that individuals with severe mental illness were patients in need of their expertise. In terms of community integration, it was assumed that individuals with severe mental illness lacked the cognitive and functional skills necessary to participate in their own care (individual level), contribute to the organizational processes of the institution (systemic level) or mainstream society (social level) (Carling, 1995; Nelson et al., 2001). The institutional-medical approach placed a primary emphasis on psychiatric stability and social security. Symptom stability was seen as important for the protection of individuals with mental illness as well as that of members of society.

The impetus for the shift away from the institutional-medical approach began in the United States in the 1950s and emerged from a number of factors, including advances in psychotropic medication, increased costs associated with institutional care, and the promotion of a social consciousness based on the values associated with civil rights and freedoms (Mechanic, 1996). Literature began to emerge that re-emphasized the role of meaningful activity in promoting the overall health of individuals with mental illness (Rebeiro, 1998; Suto & Frank, 1994). At the same time, the civil rights movement was vocal in criticizing the role of psychiatric institutions in segregating individuals with mental illness from society (Carling, 1995; Nelson et al., 2001). New generations of

service practitioners began to argue that the view of individuals with mental illness as patients perpetuated a hierarchical relationship between those who received and those who provided mental health services, creating further dependence on the mental health system and decreasing interactions with society. This growing opposition to the institutional-medical approach encouraged the emergence of new approaches, which emphasized participation in meaningful and personally satisfying activities outside of psychiatric institutions.

In response to this philosophical shift, the community-treatment rehabilitation approach emerged in the late 1970s and early 1980s. This approach focused on the provision of additional non-medical services, which aimed to enhance a broad range of psychosocial determinants of health. Cnann, Blankertz, Messinger, and Gardner (1988) proposed 15 essential principles associated with PSR ideology and by extension the community-treatment rehabilitation approach: the utilization of full human capacity, skill building, promoting self-determination; creating normalized and intimate environments; staff commitment; early intervention; utilizing an environmental approach; emphasizing participation and work-centered processes; placing an emphasis on a social model of care; emphasizing client strengths; and focusing on present needs. Services guided by the community-treatment rehabilitation approach focused on aiding individuals with mental illness to acquire the social roles of their choice by facilitating community participation (e.g., community-based living) and attention to environmental context (e.g., social networks) at individual, system and social levels. This approach also placed an emphasis on the value of de-professionalizing the therapeutic relationship and employed the term “client” to refer to service recipients.

Although the community-treatment rehabilitation approach placed a greater focus on integration than the institutional-medical approach, it was criticized for continuing to incorporate elements of the institutional-medical approach (Carling, 1995; Nelson et al., 2001). Despite efforts to physically integrate individuals with mental illness into the community and encourage social participation, choice, and autonomy, the idea that the incapacity of those with mental illness prevented full community integration remained consistent with the institutional-medical approach. It was also argued that the specialized, in-house programs provided to facilitate social functioning (e.g., mental health program-based employment, recreation and socialization groups) continued to segregate and exclude individuals with psychiatric disabilities from the broader community setting, creating a type of parallel community structure. In terms of community integration, the community-treatment rehabilitation approach emphasized the importance of aspiring to occupy mainstream roles within society but in many ways failed to provide service recipients with the opportunities to pursue these goals.

The recovery approach marks the most recent ideological shift in community mental health practice (Anthony, 2000; Jacobson, 2004; Jacobson & Greenly, 2001). Recovery ideology arose primarily out of the writing of individuals who had been recipients of services from the mental health system (Anthony, 2000). The advancement of the recovery framework occurred in conjunction with a call from rehabilitation practitioners to re-visit the core practices and principles of the field. As a result, many practitioners found a closer link between the concepts of recovery and the original conceptualization of rehabilitation, which recognized health as a product of socially meaningful roles and responsibilities. Recovery has been defined as a “deeply personal,

unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. ...Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability" (Anthony, 2000, p. 159) and highlights the concept of personal responsibility within the context of an informed society. Jacobson and Greenly (2001) present a conceptual model of recovery, which consists of both internal conditions (hope, healing, empowerment, connection) and external conditions (human rights, positive culture of healing, recovery-oriented services). To facilitate a positive culture of healing and human rights, recovery-oriented services support individual service users in goal refinement, reasonable risk taking, and shared decision making (Anthony, 2000; Jacobson, 2004; Noordsy, Torrey, Mead, Brunette, Potenza & Copeland, 2000; Noordsy, Torrey, Mueser, Mead, O'Keefe & Fox, 2002). Traditional mental health practices, such as the institutional-medical approach and the community-treatment rehabilitation approach, have traditionally focused on aiding individuals with mental illness to overcome biological and functional limitations in order to better facilitate community integration. That individuals with mental illness must first demonstrate behaviours consistent with members of mainstream society before attempting to re-integrate into society is a primary assumption underlying both of these service delivery approaches. Recovery philosophy, on the other hand, poses a new frame of reference for service delivery practice: the underlying assumption is that individuals with mental illness should guide their own integration according to their personal goals and strengths, regardless of biological and functional states.

The recovery approach, though, does not focus on social determinants of integration including economic, political, and social factors. Despite its focus on

individual rights, self-determination, and personal choice, the recovery approach does not embrace the social model perspective critical to the concept of strengthening social capital.

An empowerment-community integration approach began to emerge in the 1990s and was based on a social model perspective, which emphasizes the participation and integration of individuals with mental illness in political, economic and social arenas (Carling, 1995; Nelson et al., 2000). Similar to recovery, this approach developed out of the writings and advocacy of consumers/survivors. The psychiatric survivor movement, led by such prominent consumers/survivors as Judi Chamberlin (1978, 1990), Pat Capponi (1992, 1997), and Patricia Deegan (1988, 1991, 1996, 1999), demanded recognition of the detrimental effects of power imbalances that occur as a result of the individual model of disability employed by professional mental health services. The movement rejected the assumption that individuals with mental illness must acquire normalized levels of functioning through medication or rehabilitation before they could be eligible for re-integration into the community. Most significantly, the empowerment-community integration approach places responsibility on society to provide the opportunities, resources, and adaptations to enable individuals with mental illness to participate in mainstream society (Trainor, Pomeroy & Pape, 1993; Trainor & Church, 1984). Likewise, the approach places responsibility on individuals with mental illness to access the resources they require to meet these needs (provided they are made available). In this context mental health becomes conceptualized as a social system promoting dual responsibility and rights between those with and without mental illness, as opposed to

simply being conceptualized as a system of service-delivery (Nelson et al., 2000). The following quote from Carling (1995) clarifies this point:

The empowerment-community integration paradigm assumes that mental health problems do not lie solely within the individual, but also within the mental health system, the community, and in social policy, thus requiring systemic as well as individual change (p. 29).

Consequently, the empowerment-community integration approach does not intervene at the level of the individual service user, but rather at the level of the community. The approach advocates for service practitioner to focus on the capacity of community members and organizations to create viable opportunities for service users to participate in mainstream economic, political, and social arenas.

3.4 Community Integration Practice: Ideology Versus Application

The different approaches to mental health practice reflect shifts in the values, assumptions, and focus used to determine whether, and to what degree, individuals with mental illness become a part of the fabric of mainstream society. The ideological shift, which has taken place over the past several decades, has not been entirely linear. Although the recovery approach is a key concept promoted within Ontario Ministry of Health and Long-Term Care documents (1999; 2000) and is featured prominently in mission and vision statements of programs throughout the field, practices consistent with both the institutional-medical approach and the community-treatment rehabilitation approach proliferate throughout the field (Nelson et al., 2001). Likewise, examples of the empowerment-community integration approach can be found primarily in organizations that operate outside of the traditional mental health system such as peer support programs and consumer led initiatives (Nelson et al., 2001). Therefore, though the field marches forward ideologically,

practice has remained fragmented: old approaches are held onto in some instances. It is the intent of this thesis to demonstrate the impact of organizing structures on the sustainability of certain approaches over others.

Traces of the institutional-medical approach, the community-treatment rehabilitation approach and more recently the recovery approach can be found in the delivery of ACT services. The institutional-medical approach is reflected in the activities and processes, and focus related to medication delivery and symptom assessment. Traces of the community-treatment rehabilitation approach, on the other hand, can be seen in the activities, processes and focus attributed to vocational, recreational and social activities. The recovery approach, on the other hand, is most evident in the recent move to include peer support workers as part of the multidisciplinary team. The empowerment community-integration approach, however, does not appear to be a guiding framework for any aspect of ACT service delivery. There is no evidence of an approach that encourages reciprocal relationships or community-level interventions. A few interesting questions arise from this: why, if the community mental health field has moved forward philosophically from the institutional-medical approach and the community-treatment approach to a recovery and empowerment-community integration approach, do elements of former approaches still appear to guide day-to-day service delivery? Certainly, the integration of contrasting approaches to service delivery alone with the exclusion of an approach that focuses on reciprocal relationships and community-level interventions has implications for how community integration practice is conceptualized, carried out and accounted for on an everyday basis.

Clearly, ACT practitioners experience the effects of such a fractured approach to care while carrying out everyday practice. A qualitative study conducted by Krupa et al. (2004)

examined the delivery of ACT services by practitioners of four ACT teams in southeastern Ontario. The study identified 8 areas of challenge that arose for practitioners when attempting to carry out features of the model as determined by the Index of Fidelity of Assertive Community Treatment (IFACT, McGrew et al., 1995). The IFACT was used as a semi-structured interview guide “to engage staff in discussions of their experiences in delivering ACT services.” Of primary importance to this study were the challenges associated with integrating treatment with rehabilitation and recovery and ambiguity surrounding certain ACT standards. Participants of the study felt that the composition of the ACT teams was “weighted towards clinical services,” making it difficult to staff the programs with sufficient rehabilitation personnel. Although rehabilitation functions were largely embedded in the daily work of all staff, participants reported that day-to-day activities consisted primarily of treatment, assistance with daily living tasks and supportive counseling. Ambiguity related to the extent to which the team psychiatrist should participate in community visits, or the incidents of service users attending scheduled visits at the central ACT office, and the division of time between generic and discipline specific functions made it difficult to consistently implement these program components. The findings from this study demonstrate that organizing structures found at organizational and system levels can impact the way in which activities are carried out on a day-to-day basis by ACT practitioners and may conflict with personal and professional intentions for carrying out those same activities.

The community mental health literature abounds with calls for practice to better reflect recent progressive shifts in ideology. For example, Huxley and Thornicroft (2003) propose that mental health service practitioners, particularly psychiatrists, begin to focus

their everyday activities on directly influencing aspects of integration such as employment, income and social quality. The authors suggest that practitioners, particularly psychiatrists, take an active intermediary role between clients and employers, advocating for reasonable employment accommodations in an effort to increase the likelihood that service users will remain employed, and decrease the amount of sick leave required during times of symptom exacerbation. According to Huxley and Thornicroft (2003), this expansion of the clinician role would also involve actively referring service users to facilities that offer expert welfare benefit advice in order to maximize the flexibility of disability payments. As well, clinical educators could place greater emphasis on the association between the assessment of societal roles and the experience of mental illness within the psychiatric training curriculum. Likewise, Nash (2002) suggests that service practitioners actively support the participation of individuals with mental illness in governmental elections as a means of building socio-political participation and promoting access to valued resources. He states:

In an era where the drive to full integration of the mentally ill in the community is a core feature of mental health policy, social functioning assessment may no longer be achieved solely by practical measures such as budgeting and shopping. An assessment of social integration e.g., measures such as voting, membership of social clubs, and activity groups, etc., may show how integrated the person is in his/her community (p. 698).

Overall, there have been recent calls for a shift from an individual to a social model of disability and intervention which shifts the roles and responsibilities of practitioners from those of direct care to those of building the capacity of the community to better accommodate the needs of individuals with mental health issues (Ontario Ministry of Health and Long-Term Care, 1999; 2000).

3.5 Assisting the Community Integration of Individuals with Severe Mental Illness

3.5.1 Training in Community Living (TCL)

The first systematic effort to establish community-based supports for individuals with mental illness was the Training in Community Living (TCL) program at Mendota State Hospital in Madison, Wisconsin (Marx, Stein & Test, 1973). The TCL program was established to provide integrated treatment, rehabilitation and support services to individuals with mental illness within a community context. The founders of the TCL program were motivated by a concern that existing psychiatric services did not provide key factors critical to successful community living. These factors included: a) access to basic resources such as food, shelter and clothing; b) the development of skills needed to negotiate one's way through daily chores such as budgeting, housekeeping, accessing public transportation, and attending to personal hygiene; c) the promotion of participation in one's community; d) the establishment of respectful, non-dependent relationships; e) supporting and educating community members to interact in ways that do not reinforce dependent relationships; f) assertively engaging individuals with psychiatric disabilities in program activities (e.g., ensuring service users keep appointments); g) providing support to service users, their families and community members (Stein & Test, 1980). The program aimed to incorporate the above elements into day-to-day service delivery activities.

The original TCL program was comprised of 61 individuals diagnosed with severe mental illness who were considered to be at risk for repeated psychiatric hospitalizations (Marx et al., 1973). The program was based in a rented house in the city centre of Madison, Wisconsin. All treatment, rehabilitation and support services were

provided in the community. Particular emphasis was placed on avoiding re-hospitalization. The staff was asked to treat clients as responsible individuals and to develop working relationships with other community agencies. The focus of the program was to provide support in five major areas: a) vocational and work related skills; b) activities of daily living; c) social and recreational activities; d) family support; and d) medications, psychotherapy, and nursing care. Participants lived in a variety of places within the community including the local YMCA, YWCA, hotels, apartments, and boarding houses (Estroff, 1981). Treatment consisted of a “full schedule” of daily living activities in the community and ongoing pharmacotherapy (Marx et al., 1973). Participants in the program also received intensive assistance in locating jobs either in the community or in sheltered workshops. Staff members were described as being in daily contact with clients and their job supervisors in order to aid with on the job problems. Assistance with activities of daily living included laundry, house cleaning, shopping, cooking, personal grooming, budgeting and use of public transportation. Marx et al., (1973) described the frequency of client-staff interaction as “daily, even hourly, contact of staff with patients” which was “gradually diminished based on each patient’s progress in the treatment program” (p. 506).

The effectiveness of the TCL program was measured against a control group. The participants in the experimental group received TCL services for a 14-month period (treatment phase) and were then transferred to traditional community programs (post-treatment phase). The participants in the control group received progressive inpatient services for 14 months (treatment phase) and were then transferred to the same community programs as those in the experimental group (post-treatment phase). Data were gathered

from both groups during the 14-month treatment phase (Marx et al., 1973) and then again during the post-treatment phase (Stein & Test, 1980).

The results of the treatment phase (Table 1) indicated that after 4 months, the participants in the TCL program experienced significantly less time in hospital and at 8 months were shown to experience more time in independent living situations than the control group. After 8 months both the experimental and control groups experienced a significant drop in symptomatology. At 12 months a significant increase occurred in the degree to which TCL participants were engaged in social groups, had contact with friends, experienced satisfaction with life, and complied with medication instructions compared to individuals in the control group. No significant differences were found between the two groups in areas of family burden, satisfaction with life, adequacy of living arrangements, leisure time activities, social relationships, and competitive employment. Interestingly, participants in the TCL program were significantly more likely to be employed in sheltered workshops (Stein & Test, 1980) whereas those in the control group were more likely to be employed in competitive employment roles. Those participants in the TCL program who did occupy competitive employment roles, however, earned significantly more money than those in the control group (Marx, Stein, & Test, 1973).

Assessments taken throughout the post-treatment phase indicated that once program participants “graduated” from the program, gains seen at the 12-month period began to diminish significantly (Stein & Test, 1980). Once participants in the experimental group left the TCL program their time spent in hospital doubled, participation in sheltered workshops

declined, and unemployment increased, as did competitive employment rates¹⁴. Likewise, gains that had been demonstrated in life satisfaction, medication compliance, and contact with friends declined. Areas where no gains had been made during any portion of the program, such as leisure time, social relationships, adequate living arrangements, self-esteem, and participation in competitive employment, continued to show no difference (Stein & Test, 1980). These results suggest that the TCL program helped to decrease rates of hospitalization and increase levels of psychiatric stability in the community (Table 1). These results created the opportunity for sustained physical community integration of individuals with severe mental illness, thus, leading to an infusion of funding for the model throughout the U.S. and eventually Canada, Australia and the U.K. (Stein & Santos, 1998). The results also indicate, however, that despite the success in basic-level integration, participants in the TCL program were limited in their achievement of higher-order aspects of integration such as social participation, autonomy, and empowerment.

¹⁴ Although increased competitive employment rates is certainly a positive effect seen during the post treatment phase this cannot be attributed to the effects of the TCL program.

Table 1: Outcome Findings on TCL

TCL STUDIES	Control	Follow up Period	N	Hospitalisation TCL vs. control Group	Symptomatology TCL vs. control group	Vocational function TCL vs. control group	Social function TCL vs. control group	Independent Living TCL vs. control group	Service Satisfaction TCL vs. control group	Quality of Life TCL vs. control group
Marx et al., (1973)	Inpatient Unit	4,8,12 months	61	sig.	ns	sig.	ns	sig.	nr	nr
Stein & Test (1980)	Community After Care	16,20,24 months	130	sig.	sig.	sig.	ns	sig.	nr	sig.

nr-not reported,
ns-not significant,
sig.-significant at $p < .05$,
SMI-severely mentally ill
Note: the last two entries

(Stein & Test, 1980) reflect the same study but the 12 and 28th month outcomes have been separated to show variations in the outcomes at these time frames.

Estroff (1981) conducted an ethnographic study on the TCL program, providing an in-depth look at the experiences of participants in the program. During her 2 year exploration Estroff embedded herself in the daily culture of TCL clients, which enabled her to “discover the richness and diversity of the clients’ world” (Estroff, 1981, p. 249). Her concern with the findings of the TCL model lay with the lack of significant outcomes in areas of leisure time, self-esteem, social relationships and competitive employment despite emphasis in these areas both conceptually and in practice. Estroff’s (1981) study provides an analysis of the culture of practice, which constituted the TCL program. Contained within the study is an in-depth description of the nature of clients’ employment experiences while participating in the program.

Most of the work that lasted more than four weeks was sheltered. The competitive pattern showed frequent, short-lived employment. It is interesting to note that clients quit various jobs more frequently than they were fired, though this total may be biased [self-report]. Clients often quit before they could be terminated. Although twenty-six clients held some type of competitive job during the research period, only twelve of these were for periods of longer than four weeks. Seventeen never had a competitive job, though everyone did volunteer work or had a sheltered job at some time (p. 132).

The social interactions of participants in the TCL program are described by Estroff as occurring primarily with other clients as opposed to individuals in the community.

Usually...when clients spent time and shared space with other persons, it was with other clients, family, or PACT staff and mental health professionals. Only five (of 43) spent time with one or more ‘outside’ or non-client friends...[TCL] has had a program of community volunteers who have developed one-to-one relationships with clients, but on the whole these have not been long-lasting contacts. Of the group of 43 clients, two had relationships with volunteers that exceeded several months. These contacts diminished usually because the client and/or volunteer lost interest. Less often, the pair were mismatched vis-à-vis interests and personalities and could not establish a basis on which to interact in comfort (p. 62).

Interactions that did occur with community members were often infrequent and solely for purposes of providing resources.

Clients interacted with Outside Normals [community members having nothing to do with the mental health system in any way] as infrequently as possible. When they did, it was usually for a formal or goal-oriented purpose. My observation was that the same held true for Outside Normals vis-à-vis clients. Few persons other than those offering resources (such as apartments, food, or jobs) or services (such as police) had reason to interact with the clients (p. 184).

The experience upon graduating from the program is described by Estroff (1980) as plagued by lack of activity and motivation.

Near the end of active treatment and after discharge, many clients spent much of their time sitting, either alone or together, watching television, smoking cigarettes or marijuana, drinking beer, and listening to music. The day might be marked by medication doses, appointments with help-giving professionals, or the arrival of meal times. Many reported that they were bored or had nothing to do. Others never mentioned this problem and seemed content with possessing large quantities of solitary, silent time (p. 60).

Hence, both randomized trials conducted on the TCL program, as well as Estroff's qualitative study, suggest that individuals receiving services from the TCL program experienced limited degrees of higher-order integration.

3.5.2 Replications of the TCL Model: Assertive Community Treatment

Since the results of the TCL program were first published, replications of the model have been developed throughout North America. These replications are referred to as either Programs for Assertive Community Treatment (PACT) or simply Assertive Community Treatment (ACT) teams. PACT and ACT programs are direct replications (both practically and philosophically) of the TCL program. The change in name reflects a commitment to assertively connect with service users on a daily basis and to be available to respond to crisis situations on a 24-hour, 7 day/week basis. This model of

assertiveness is unlike other community based mental health service delivery models. Program fidelity criteria were developed to ensure that PACT and ACT programs were consistent (both across sites and with the original TCL program) in their application of critical service delivery features. A panel of experts developed the following list of critical factors for the ACT model: a) small client-staff ratio (this ratio is ideally 10:1); b) limited team size of seven full-time equivalent clinical staff; c) a minimum of 13 hours of psychiatrist hours per week; d) a minimum of 0.75 full-time equivalent nursing hours; e) team functions as primary therapist (e.g., primary clinical, record-keeping responsibility for the client); f) the physical office is separate from that of any parent agency (including psychiatric hospitals) (Drake & Burns, 1995; Bachrach, 1988; Mechanic, 1991; Test, 1981). The results of fidelity studies indicate that the replication models have tended to vary in terms of location (i.e., rural vs. urban), demographic distribution (i.e., age, gender, substance abuse), resource availability (i.e., housing, employment etc.) and service user characteristics (McGrew, et al., 1994).

3.5.3 Review of Replication Studies

To date, over 40 empirical studies of ACT exist in the literature (Mueser et al., 1998). Eighteen randomized controlled trials of ACT were included in this literature review. To focus the review on mainstream ACT programs, randomized controlled trials comparing ACT clients to control groups other than inpatient or case management populations (i.e., homeless, veteran, or dual diagnosis populations) were excluded. Also, as a way of controlling for fidelity, the review was limited to studies located in countries with highly correlated operational definitions of ACT including the U.S., Britain, Australia, and Canada.

Table 2 provides a summary description of the reviewed studies.

Eighteen of the studies examined the effects of ACT services on hospitalization and symptomatology. Of these studies, 10 reported significantly less time in hospital for ACT service users over controls (Bond, Miller, Krumwied & Ward, 1988; Bush, Langford, Rosen & Gott, 1990; Essok & Kontos, 1995; Hoult, Reynolds, Charbonneau-Powis, Weekes & Briggs, 1983; Lafave, de Souza & Gerber, 1996; Lehman, Dixon, Kernan & Deforge, 1997; Marks, Connolly, Muijen, Audini, McNamee & Lawrence, 1994; Marx et al., 1973; Merson, Tyrer, Onyett, Lack, Birkett, Lynch, et al., 1992; Salkever, Domino, Burns, Santos, Deci, Dias, et al., 1999; Stein & Test, 1980). Hospitalization was the one variable most often found to be significant, making it the one consistent finding across studies. Five of the 20 studies found that clients experienced significantly decreased symptomatology as a result of ACT services (Hoult et al., 1983; Lafave et al., 1996; Marks et al., 1994; Merson et al., 1992; Morse, Calsyn, Klinkenberg, Trusty, Gerber, Smith, et al., 1997; Stein & Test, 1980).

The effects of ACT services on other variables such as independent living, vocational functioning, social functioning, quality of life, and service satisfaction were also investigated. Ten of the reviewed studies investigated the effects of ACT services on independent living. Seven of these studies found a significant increase in independent living (Essok & Kontos, 1995; Lehman et al., 1997; Lafave et al., 1996; Marx et al., 1973; Morse, Calsyn, Allen, Tempelhoff, Smith, 1992; Stein & Test, 1980)¹⁵. Seven studies examined outcomes in vocational functioning. Of these, only two reported increase vocational outcomes for ACT service users (Marx et al., 1973; Stein & Test, 1980). Both of these studies incorporated specific vocational components into the ACT program. A direct relationship may exist

¹⁵ Independent living refers to a “living situation in which the client lives in the community where there is no

between vocational functioning and specialized vocational programming (Bond, Drake, Mueser & Latimer, 2001, Mueser et al., 1998; Mueser et al., 2001). Ten studies examined satisfaction with services. Seven of these found that ACT service users were significantly more likely to be satisfied with services than those in control groups (Chandler, Meisel, McGowen, Mintz & Madison, 1996; Hoult et al., 1983; Marks et al., 1994; Merson et al., 1992; Morse et al., 1992; Morse et al., 1997). Fifteen studies reviewed examined social adjustment¹⁶ as an outcome variable. Only two of these studies reported significant improvements (Bush et al., 1990; Marks et al., 1994). Of the 11 ACT studies that investigated quality of life¹⁷ only four found any significant improvement in the quality of life of service users (Chandler et al., 1996; Essock & Kontos, 1995; Stein & Test, 1980). Meuser et al. (1998) suggest that these improvements may be most attributable to changes in hospitalization and housing stability.

In summary, the majority of the studies reviewed reported significantly decreased hospitalization and symptomatology for ACT service users. Variables associated with higher order aspects of community integration, such as rehabilitation and support, were less likely to be included as areas of investigation and when included were less likely to demonstrate significant outcomes. Variables related to social cohesion (shared responsibility) and empowerment (social, cultural, political, and economic influence) were absent from these investigations.

‘built in’ psychosocial support” (Marx et al., 1973, p.510).

¹⁶ Social adjustment is defined as the “quality of social relationships, the ability to meet social role expectations, or social networks” (Mueser et al., 1998, p.42).

¹⁷ Mueser (1998) defines quality of life as a “patient’s subjective satisfaction with different areas of living such as housing, finances, relationships and health” (Mueser, 1998, p.42).

Although limited in their capacity to shed light on integration related outcomes, the findings produced from clinical trials were considered to be indications of the model's success. An overwhelming endorsement occurred despite indications that the model did not significantly improve employment, social relationships, and recreational activities. The conclusion of most ACT review studies has been that "ACT increases the community integration of people with severe mental illness" (Bond, et al., 2001, p. 148). Bond et al., (2001), however, suggest that in the decades since early randomized controlled trials, new expectations have arisen in relation to the concept of integration. Mental health practitioners, advocates and service users have begun to expect more than basic-level integration from community mental health services, particularly ACT. This is expressed in a quote from Bond et al., (2001) in reference to the future of ACT:

Despite its status as evidence-based practice, ACT should also be examined from the stand-point of what ACT programs are not achieving. In most areas, the inclusion of a vocational focus has not been realized, despite the evidence showing the effectiveness of supported employment and its compatibility with ACT. Social skills training and development of social networks, in addition to working with family members, have also been neglected despite ample support for these approaches. (Bond et al., et al, 2001, p.151).

Likewise, consumer / survivor literature has arisen which accuses ACT of being "much like hospital-based treatment" in that it does not help individuals to build natural supports within the community (Nugent & Spindel, 1998).

Table 2: Outcome Findings on ACT

ACT Studies	Study Pop.	Follow up Period	N	Hospitalisation ACT vs. Control	Symptomatology ACT vs. Control	Vocational function ACT vs. Control	Social function ACT vs. Control	Independ. Living ACT vs. Control	Service Satisf. ACT vs. Control	Quality of Life ACT vs. Control
Hoult et al. (1983)	ACT(60); Std.CM (60)	1 year	120	sig.	sig.	ns	nr	nr	sig.	ns
Bond et al. (1988)	ACT(84); Std. CM (83)	6 mths.	167	sig. (2 centres)	ns	nr	ns	nr	nr	ns
Jerrel & Hu (1989)	ACT; Std. CM (35 total)	2 years	35	ns	ns	nr	ns	nr	nr	ns
Bond et al. (1991)	ACT (45); DIC (43)	18 mths.	97	ns	ns	ns	ns	ns	ns	nr
Bush et al. (1990)	ACT (14); Std. CM (14)	12 mths.	28	sig.	nr	nr	sig. (judged by cm)	nr	nr	nr
Morse et al. (1992)	SMI (52); Std. CM (64); DIC (62)	12 mths	178	nr	ns	nr	ns	sig.	sig.	nr
Marks et al. (1994)	ACT(92); Std. CM (97)	20 mths	189	sig.(# of days)	sig(BPRS at 20 mths)	ns	sig. (20 mths)	nr	sig.	nr
Merson et al., 1992	ACT (48); Std. CM. (52)	3 months	100	sig.	sig.	ns	ns	ns	sig.	ns
Muijen et al. (1994)	CNT(41); GCN (41)	18 mths	82	ns	ns	nr	ns	nr	ns	nr

Essok & Kontos (1995)	ACT(131); Std. CM (131)	18 mths	262	sig.	nr	nr	nr	sig.	nr	sig.
Quinlivan et al. (1995)	ACT (30) Std. CM. (30); No CM (30)	2 yrs	90	ns	nr	nr	nr	nr	nr	nr
Solomon & Draine (1995)	ACT(42); Std. CM (37); FCM (38)	1 year	200	nr	ns	nr	ns	nr	nr	ns
Chandler et al. (1996)	ACT (217); Std. CM (222)	1 year	439	ns	ns	ns	ns	ns	sig.	sig.
Lefave et al. (1996)	ACT (24); inpatient (41)	5 year follow-up study	65	sig.	ns	ns	ns	sig.	ns	sig.
Morse et al. (1997)	ACT; ACT & P; Std. CM (165 total)	18 mths.	165	nr	sig. (over broker model)	ns	nr	sig.	sig.	nr
Lehman et al. (1997)	ACT(77); Std. CM. (75)	1 year	152	sig.	ns	nr	ns	sig.	nr	ns
Salkever et al. (1999)	ACT (104); Std. Cm (69)	18 mths.	173	sig.	ns	ns	ns	ns	ns	ns
Killaspy et al., 2006	ACT (127); CMH (124)	18 mths.	251	ns	ns	nr	ns	nr	sig	ns

nr-not reported, ns-not significant, sig.-significant at $p<.05$, SMI-severely mentally ill, Std. CM. – standard case management, DIC – drop-in centre; GCN – generic community nursing; FCM – forensic case management; P – paraprofessional community worker; CNT – community nursing team, CM – case manager, CMH – community mental health program.

3.6 Organizing Structures: Impact on Everyday Practice

Critics of the ACT model argue that despite stated associations with psychosocial rehabilitation and recovery principles, everyday service delivery practices limit, rather than facilitate, higher-order integration for service users (Estroff, 1981; Gomeroy, 2005; McGrath & Jarrett, 2004; Nugent & Spindel, 1998). Structural analysis offers a way of understanding the lack of effectiveness demonstrated by community mental health services in areas of community integration. Wide in its following, structural analysis has influenced scholars in the fields of economics, political science, anthropology and sociology. These analysts advance the notion that “no [environment] can be properly understood apart from its wider social and cultural context” (Scott, 2000, p. 151). They claim that infrastructures operating at macro and meso levels constitute the beliefs, values, ideas, texts, and social relations that, in turn, create the means by which organizations, systems, and societies operate. Structural analysis is based on the premise that individuals’ everyday actions are largely determined by organizing structures operating in the background and obscurely shaping the conditions in which these activities take place (Meyer & Rowan, 1991; Scott, 2000).

Organizing structures exist concurrently at social, systemic, and organizational levels (Scott, 2000). Organizing structures comprise the ideas, opinions, and morals that formulate “social facts” as well as the material conditions that regulate daily activity to correspond with social values. In other words, social ideas and opinions regarding the integration of individuals with mental illness are integral in shaping the everyday practice of community mental health practitioners, as are systemic structures comprised of legislative, economic, and political policies. At social, systemic, and organizational

levels, community integration practice is influenced by the degree to which community participation becomes a political platform, money is allocated to support community integration practice activities, and legal policies enforce equal participation for disadvantaged groups. Practice is also influenced by the physical and material conditions that govern modes of conduct within organizational fields and organizations such as professional hierarchies, disciplinary values, professional reimbursement, professional licensing requirements, and rules of organizational networking.

Two primary schools of thought exist amongst structural analysts. The first school adopts what is termed the institution-as-constitutive model, wherein structure is seen as a necessary and critical element that serves to ensure consistency in productivity both within organizations and across fields (Scott, 2000). The second school adopts an institution-as-constraint model, which focuses on the impact of structures in shaping the everyday activities of individuals in ways that contrast with intended directions (Nee & Brinton, 1998). Both approaches provide insight into the impact of organizing structures on everyday human activity. In keeping with the focus of the current study on the tensions experienced by individual practitioners, an institution-as-constraint model has been adopted. In other words, the study assumes that infrastructures operating at organizational, systemic, and social levels shape everyday practices in ways that constrain the ability of practitioners to be consistent with ideological shifts in community integration practice thus producing tensions in their everyday work.

Structural analysts believe that organizing structures consist of regulative, normative and cognitive elements. The different schools of thought stress particular

elements (either regulative, normative or cognitive) as being of primary importance to the creation and maintenance of everyday order (Meyer & Rowan 1991; Scott, 2000).

3.6.1 Normative Elements

Normative theorists emphasize the impact of wider belief and rule systems on the choices made by individuals and stress the role of prescriptive and proscriptive signals from mainstream society on the organization of everyday activity. Social rights, responsibilities, privileges, duties, licenses, and mandates come to be viewed as “social facts” and are transmitted directly to individuals and organizations on that basis (Scott, 2000). In terms of ACT, normative theorists would draw attention to the role that assumptions of normalcy (in terms of behaviour cognition) have on the way in which community integration practice is organized to support individuals with severe mental illness.

3.6.2 Regulative Elements

Regulative theorists stress the role that ideas, opinions, and actions of majority groups play in shaping what are considered to be acceptable social, systemic, and organizational activities. The cultural norms attributed to the majority become formalized into a way of life. In the process they form an external, non-negotiable, hierarchically arranged set of values and expectations that are attributed to all members of society. The existence of a collectively imposed set of values and expectations results in social power for those individuals who hold membership within the majority group (Scott, 2000) and disempowers those who exist outside of it. In terms of ACT, regulative

theorists would assert that the primary factor shaping the everyday activities of ACT practitioners is the values and expectations regarding mental illness that are held by the majority group within broader society.

3.6.3 Cognitive Elements

Cognitive theorists stress the mediating relationship between social relations and broad governance structures. Social relations refer to the interactions of those who construct the organizational field, “those who create [and participate in] the categories, the norms, the rules and standards” (Scott, 2000, p. 78). These theorists contend that individuals and everyday activities are shaped by the interaction between governance structure and the social relations engaged in by practitioners. In terms of ACT, cognitive theory would focus on how social relations impact practitioners in their ability to carry out their everyday activities according to their own desires, as well as the degree to which practitioners themselves participate in sustaining broad governing structures. The current study will seek to understand the regulative, normative and cognitive elements of the organizing structures that shape the everyday activities of ACT practitioners.

3.6.4 Organizational Legitimacy and Decoupling

Meyer and Rowan (1991) contend that in order to increase their legitimacy, publicly accountable organizations, such as ACT, are pressured through formal and informal means to adopt practices and procedures which conform to prevailing social ideals. Conformity ultimately increases the likelihood that the organization will receive continued funding and government support. Hence, the shaping of everyday activities

within organizations often occurs independent of the conceptual framework selected to guide organizational practice. It is possible for everyday activities to conflict with the originally stated intentions of the organization. Meyer and Rowan (1991) expound upon this idea:

In modern societies, the elements of rationalized formal structure are deeply ingrained in, and reflect, widespread understandings of social reality. Many of the positions, policies, programs, and procedures of modern organizations are enforced by public opinion, by the views of important constituents, by knowledge legitimated through the educational system, by social prestige, by the definitions of negligence and prudence used by the courts. Such elements of formal structure are manifestations of powerful institutional rules which function as highly rationalized myths that are binding on particular organizations.... The impact of such rationalized institutional elements on organizations and organizing situations is enormous (p. 343).

Thus, organizations come to reflect structurally the ideals of society through a complex system of interdependencies. Organizations created for the purpose of “advancing” new or alternative social norms (such as community integration for individuals with mental illness) may either fail to survive or adopt an organizational structure reflective of existing social morals. The organization then becomes committed to organizing itself according to external ideologies and criteria, creating a tension between external and internal forces. This tension renders the organization dependent on the attitudes, beliefs and opinions of broader society. Townsend (1998) argues that in mental health care, social, systemic, and organizational rules may ultimately come to overrule the original mission and vision of the organization as well as the personal and professional intentions of individual practitioners.

In the event that the organization remains true to its intended purpose, it may become vulnerable to extinction in terms in that funding may be withdrawn from the program. The conduct and legitimacy of the organization may conflict with mainstream

morals, which in turn may impact funding support. Organizations, particularly those that are publicly funded, often seek to strengthen their sustainability by either adopting vocabulary reflective of social ideals or adopting legitimate external assessment criteria, or both. Meyer & Rowan (1991) comment:

Ceremonial criteria of worth and ceremonially derived production functions are useful to organizations: they legitimate organizations with internal participants, stakeholders, the public, and the state They demonstrate socially the fitness of an organization. The incorporation of structures with high ceremonial value, such as those reflecting the latest expert thinking or those with the most prestige, makes the credit position of an organization more favorable [Hence], independent of their productive efficiency, organizations which exist in highly elaborated institutional environments and succeed in becoming isomorphic with these environments gain the legitimacy and resources needed to survive (p. 352).

Under these circumstances, an ambiguous environment can arise in which practitioners overlook or avoid detailed examination of inconsistencies between organizational intent and everyday work activities. This can result in what Smith (1990) refers to as ‘a state of bifurcated consciousness’ on the part of employees. When a person experience bifurcated consciousness they are caught between the formal organizational structure that guides their workday and provides a direction for the way things are done, versus personal and professional values that inform how they intend to carry out everyday activities. Individuals are often unaware, on a conscious level, of how this tension becomes manifested in a systematic way at structural levels.

Although the activities of individuals are influenced by organizing structures, individuals are capable of making reasoned choice. The degree of adoption or innovation on the part of individual workers and individual organizations is referred to in organizational literature as agency. Agency is defined specifically as “instrumental behaviour taken in order to reach desired ends” (Scott, 2000, p. 138). Figure 1 is adapted

from a model of institutional creation and diffusion processes put forth by Scott (2000, p. 42). The model demonstrates the reciprocal relationship between organizing structures operating at organizational, systemic, and social levels, and individual agency in shaping models of service delivery.

3.7 Organizing Structures and Community Integration Practice

Townsend (1998) conducted a study using the method of institutional ethnography to focus on the social organization of the mental health work of occupational therapists. The study findings illustrate how the desire and intention on the part of occupational therapists to enact practices consistent with an empowerment philosophy become constrained as a result of organizing structures, which overrule the original intentions of the individual practitioners. Townsend (1998) found that occupational therapists experience bifurcated consciousness when attempting to provide services consistent with the idea of empowering service users while concurrently conducting systemically-driven activities aimed at preserving the role of direct care. Findings suggest that the routine organization of power that becomes legitimated by ruling structures such as accountability standards, hierarchical decision-making, and procedures of risk management act together to create a mental health system that promotes practices of caregiving over empowerment. Consequently, the activities of occupational therapists who function within this ruling structure come to reflect caregiving, despite personal and professional intentions to engage in empowerment practices.

Socialization, Identity Formation, Sanctions



Social Environment

Structure at this level comprises all encompassing views, beliefs, opinions regarding equal participation of individuals with psychiatric disabilities within economic, intellectual, recreational and legal aspects of society.



System

Structure at this level includes community mental health programs including ACT, provincial psychiatric hospital outpatient programs, consumer/survivor advocate groups, service users, families of service users, professional mandates.



Organization

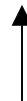
Structure at this level includes ACT standards, ACT policy & procedures, Community Treatment Orders, funding criteria, exchange relations with other organizations, worker selection, assessment materials.



Everyday Activities and Practices of Service Practitioners

What activities are engaged in, by whom, for what purpose, and the logic attributed (by individual practitioners) to carrying out these activities in the particular ways in which they are carried out.

Examples of everyday activities include scheduling meetings, individual advocacy, home visits, and travel required to provide services.



Interpretation, Innovation, Error

Figure 1: Opposing and Interdependent Forces: Organizational Structure vs. Personal Agency (adapted from Scott, 2000).

Boyce (2001) examined disadvantaged persons' participation in health promotion projects in an effort to identify barriers to facilitating community participation for members of minority groups. Several organizational structures are identified as powerful influences over day-to-day service delivery activities. Boyce (2001) identified 14 principal factors across three dimensions of structure that affect the community participation of disadvantaged persons. At the social-cultural level, imbalances in participation based on age, gender, and ethnic attributes, as well as assumptions regarding participant competency, serve to create hierarchical divisions amongst group members. At a political-legal-economic level, limited financial commitment from external resources, lack of administrative resources, and unreliable support for strategic planning served to undermine efforts to embed equal community participation for socially, economically and politically disadvantaged groups. Finally, elements comprising the organizational dimension of structure, including decision-making power, working definitions of community participation, funding requirements, and governance models, served to reinforce existing systemic and cultural barriers by limiting the input of disadvantaged persons into support services.

Similar to the studies conducted by Townsend (1998) and Boyce (2001), the current study is based on the assumption that the organizational structure of community mental health agencies can contribute to a systematic overruling of practices associated with the facilitation of higher-order integration. The aim of the current study is to examine how the community integration practice of ACT practitioners becomes shaped by organizing structures that exist at organizational, systemic and social levels.

Community integration can be viewed as a continuum comprised of interdependent stages including social security and stability, social participation, social autonomy, and social empowerment. With each new layer, a transformative effect takes place rendering a qualitatively different experience of integration. Collectively, these elements form a comprehensive model of the determinants necessary for individuals to achieve broad community integration (Berman & Phillips, 2000).

Service approaches can be discussed in terms of their capacity to facilitate levels of integration; the institutional-medical approach targets social economic security by treating psychiatric symptoms and ensuring a safe place to live. Over time, and with the introduction of new disciplines (social work, occupational therapy, etc.), the emphasis shifted to focus on social participation through access to social goods, education, and economic productivity. The community-treatment rehabilitation approach attempted to promote social participation by helping individuals with mental illness to access community-based housing and by attempting to create employment, recreational, and educational opportunities. Recently, the emphasis has been placed on the recovery approach, which encourages service users to take control over, and responsibility for, their own road to recovery. Finally, the empowerment-community integration approach focuses on building the influence of individuals with mental illness within political, economic, and social spheres, creating opportunities for individuals to become involved in opportunities such as mainstream housing, work, social, and recreational events.

Structural analysis literature provides important insights for explaining the criticism that everyday practice fails to reflect these recent ideological shifts. According to Scott (2000) and others (Meyer & Rowen, 1991; Nee & Brinton, 1998), organizing

structures at social, systemic, and organizational levels exist as powerful forces that shape the everyday activities of practitioners in ways that do not always conform with personal and professional intentions. These tensions are reflected in the experience of bifurcated consciousness on the part of mental health practitioners. Some of the specific structures that have already been identified as playing a role in shaping the participation of disadvantaged individuals include imbalances in participation based on conceptions of competency; limited financial commitment for the creation of opportunities for participation; and limited involvement of disadvantaged groups in service design.

By examining the impact of organizing structures on the community integration practice of ACT practitioners the current study aims to contribute to the development of a knowledge base for which there is a dearth of knowledge and which may shed light on new and sustainable approaches to community integration for individuals with severe mental illness.

CHAPTER 4: METHODOLOGICAL FRAMEWORK

4.1 Chapter Overview

The current study used the method of institutional ethnography to examine how infrastructures existing at organizational, systemic, and societal levels shape the everyday community integration practice of ACT practitioners. Institutional ethnography is a methodology that has been used by Townsend (1998) and others (Smith, 2006; Devault & McCoy, 2002) to trace the linkages between organizing structures and everyday practice. The purpose of using this methodology is to make clear the complex field of organizational, systemic, and social coordination and control that accounts for, and is reinforced by, everyday community integration practice (Campbell & Gregor, 2002).

4.2 Institutional Ethnographic Method

Institutional ethnography is a methodology popularized by D.E. Smith in her work “Everyday World as Problematic; A Feminist Sociology” (1987) and in subsequent works (1990, 2006). The method draws on sociological as well as feminist schools of thought (for a more thorough description of the theoretical underpinnings of this method see Smith, 1987). The method of institutional ethnography is an unconventional form of inquiry both within the health sciences field where positivist approaches tend to dominate and within traditional qualitative approaches. An institutional ethnography attempts to investigate, ethnographically, the organization of everyday activities (Smith, 1990). Institutional ethnography locates the research problematic in the everyday tensions

experienced by marginalized or oppressed groups¹⁸. The ultimate goal of institutional ethnography is to trace these everyday tensions to external forces, which systematically organize everyday life in ways which are external to the values and intentions of individuals. These external forces are comprised of organizing structures¹⁹, which are instrumental in the social organization of knowledge and power through official texts and organized social relations. The method of institutional ethnography is based on the assumption that the knowledge and power agendas contained within organizing structures come to overrule contrasting values and intentions held by individuals of minority groups (Campbell & Gregor, 2002). This overruling is conducted in the background of everyday activity, and thus becomes hidden from everyday view. The effects of overruling by organizing structures may appear to the individuals as tensions or personal problems that they may be attributed to personality or competence factors. In fact these tensions are more likely attributed to systematically organized value struggles that occur at overarching levels of government and society. Institutional ethnography seeks to trace the linkages between these organizing structures and the everyday tensions of marginalized individuals for the purpose of explicating linkages between everyday activities and the social organization of knowledge and power to empower those who become overruled within this process. The task of the investigator is greater than recording the organization of everyday activities. The investigator must also seek to recognize and analyze the relations of power operating within such organization. The purpose of investigating and thus exposing the linkages between everyday experience and

¹⁸ Within the world of health, and society in general, those who work to integrate individuals with severe mental illness can themselves be an oppressed group (Townsend, 1998).

organizing structures is to promote the acquisition of skills which will enable individuals to see explicitly how power can come to organize everyday life and empower them to resist organizing practices which overrule their values and intentions.

The data collection involves first identifying an everyday experience to inquire as to its social organization. The institutional ethnographic method typically begins with a problematic located within everyday experience. Often this problematic relates to an experience lived by the investigator. The method then involves observing what individuals do within a particular setting and identifying common responses to tensions across multiple sites. Subsequently it is important to interview the individuals operating within these settings to understand, from their perspective, the logic behind their daily practice. Because “people’s knowledge and actions are already organized before they talk about them” (Smith, 1990, p. 35), it is through these accounts that the knowledge and power involved in this logic is revealed. A review of the texts²⁰ that appear in people’s talk begins to explicate the organizational priorities into everyday practice and the compatibility of these priorities with theoretical proclamations of practice, aim and purpose. Finally, social relations are examined in order to trace how organizational priorities contained within texts directly and systematically affect decision-making and social influence, which account for everyday tensions. The analysis seeks to show how the particular organization of knowledge and power in this setting is both systematically organized across similar settings and can account for the common experiences of tensions by individuals practicing within these settings. The process of tracing the linkages

¹⁹ Smith (1987, 1990, 2006) and Townsend (1998) both use the term “ruling apparatus” and Campbell and Gregor (2002) use the phrase “social and material organizing conditions” to refer to the same phenomenon.

between their experience, and organizing structures does not involve a static approach. Campbell and Gregor (2002) point out that identification of research sites, informants, texts to analyze, and questions to pursue are emergent; each step building upon the previous (Campbell & Gregor, 2002). The data collection and analysis are iterative in that they take into account two levels of inquiry. The investigator is tasked with asking the question “what do individuals in a particular setting know and do?” and “what outside forces affect and obscure what individuals know and do?” Campbell and Gregor (2002, p.85) caution against “cutting up and sorting data, for fear of distorting or obscuring the relations at the crux of the problematic.”

4.3 Point of Entry

An institutional ethnography is grounded in a personal account of an everyday experience (Campbell & Gregor, 2002). The problematic²¹ provides the research study with both an entry point into the investigation and a focus for data collection and analysis. Consequently, the research question, the selection of participants, the data collected, and the analysis of the data are all generated from the problematic (Campbell & Gregor, 2002). The research question ultimately examines how the tensions illustrated in the problematic come to be organized at organizational, systemic, and social levels. The specific research question for the current study is: how does the community integration practice of ACT practitioners become shaped by infrastructures existing at organizational, systemic, and social levels?

²⁰ Texts constitute all manner of written materials including research literature, books, policy and procedure manuals, daily schedules, bus tickets, and e-mails.

4.3.1 Selection of Study Informants

Individuals who are selected to participate in an institutional ethnography act as informants to the study rather than subjects. DeVault and McCoy (2002) describe the role of study informants thus:

The point of entry is in organizational work processes and the activities of the people who perform them. Rather than arriving at these processes through an explanation of the experience of people who are the objects of that work or who are in some way affected by it, the researcher . . . jumps right into the examination of organizational work sites. The researcher knows about a set of administrative or professional practices and sets about studying how they are carried out [by individuals] and how they are discursively shaped [and] how [these activities] organize other settings (p. 756).

The objects of study are the collective activities performed by informants. Sampling within an institutional ethnography attempts to locate informants operating in scenarios wherein the issues explored in the problematic are likely to surface. As the goal in institutional ethnography is to determine how uniformities in organizational structure cause everyday practice to be shaped in similar ways across multiple sites, it was necessary for the investigator to engage with more than one ACT team. Given that ACT is a standard model with high fidelity, it was determined that the investigator need not examine a large number of teams. For these reasons and due to time constraints and financial feasibility on the part of the investigator, a total of three ACT teams were selected to act as informants for the study. The investigator sought teams in central, eastern and southeastern Ontario. These teams met the following criteria: a) stated commitment to psychosocial rehabilitation or social justice values; b) governance by a

²¹ The problematic for the current study was presented in the introductory chapter.

community-based organization²²; c) proximity to the investigator; and d) willingness of the organization and program directors to participate in the study.

4.3.2 Entering the Field

The first act of the data collection process is to engage with the field. How the investigator engages with the field is integral to the entire study and depends largely upon her or his research skills and experience. For example, gaining access to organizational documents and the trust of informants affects the quality and quantity of the data. In the present study, the investigator drew upon prior experience as a research coordinator in the mental health field. The investigator drew upon associations developed through past research projects to gain access to the three participating ACT teams and to access organizational documents such as policy and procedural manuals. Care was taken to present a detailed overview of the study, its purpose, and emerging insights in order to maintain the trust of service practitioners.

4.4 Data Collection

Townsend (1994) describes data collection in an institutional ethnography as a process of funneling. That is to say, the investigator begins by gathering data based on a broad criterion and eventually narrows the criteria for inclusion over time. Townsend (1994) succinctly describes this process:

²² Approximately half of ACT teams in Ontario are governed by community-based mental health organizations (correspondence with Steve Lurie, Executive Director of CMHA Metro Toronto Branch). To maximize the community integration focus, all three teams participating in this study are from teams governed by community-based mental health organizations as opposed to those governed by Schedule I psychiatric hospitals.

Data collection begins broadly to record the full scope of a particular practice. The focus of data collection gradually narrows until there is “saturation”²³ (p. 33).

In the current study the broadest gathering of data occurred in phase 1 and narrowed in subsequent phases as the route to tracing the problematic back organizing structures became clearer (Figure 2). Campbell and Gregor (2002) suggest that the period of data collection comes to an end when the investigator has sufficient data to expose the linkages between the various levels of analysis. Institutional ethnography does not advocate a particular set of data collection methods to be used nor does it suggested particular amounts of data to be collected. Rather each individual study is different and data collection is dependent upon the amount and types of data required to explicate the organizing processes at play within the problematic (Smith, 2006). The present study utilized multiple methods of data collection, including: field observation, personal interviews, and document review (see Table 3 for a listing of examples of data sources at program, organizational and system levels).

The investigator began by observing the actual work processes (e.g., activities, talk, and interactions) and organizational conditions (e.g., schedules, job descriptions, funding, and policy documents) that come to shape the everyday community integration practice of informants. Data collection consisted of 22 full days of field observation. These included (among others) observations of daily team meetings, treatment planning meetings, home visits with service users, community excursions and service users.

²³ The term saturation refers to the point at which the generation of new data does not offer new knowledge relevant to answering the study question.

Twenty-six personal interviews (12 formal²⁴ / 14 informal²⁵) were conducted. The discipline break-down for formal interviews consisted of: 3 nurses, 2 occupational therapists, 3 addictions specialists, 1 psychiatrist, 3 team managers (this group consisted of 2 social workers, 1 nurse). Informal interviews were conducted with 2 peer support workers, 1 mental health worker, 2 psychiatrists, 2 social workers, 4 nurses, 1 executive director, and 2 vocational specialists. Five interviews were also conducted with key informants. This group consisted of two executive directors from long standing ACT Teams located in central Ontario (one executive director invited the occupational therapist from her team to participate in the interview with her), a program manager in southeastern Ontario with a formal educational background in PSR, and an employment counselor of an external agency also located in South Eastern Ontario. Two focus groups were conducted; the first took place with 6 peer support workers (2 of whom were also interviewed formally) and the second took place with 3 occupational therapists. A review of 30 program and policy documents was conducted. Examples of reviewed documents include program and policy guidelines, the original ACT handbook written by the founders of ACT, job descriptions, activity calendars, medication charts, peer newsletters, evaluation measurement tools (e.g., workload measurement tools, PSR Toolkit, ACT client-satisfaction), ACT research (e.g., variable selection for clinical trials), ACT conference proceedings, treatment plans, and daily activity rosters. Team summary sessions took place with 2 of the 3 teams. Team summary sessions consisted of

²⁴ For the purposes of this study formal interviews refer to planned interviews structured by the use of an interview guide.

²⁵ For the purposes of this study informal interviews refer to unplanned interviews stemming from questions arising during participant observation. Informal interviews are “casual conversations in which

one large meeting with all (or the majority) of team members to discuss and validate emerging themes in the initial phases of analysis. The investigator was only able to conduct a partial team summary session with the final ACT team as a result of significant changes in personnel during the data collection phase.

The data collection was divided into three phases. The first phase took place over a period of 9 weeks, with an ACT team located in central Ontario. This data collection phase consisted of 9 field observations; 14 personal interviews (3 formal / 8 informal), 3 key informant²⁶ interviews, 1 focus group, 1 team summary session; and an extensive document review, including job descriptions; policy manuals; daily and weekly activity schedules; program mission and vision statements; Ministry of Health and Long-Term Care documents (Community Treatment Orders, Mental Health ACT); ACT conference program book; ACT handbook; and the Ontario Program Standards for ACT Teams. At the end of the 9- week period, the investigator contacted a second ACT team located in eastern Ontario. A second phase of data collection took place over a 7- week period and consisted of 7 full days of field observation; 8 personal interviews (4 formal / 6 informal), 1 focus group, 1 team summary session; and a document review that included policy manuals; measures of vocational function; client newsletters; psychosocial rehabilitation and recovery educational materials; and program mission and vision statements. Subsequently, the investigator contacted the third ACT team located in southeastern Ontario. Data collection took place over a 6-week period and consisted of 6 half days of field observations; 5 personal interviews (all formal); 2 key informant interviews; 1 team

the questions are spontaneous and based on interaction between researcher and respondent.” (Grbich, 1999, p. 93).

²⁶ Individuals who are prominent within the ACT field in Ontario.

summary session; and a limited document review, including policy manuals; program mission and vision statements; and accreditation standards. The following section describes in detail the data collection process.

4.4.1 Field-Observations

Field observation consists of observing the behaviours, actions, and interactions of individuals to determine how individuals make sense of their everyday activities. Grbich (1999) explains, “these understandings are used to generate conceptual/theoretical explanations of what is being observed” (p. 124). Campbell and Gregor (2002) suggest that within the range of possible observations, only certain ones will be most relevant to the problematic being studied. They suggest that observational data in institutional ethnography “can often be treated as clues to the next step in data inquiry. [These observations] might suggest individuals who know important things about the process and who, therefore, might be interviewed” (p. 72).

Field observations consist of observations of actual activities, as well as the investigator’s initial reflections. Observations included daily team scheduling meetings; weekly treatment planning meetings; home visits related to symptom management and psychosocial assessment; hospital visits; and medication injections. All observations were recorded in a field notebook.

Phase I (Toronto)

9 full days field observation
3 formal interviews
8 informal interviews
3 key informant interviews
1 focus group
extensive document review
1 team summary session

Phase II (Ottawa)

7 full days field observation
4 formal interviews
6 informal interviews
1 focus group
extensive document review
1 team summary session

Phase III (Kingston)

6 half days field observation
5 formal interviews
2 key informant interviews
limited document review
1 partial team summary

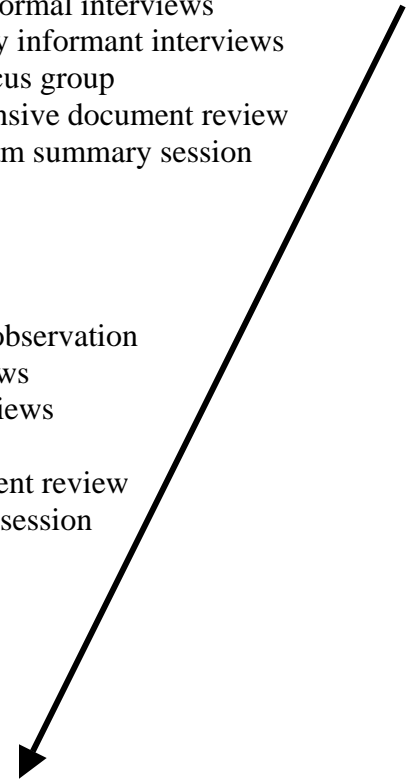


Figure 2: Data Collection Funnel

4.4.2 Personal Interviews

Interviews conducted for this study consisted of in-depth personal interviews and focus groups. The interviews sought to explicate the organizational structures that shape the everyday activities observed in field observations. DeVault and McCoy (2002) state that “the purpose of the interview [in institutional ethnography] is to build up an understanding of the co-ordination of activity in multiple sites, [hence], the interviews need not be standardized” (p. 757). Campbell and Gregor (2002) add, “interviews [in institutional ethnography] will be chosen as the research progresses, and as the researcher learns more and more about the topic. She will see what she needs to know and will find out who would know it” (p. 77).

4.4.3 Formal Interviews

Formal interviews were arranged with several key informants, including an individual with historical knowledge of the development of ACT in Ontario, as well as a program director and an occupational therapist from one of the original ACT teams in Canada. The formal interviews were semi-structured in nature, meaning that a set of open-ended questions prepared ahead of time was used to guide the interview process. The interview topics were not consistent across informants as the purpose was to uncover organizing structures affecting various aspects of community integration practice. Interview topics covered a variety of topics, including formal linkages with other organizations, multi-disciplinary training, working relations, overarching ideologies, origins of the ACT model, ACT priorities, and funding mandates. The formal interviews

were tape recorded with permission from the interviewees and transcribed. Copies of the transcripts were provided to the interviewees for comment and correction before being analyzed.

4.4.4 Focus Groups

Focus groups are a semi-structured form of interview that enable the investigator to explore a specific set of issues with multiple members of a group. Two focus groups were conducted, one with a group of peer support workers and one with a group of occupational therapists.

4.4.5 Informal Interviews

One of the major barriers in ethnographic interviewing is encouraging informants to reveal inner tensions (DeVault & McCoy, 2002). Hence, tensions that arise as a result of personal or professional conflicts with the official organization of activities become difficult to detect (Campbell & Gregor, 2002). Informal interviews can be a more effective vehicle for eliciting these inner tensions than formal interviews. The informal interviews conducted for this study were spontaneous and opportunistic in that data collected from previous interviews, as well as from observations and document reviews, would often prompt the need to interview a particular person regarding a specific topic. Interviews took place primarily while traveling to and from client visits. Although the interviews were informal, all members of the ACT team were informed that any conversation with the investigator would inform the study. The investigator wrote

detailed notes regarding each conversation as soon after the event as possible²⁷. These notes were either made directly after the field visit, or at the end of the working day. A detailed outline of the conversation was recorded and included verbatim excerpts, descriptions of the general mood of the interview and the context surrounding the interviews.

4.4.6 Document Review

Campbell and Gregor (2002) describe the importance of document review in institutional ethnography:

Texts appear in people's talk because they are an integral part of what people do and know. The texts that researchers see being used by informants during field observations are often central to everything that happens. Therefore, to understand the setting and to explicate the problematic arising in it, texts are a very useful ethnographic data source. Their analytic use will vary, depending upon the nature of the inquiry being conducted. Sometimes publicly available brochures or forms will suggest some avenue to follow to help fill in what the researcher needs to know. Perhaps a text will reference an office, a program, or a policy. More frequently in institutional ethnography, rather than being used as sources of factual information, texts are relied on as crystallized social relations. Institutional ethnographers consult them as an alternative to, and an antidote for, accepting ideological accounts (p. 79).

The documents reviewed for the current study included job descriptions; social and recreational activity schedules for service users; program and organizational mission and vision statements; and mission and vision statements of programs with which the ACT team interacts (i.e., vocational programs, social/recreational programs, housing programs). Documents were made available to the investigator by the program director and program staff. The purpose of gathering these particular documents was to provide the investigator with a surface knowledge of the processes of work as it relates to

²⁷ Grbich (1999) suggests that field notes be written no longer than 12 hours after the interview.

community integration with ACT teams. The investigator also focused on gathering documents that inform ACT practices across sites, including psychosocial rehabilitation handbooks and resource books; ACT standards; ACT fidelity measures; literature describing randomized control trials of ACT; the ACT Handbook; measures of the effectiveness of ACT services; provincial ACT conference proceedings; Community Treatment Orders; and consumer literature.

Table 3: Examples of Data Sources

Participant Observation	Systemic	<ul style="list-style-type: none"> • Southeastern Ontario ACT Network • ACT conference
	Program	<ul style="list-style-type: none"> • Daily routine of ACT services i.e., medication run, client visits • Staff meetings (treatment/administrative)
	Individual	<ul style="list-style-type: none"> • Staff activities
Personal Interviews	Program	<ul style="list-style-type: none"> • Staff interviews across disciplines (variation across age, length of time in program, education)
	Individual	
Key Informant Interviews	Systemic	<ul style="list-style-type: none"> • Key informant from Ministry, academia, and consumer community
Document Review	Systemic	<ul style="list-style-type: none"> • Government Policy • ACT standards • Disciplinary licensing requirements
	Program	<ul style="list-style-type: none"> • Job descriptions • Mission statements • Evaluation surveys • Staff activity forms / statistics • Admission criteria • Schedules / calendars of activities
	Individual	<ul style="list-style-type: none"> • Individual treatment plans • Notes on individual clients

4.4.7 Withdrawal from the Field

The investigator conducted summary sessions with each of the ACT teams. Emerging analyses were presented to the ACT staff and administration. The primary purpose of the summary sessions was to create a forum for feedback and validation and to continue to strengthen the rapport and trust between staff and the investigator. The investigator utilized the data collected from these sessions to further the analysis process.

4.5 Data Analysis

A process of immersion/crystallization, was used to analyze the data. Borkan (1999) describes immersion/crystallization as a cyclical process “whereby the analyst immerses him or herself into and experiences the text, emerging after concerned reflection with intuitive crystallizations, until reportable interpretations are reached” (p. 180). This approach to data interpretation is less formal than other qualitative techniques (template style or computer-assisted data management strategies) and is in keeping with the concern of Institutional Ethnographers to not arbitrarily “cut” the data but rather to view the data in a holistic manner (Smith, 2006).

An iterative process of analysis is used whereby the data are interpreted at multiple levels consistent with theories of systems analysis (Patton, 2002). Borkan (1999) describes the immersion/crystallization process as

A series of linked sub-processes of data reduction, display, conclusion drawing, and verification that occurs before data collection, during study design and planning, during data collection as interim and early analysis are carried out, and after data collection as final products are approached and completed (p. 180).

The particular processes involved in immersion/crystallization are initial engagement and describing; crystallization, immersion and illumination; and explication and creative synthesis.

4.5.1 Initial Engagement and Describing

Initial engagement and describing refers to the process of developing an initial theme or issue of interest into a researchable question. This process is characterized by an exploration of personal and professional biases, experiences, and intuition. Although the research question is, necessarily, honed through the problematic prior to the commencement of data collection, the process of engagement does continue throughout the entire study. Borken (1999) describes the process of initial engagement as “a process of self-dialogue and discovery of an intense and passionate concern that calls out to and engages the researcher.” In the case of the present study, the initial engagement phase began with the writing of the problematic and re-surfaced whenever emerging data challenged or contradicted the original direction set by the problematic. When interviewing study informants, for example, practitioners would often allude to tensions in their daily work practices and then quickly rationalize how these tensions were isolated minor irritants, or that they were a necessary part of carrying a specific practice. By continually returning to the problematic throughout data collection the investigator attempted to re-think these rationalizations and to focus on explicating organizing properties despite the fact that these properties were largely obscured from the view of informants.

4.5.2 Crystalization

Crystalization refers to insights about the potential connections between phenomena. These insights are recorded at multiple points in the research process. This material is “used immediately to help focus and improve data collection.... Changes in observational or interview protocols during a field study (for example) are likely to reflect a better understanding of the subject and the setting, thus, heightening internal validity” (Borkan, 1999, p. 185). In the present study, crystallization took place throughout all stages of the data collection process, in a continuous effort to connect current insights with the problematic. Field notes regarding emerging insights were recorded continuously throughout the engagement, data collection, and analysis stages. These insights informed actual interview questions, enlightened the investigator about whom she should seek to interview, and identified critical documents, as well as new areas of literature to review, all in a constant effort to better understand and explicate the dynamics at play within the problematic.

4.5.3 Immersion and Illumination

Immersion and illumination refers to the critical and systematic review of accumulated data, texts, and preliminary analysis notes. This is accomplished through the process of “reading, re-reading and immersing” oneself in the data. Critical questions are asked at both a preliminary (what is going on here?) and a thematic level (what accounts for what is happening?). The investigator devoted several hours to reviewing and reflecting upon each of the various stories relayed by study informants. This

reflection involved re-immersion into the situation, attempting to “see” the threads of organization that attach themselves to practice functions. This process of immersion also consisted of conscious efforts to contemplate alternate organizing threads and potentially altered practices. After conducting this exercise for individual stories, the investigator then attempted to identify common patterns of organization across individual stories and sites of ACT.

4.5.4 Explication and Creative Synthesis

Explication and creative synthesis involve the investigator again emerging her/himself in the data, this time “reviewing all material from multiple horizontal passes” (Borkan, 1999, p. 186). In doing so, the investigator asks synthesizing questions of the data such as “what linkages exist between elements that determine the activities that take place on an everyday basis?” This enabled the investigator to begin the process of attempting to understand the overarching structures organizing practice in particular ways as well as attempting to link this practice to societal and political investments.

The process of immersion/crystallization enabled a continuous, interconnected and interdependent process of data collection and analysis to take place. Though each step took precedence at various times throughout the research process, each layer was engaged in a concurrent and continuous manner throughout the study, enabling the emergence of a process to understand the impact of organizing structures on everyday experience.

4.6 Rigor

Despite the implementation of methods to strengthen the trustworthiness of the analyses, the qualitative investigator is inevitably forced to make certain choices about which data to include and which to leave out. Ultimately, these decisions are necessarily influenced by the investigator's previous experiences and personal lens and are formative in nature. Schram (2003) comments:

[The investigator's] task, both derived from and constrained by [her/his] presence [in the research process], is thus inherently interpretive and incomplete. The bottom line is that there is no bottom line; it is not necessary [or feasible] to reach some ultimate truth in order for [a qualitative] study to be credible and useful ... credibility does not demand certainty (p. 97).

Hence, the purpose of activities aimed at enhancing rigor is to ensure that careful attention is paid to the conduct of data collection and analysis such that the multi-perspective endeavor of naturalistic inquiry strengthens rather than weakens the study. Five methods were used to maximize the rigor of the study. These methods included creating a problematic, reflexivity, audit trail, summary sessions and triangulation.

4.6.1 Creating a Problematic

The purpose of the problematic is to ground the research study in an everyday life experience (Campbell & Gregor, 2002). This problematic reflects a subjective experience fraught with real-life institutional and organizational interdependencies and interconnections that provide a guideline for a systematic approach to data collection and data analysis.

4.6.2 Reflexivity

Reflexivity is a method wherein the investigator acknowledges her/his personal and theoretical stance (Schram, 2003). This is done as a means of orienting the research study and making explicit the investigator's personal values and assumptions by laying bare issues that often become concealed within the research process, including the investigator's previous experience with the phenomenon under investigation. The aim is to highlight, for the investigator, areas wherein she/he must be rigorous.

4.6.3 Audit Trail

Tracing the development of the research study provides an audit trail and enables accurate reconstruction of the study (Grbich, 1999). The investigator keeps a detailed logbook, which contains the notes on the formation of the research question, entry into the field, starts and stops in the data collection process, crystallization during field work, the analysis process, and final interpretations.

4.6.4 Summary Sessions

Summary sessions, in which emergent analysis is presented to participants, strengthen the face validity of the study. The feedback from informants provides the investigator with verification of the experience from their perspective and informs further analyses (Campbell & Gregor, 2002).

4.6.5 Triangulation

Triangulation refers to the gathering of information from different points (Grbich, 1999), which serve to strengthen the interpretation of the data. This can be done either by employing multiple people to rate the data (as in the case of content analysis) or by obtaining data from multiple sources (as in the case of a naturalistic design). The current study gathered data from multiple sources (field observation, personal interviews, focus groups, and document review) and also involved several members of an advisory committee comprised of professors in Rehabilitation Science and Philosophy at Queen's University. Each advisory member had a different area of expertise: structural analysis, mental health, rehabilitation science, or philosophy. The inclusion of multiple methods and perspectives within the committee ensured that hypotheses and interpretations were considered from multiple perspectives.

4.6.6 Generalizability

The current study presents a means to think about the organizing structures that impact community integration practice of ACT. The present study does not propose to make generalizable claims about the activities of ACT teams. Rather, the purpose of the study is to trace the everyday activities of individuals functioning across program sites to organizing structures, thus, exposing common structural elements which come to shape the activities of individual practitioners across ACT teams. The findings of the study are generalizable to the extent that similar structures shape practice in a generally consistent pattern across sites.

In discussing the nature of generalizability as it applies to qualitative research, Schram (2003) states:

The complexity we seek to uncover as qualitative inquirers is understood by attending to the particular (and unpredictable) nature of events or cases, rather than to their general character and overall distribution. Depth, richness, and detail provide the basis for a qualitative account's claim to relevance in some broader context (p. 97).

4.7 *Role of the Researcher*

Schram (2003) describes the qualitative investigator as a primary research tool in that the success of the data collection and analysis is determined by her/his skills and experience. The presence of the investigator is “manifested through talking, listening, looking, reading, and reflecting in greater or lesser degrees of engagement with study participants, filters and affects what counts as meaningful knowledge for [the] inquiry” (Schram, 2003, p. 8). In the current study, the investigator chose to enact an observational role as opposed to a participatory one. The investigator accompanied staff in their activities and asked them (through informal and formal interviews) to reflect upon these activities both prior to, and after the fact. The investigator's perspective and subjective lens is examined in the values and assumptions section.

4.7.1 *Ethics*

Schram (2003) suggests that ethical considerations in qualitative research form an important and unique role:

Ethical considerations are inseparable from your interactions with study participation in the field. Although ethical decisions are certainly not peculiar to qualitative inquiry, the negotiated and heavily contextualized nature of ethical dilemmas is a defining characteristic of qualitative fieldwork (p. 100).

Schram goes on to state that there are three key considerations in establishing the trustworthiness of a qualitative inquiry from an ethical standpoint: posturing and role presentation, disclosure and exchange, and making public the private.

4.7.2 Posturing and Role Presentation

Posturing and role presentation refer to the ability of the investigator to make explicit her/his role as a participant observer. Schram (2003) postulates:

The dual responsibility as a researcher – to engage (walk together) with others while remaining faithful to the primary aim of conducting research – is a pairing of intentions separate from participants' everyday lives, although [the investigator] hope[s] participants will understand and support [her/his] efforts (p. 101).

To develop a rapport with informants the investigator must first ensure that she/he is transparent about this role. In the current study, the investigator took opportunities both at the outset and at the completion of each data collection phase to discuss the purpose and emerging insights of the study with team members. Likewise, the investigator was available to answer any questions regarding the study from individual staff members throughout the study.

4.7.3 Disclosure and Exchange

Schram (2003) states that, “tensions and dilemmas naturally emerge from the effort required to balance the level of shared knowledge necessary to establish rapport and the sense of responsibility that accompanies earned trust” (p. 103). In an effort to gain participants' trust²⁸, the investigator made a conscious effort to be transparent about the research process. For example, meetings were held with participants at the end of each data collection phase. This activity enabled a forum for the shared exchange of knowledge between the investigator and participants regarding the intent of the study and

²⁸ It should be noted that trust refers to the trust that a subject has in the experience, expertise and ethical conduct of the investigator. The term does not refer to an assumption that the investigator will interpret the data in accordance with the wishes of an individual subject.

also enabled participants to voice alternative perspectives regarding the emerging analysis.

4.7.4 *Making Public the Private*

Schram (2003, p. 104) describes the concept of making public the private thus:

With the access that participants grant you to trusted and privileged information and observations of unguarded behaviour come the concerns about what you should disclose, at what cost, and for what audiences. Anticipation of this responsibility should inform every step [the investigator] takes toward and within the field.

Occasionally an informant, after participating in a formal or informal interview, would express concerns about the information they had provided. Although informants reported that they felt comfortable discussing tensions in their everyday work lives with the investigator, there was sometimes a need for additional reassurance that their words would not be identifiable by co-workers and program managers. In these instances, the investigator reminded the individual that the information they had provided was confidential and that they need not feel vulnerable to any negative recourse linked to their statements.

4.8 Organizing the Analysis

Chapters 5 through 9 present the findings of the current study. The findings have been organized according to the various stages involved in tracing the tensions experienced in the course of carrying out everyday community integration practice to obscure organizing structures. The level of analysis builds incrementally from the first to the last chapter. The ultimate intention is to trace how experiences of bifurcated consciousness on the part of individual practitioners can be accounted for by the presence

of powerful organizing structures, communicated through texts, which orchestrate social relations and play out in particular ways. Only through purposeful acts of agency are individuals able to counteract the influences of organizing structures in their day-to-day activities. As the method of institutional ethnography is grounded ultimately in the personal tensions of individuals, the first analysis chapter begins with the identification and explication of personal tensions described by ACT practitioners in the course of carrying out community integration practice. These tensions are then traced to organizing structures through key texts (Chapter 6), social relations (Chapter 7) and individual agency (Chapter 8). Finally, the key factors involved in the systematic overruling of community integration practice are explored (Chapter 9). The reason for choosing this framework is to provide an organizing model for tracing the rather complex path from ruling structures to everyday activity. Data is presented in the form of quotes, and italicized when embedded within the text.

CHAPTER 5: TENSIONS

Issues [and directions] are formulated because they are administratively relevant, not because they are significant first in the experience of those who live them (Smith, 1990, p. 15).

5.1 Background and Chapter Overview

Smith (1987, 1990, 1996, 2006) asserts that individuals experience states of bifurcated consciousness when they become aware of conflicts within the course of carrying out everyday activities. These conflicts stem from structured, legitimated, and approved ways of carrying out activities that contrast with personal (and professional) values and beliefs. The nature of organizing structures is such that their influence on the everyday world is often obscured, causing individuals, organizations, and societies to downplay their role in determining patterns of everyday life. Thus, ensuring that one's activities reflect one's values requires that the imprint of organizing structures on everyday tasks be explored and explicated (Smith, 2006). It is through the heightened awareness derived from such explication that individuals build the capacity to better align their everyday activities with their values (Smith, 2006).

The current chapter explores instances of bifurcated consciousness as experienced by ACT practitioners within the course of carrying out community integration practice. Tracing the ways in which organizing structures silently, yet powerfully, overrule the values associated with community integration practice will better enable practitioners, organizations, and society to resolve conflicts between community integration values and the organizing structures that shape practice. This first section of the analysis is concerned with identifying and explicating actual experiences of tension (or bifurcated

consciousness) that will be traced, in subsequent chapters, to the content contained in official texts, patterns of social relation and demonstrations of agency.

5.2 Analysis

5.2.1 *Bifurcation of Role*

The following quote exemplifies the way in which daily activities become prioritized by structures that exist outside of the practitioner's sphere of control. The potential conflict between the activities with which a practitioner is tasked and the perception of herself/himself as a facilitator of community integration is also revealed:

It's interesting because I am in the [vocational specialist] role, but [practitioners in] other roles have certainly said the same thing as me, that they don't feel like they're doing their job. You know, they don't feel that they get enough time to actually focus on what it is they're supposed to be doing. So, that's my...biggest frustration is that uh, it um, it's very hard to, you know, to perform the role plus the generic part. The biggest frustrations are the expectations. We have educational sessions to learn about other perspectives and to clearly define what your role is, and again the bottom line [for vocational specialists] is how many people are working, you know, and it's like well there is a lot more to it than that, you know. You spend a lot of other time doing, you know, vocational support things with people, but the bottom line is how many people are working.

The source of the tension is directly related to time allotted to focus on higher-order integration activities such as vocation. Personal frustration arises from the lack of time available to carry out the primary activities associated with the vocational specialist role due to the balancing of what appear to be competing priorities. It seems that the distribution of time is somehow orchestrated external to the intentions of the individual which creates an unintended tendency to prioritize activities other than those associated with this individual's specialty area. Hence, the lack of time devoted to the specialist role does not appear to reflect a lack of training or interest on the part of the practitioner, but rather a set of rules and regulations that organize time and resources in a particular

manner. The practitioner feels compelled to abide by this set of rules despite the personal perception that they constrain her/his ability to carry out her/his job. Importantly, it is largely within the specialist role, in which higher-order aspects of integration receive attention. Thus, the lack of time available to devote to the specialist role may inhibit a focus on higher-order integration. The practitioner perceives that this is a common, or shared, experience across professions. Likewise, the criteria used to assess the effectiveness of these activities pose an associated tension. The criteria by which vocational success is evaluated do not take into account many of the initial steps that occur long before an individual is successful in obtaining a paid work position. Many of these initial steps (writing a resumé, approaching potential employers, attending job interviews) are integral to integration yet are not accounted for in the everyday work of a vocational specialist. It can be concluded that the common measures used to evaluate the work and contribution of vocational specialists (and potentially other specialists on the team) are not sensitive to the incremental nature of promoting higher-order integration activities. Instead the evaluation focus is related to socially and individually defined measures of integration. For example, vocation is measured and success is garnered according to how many people are working - not how many feel more comfortable looking for work, how long vocation is sustained, or how many work places offer adequate and sustainable support for individuals with mental illness. The tension arises when an individual practitioner's training and understanding of her/his role are not what drives the everyday activities in which she/he engages. Material conditions such as evaluation will actually be a more powerful influence on the type of activities in which they are engaged.

The tensions relayed by this practitioner raise several key questions concerning the organization of community integration practice. For example, why would a vocational specialist be limited in the time available to facilitate vocational integration? Why would vocational functioning be measured in ways that fail to capture what vocational specialists perceive to be meaningful initial steps? What are the generalist activities that consume so much time? The tensions expressed by this practitioner suggest that the organizing structure of ACT may be rooted somewhere other than in integration.

5.2.2 Facilitating Social and Economic Stability

A key factor at all levels of integration, including the most basic, is the extent to which service users are able to exercise choice. Practitioners experience tensions when they desire to facilitate service user choice but feel compelled to overrule these choices to encourage health, social, and economic stability. The organizing structures of ACT shape community integration practice in a way that places the responsibility for health, social, and economic security on the shoulders of practitioners to a greater extent than service users or the community at large. A primary indicator of the expectation that ACT practitioners will function in this way is the vetting of Community Treatment Orders²⁹

²⁹ A Community Treatment Order (CTO) is an order by a doctor for a person to receive treatment and supervision in the community given when an individual is determined to be cognitively unstable and likely to be at risk of harming themselves or others. The care plan outlines the medications, medical appointments and other aspects of care the doctor believes are necessary to allow the person to live in the community rather than hospital. If at any point the doctor believes that the person is not compliant with the care plan, the doctor may issue an "order for examination" (Form 47), which authorizes the police to bring the person to him/her for an assessment. After the assessment the doctor can issue a new CTO, detain the person in a psychiatric facility for an assessment or release him/her (Psychiatric Patient Advocate Office www.ppao.gov.on.ca).

through the ACT programs. The following passage demonstrates how the concept of service user choice becomes re-shaped within the context of Community Treatment

Orders:

Observation: During the drive to a supported employment program, the nurse with whom I was traveling discussed an experience which involved limiting the personal choice of service users. Nurses are responsible for giving medication injections – particularly for those service users who have been placed on Community Treatment Orders. The nurse offered that in these situations “it doesn’t feel good to give [enforced injections] because [service users] don’t like to get [injections] – it takes away their choice.” The practitioner went on to relay a story of once spending 2 hours trying to *convince* a service user to agree to a medication injection. Eventually the individual did agree. The nurse concluded that, “in the end it’s not that much different from giving an injection to someone against their will but, if you don’t do it [the service user] is going to go to the hospital and have it done there anyway, you feel stuck.” It is important to note that the use of injections is becoming more frequent with increased use of Community Treatment Orders.

When responsibility is placed upon practitioners for overseeing the choices of service users, as in the case of Community Treatment Orders, it becomes difficult for them to reconcile their role as facilitators of service user choice. Being in the position of having to force a service user to accept medication is an anomaly for ACT practitioners. ACT literature promotes respect for the choices made by service users with regard to medication usage. The above scenario portrays a practitioner attempting to convince a service user to agree to a medication injection. The practitioner feels the need to convince the service user to agree to the injection because she/he personally is experiencing a conflict between her/his everyday job responsibilities and her/his personal and professional values related to promoting service user choice. The question must be asked: Why does a required aspect of one’s job contradict the most basic principle of integration practice? The tension seems to point to the ways in which the prioritization of

psychiatric stability overrules the extent to which service users are able to exercise personal choice.

Importantly, despite acknowledging conflicted feelings, the practitioner does not refuse to carry out the activity. Rather, the legitimacy of giving what could be construed as an involuntary medication injection is rationalized in relation to further consequences that would potentially be imposed by the system. The medication injection is rationalized as being in the best interest of the service user--a preferable alternative to forced hospitalization. The tension experienced by this practitioner is expressed in the fact that the practitioner opts to spend an additional amount of time and energy to convince the service user rather than force her/him to take the medication. This is done primarily to create less tension between practice and intention for the practitioner (one wonders if there is really a difference on the part of the service user). Rationalizing that the person is “better off” because they would otherwise be placed in hospital is a further attempt to minimize this difference.

5.2.3 Facilitating Social Inclusion

Key aspects of the organizing structures that guide the everyday activities of ACT practitioners appear to be based on assumptions of illness that juxtapose the concept of social inclusion. The underlying concern experienced by the psychiatrist in the following quote exposes the assumptions of illness and wellness upon which the organizing structures of ACT are formed.

[I don't believe in saying] well get back in and fail again, get fired again, get sick again, get stressed again, lose it again, go through more losses. Just what can you do in your life. I say job one is staying well, taking medication, taking care of yourself, living as healthy as you can, having friendships and relationships, um,

kind of like retirement, you know, living like you are older, you are retired now. It's validation, its like you are retired from that, and um, you now you're doing, you're volunteering here like a retired person, you're living like a retired person. So I, you know, really try not to put that pressure on them to be productive – it stresses that they are not good enough as they are.

The quote alludes to both professional and societal perceptions that participation can exacerbate psychiatric symptoms and that promotion of participation may provoke illness. The tension here is that the practitioner feels a professional responsibility to wellness, which is defined as cognitive, behavioural, and social stability. Thus, the responsibility is not integration unless the stability of these elements is not jeopardized. One way to rationalize the discrepancy between promoting participation and protecting wellness is to promote a conceptualization of mentally ill people as retired. In this way the lack of promotion of participation is justified while the actual fear associated with promoting participation (cognitive, behavioural, social instability) is obscured. A few questions arise: Why is ACT a vehicle for community integration, based on an assumption that participation is incompatible with mental wellness? How will practitioners facilitate access to social goods, education, and productivity if participation is viewed as a threat to wellness? Within the context of community integration theory, participation is viewed as a means to wellness for both individuals as well as the greater society. If aspects of the organizing structure are based on an assumption that the promotion of participation is antithetical to psychiatric stability, practitioners will struggle with ambiguous messages regarding their role in facilitating social inclusion.

5.2.4 Facilitating Social Cohesion

Organizing structures promote the protection of service users in ways that constrain efforts to facilitate shared responsibility between those with and without mental illness:

We hold onto the money of some clients who in the past have spent all of their money on cigarettes and other things and haven't had the money to pay their rent at the end of the month. I think [holding the money] has been valuable, but at the same time I think you know, it's their money, and is this really our job? And they could go get their own bank account but then the trustees are depositing money three times a week, so the client goes with his bank card where they have to pay 5 dollars a month to have a bank account and pay a dollar each time they withdraw money. So this way we absorb the cost of the bank account and we withdraw the money and deposit the money, I think clients really like it. There are some clients who we've said, you know, who have the skills to be doing this themselves and so we've helped them get bank accounts.

This account suggests the presence of societal barriers (e.g., monthly fee for owning a bank account) that make it difficult for service users to access pertinent community resources on their own. A common way in which ACT teams address these barriers is to open a bank account on behalf of the service user and in some cases to keep the money and apportion it out. The tension expressed here is of a practitioner who is limited in her/his ability to work with the system to make accessible, independent bank accounts, for individuals with severe mental illness. Instead the rules possessed by banking institutions force ACT teams to assume responsibility for service fees and as a result become the governors of their clients' money. Such a practice unfortunately further isolates individuals with severe mental illness from enacting economic influence within their own lives and in their communities.

The organizing structures that exist at both organizational and societal levels encourage ACT practitioners to absorb responsibility for the social and economic

inequities experienced by service users. Such an approach compels the service user to become dependent upon mental health practitioners and the mental health system. Why is the ACT objective to abide by existing social structures that serve to separate service users from mainstream society rather than to work with society to eliminate these barriers? By taking responsibility for the social and economic gap that exists between service users and mainstream society, ACT practitioners aid in helping to obscure and displace the responsibility of society to organize itself in a way that does not marginalize those individuals with little income. Individual practitioners are then left with tensions, which stem from the discrepancy between their professional values associated with promoting autonomy and what is perceived as an unavoidable requirement to oversee the finances of individuals with severe mental illness.

5.2.5 Facilitating Social Empowerment

The following quote taken from a conversation with a mental health worker illustrates how organizing structures limit the ability of practitioners to foster social, economic, and political influence for service users:

You might have like 10 people using one [community] agency, right, and you've got one client that, in particular is causing a lot of distress, and then you're weighing, you know, you'd like to advocate for that particular client, but it's not worth jeopardizing the relationship [with the landlord] for all of the other 10. And so sometimes we don't advocate enough for that one client because it's not worth it. Like, you have to keep peace in the community, you have to keep partnerships going, relationships going, and you know, the greater good is served for the greater number if you don't advocate for that one client, or you become authoritarian about [that] one client, say enough is enough, you can't, you know what I mean?

Because individuals with mental illness are often not considered by landlords to be ideal tenants, and because affordable housing for this population is difficult to obtain, this

practitioner fears that advocating for the service user may impact future opportunities to find housing for other service users. In other words, advocating for the rights of one service user is discouraged so that others are not turned away from this service. In this case the legal rights of landlords and the limited availability of social resources impinge upon the social, economic, and political influence of this particular individual. The systematic overruling by society of the rights of individuals with severe mental illness results in situations wherein practitioners themselves feel as though their hands are tied in terms of advocacy. They may fear that such advocacy may result in increased oppression for greater numbers of individuals with severe mental illness. Thus, the allocation of legal rights and related distribution of community resources influences how practitioners facilitate social empowerment for the population of individuals with mental illness. This begs the question: Why are ACT practitioners limited in their ability to impact the social environment in which service users seek to be integrated? The distribution of societal resources is such that ACT practitioners are placed in a defensive position, working to preserve relations with, and rely on, the generosity of community members, rather than working to foster the social influence of service users. One wonders to what extent practitioners are supported in efforts to inform the social conscience that holds at bay the influence of those with mental illness.

5.3 Analysis Summary

This chapter identifies disconnects occurring between how practitioners carry out their day-to-day activities and community integration values. Tensions surface in three primary areas: (a) what practitioners are accountable for, (b) the distribution of time in accordance to generalist and specialist roles, and (c) how the concepts of service user

choice, participation, responsibility, and population well-being become reconfigured in ways that limit the ability of practitioners to facilitate elements of higher-order integration. These tensions are clearly related to organizing structures existing at social, systemic and organizational levels, which serve to overrule the community integration practice of practitioners. Chapter 5 examines how these organizing structures are established and communicated through powerful organizing texts.

CHAPTER SIX: TEXTUAL CONSTRUCTIONS

What we have, think, know and understand today was not inevitable but, because of the way our [knowledge] is ordered, we have very little chance of either understanding that things could have been different, or of speaking differently about them (Danaher, Schirato, & Webb, 2000, p. 21).

6.1 Background and Chapter Overview

Texts confer upon individuals common ways of thinking about and carrying out everyday activities. Texts also reflect specific worldviews (ideology) and are the primary tools through which these ideals are translated into everyday life. In this way, texts are themselves organizing structures. The close examination of texts, then, enables the investigator to identify the ideas around which everyday activities are organized. Campbell and Gregor (2002) suggest that the most influential texts will be reflected in the language used by individuals to describe what they do. The everyday talk engaged in by ACT practitioners reveals two key organizing texts. The first, a book entitled Assertive Community Treatment of Persons with Severe Mental Illness, is co-written by Leonard I. Stein³⁰ and Alberto B. Santos (1998). According to the authors, this text was written “so that those interested in operating an ACT program could do so by using this book as a manual; sufficient specific information is presented to start an ACT program from scratch (including necessary paperwork)” (Stein & Santos, 1998, p. 3). The second is the Ontario Program Standards for ACT Teams (OPS-ACT), published by the Ontario Ministry of Health and Long-Term Care (2004). This text is important precisely because Ontario ACT teams are bound to these practice standards for funding and accreditation purposes. What follows is an examination of how these texts reflect particular ideological values

and assumptions that systematically shape the community integration practice of ACT practitioners.

6.2 Analysis

6.2.1 Assertive Community Treatment of Persons with Severe Mental Illness

In their manual, Stein and Santos (1998) suggest that, “*the goal of service for persons with severe and persistent mental illness is for that person to achieve a stable life of decent quality and to become involved in activities that promote meaningful community living*” (p.1). The authors specifically state that, “*a major goal of Assertive Community Treatment (ACT) is to help persons with mental disabilities become integrated into their communities*” (p.5). These statements highlight community integration as a primary focus of ACT work and also hint at certain assumptions regarding the nature of this integration. The use of the terms “stable life” and “decent quality”, for instance, set in place a direction for how community integration will be approached in everyday practice scenarios.

The remainder of the manual describes the roles, responsibilities, and service activities that comprise ACT services. This description is significant in that it explicates the organizing structures that shape community integration practice.

The manual begins by outlining the purpose of the continuous care team:

ACT teams are best conceptualized as continuous care teams, that is, vehicles to provide whatever service or practical need a client requires. Services to address these needs fall into three broad categories: treatment, rehabilitation, and case management [practical help and support]. By being the provider of most of these services (brokering for only a few), the continuous care team assures that the

³⁰ L. Stein was a co-founder of the ACT model with M. Test and A. Marx.

services are integrated and provided in the context of the client's current needs, with all activities directed toward helping the client make a stable life of decent quality in the community. Unfortunately, a high percentage of people with serious and persistent mental illness also suffer from substance abuse. This dually diagnosed group is best served when the substance abuse problem and the mental health problem are both addressed by the ACT team, rather than requesting another agency to deal with the drug problem. This same principle holds true for rehabilitation. A safe generalization is, whatever the intervention, it will be more effective if it can be provided as an integrated part of the entire ACT program. In sum, then, the continuous care strategy is comprised of three primary strategies: a broad focus on any and all factors impacting an individual's stability in the community; b) providing a fixed point of responsibility for service delivery; and c) acting as a liaison between client and externally-based services (p. 71).

The description of the continuous care team sets a standard direction for how community integration practice will be conceptualized, carried out, and accounted for on an everyday basis. Continuous care is conceptualized as an integrated service delivery model comprised of three distinct components: treatment, rehabilitation, and practical (or generic) support. Treatment refers to interventions implemented to address the symptoms associated with mental illness. Rehabilitation, on the other hand, refers to interventions that address social functioning. Finally, support encompasses interventions that stabilize and maintain a basic level of social welfare. The focus on treatment, rehabilitation, and support services suggests that the activities of ACT practitioners will be concerned with increasing the psychiatric stability and social capacity of service users as a means to achieving integration. It seems that the integration activities of ACT practitioners are not aimed at building the capacity of society to better accommodate individuals with severe mental illness, as would be indicative of a model that sought to enhance social inclusion, cohesion, and empowerment as well as social and economic security.

In establishing a fixed point of responsibility, the ACT team assumes the responsibility for ensuring the delivery of all services and, in turn, limiting linkage to outside services and supports. In fact, the manual draws a correlation between fewer linkages and effective service delivery. What does this say about the view of integration underlying ACT activities? Were the purpose of integration to create equitable social opportunities, one would expect to see an emphasis on linkage and a shift in the role of the practitioner from one of expert to one of facilitator. However, if the purpose of integration is to better enable individuals with mental illness to emulate normal social behaviours, one might expect to see roles designed similar to that of the continuous care team. In this way, practitioners function as experts and linkages with the community are discouraged until service users are deemed ready for integration. In fact, the use of the terms “stable,” “decent,” and “quality” strongly suggest that normalization is the primary assumption underlying the activities of the continuous care team. This is in contrast to the psychiatric survivor and self-help models. In terms of community integration practice, then, activities that do not result in “normalized” integration may be interpreted as a failure on the part of the practitioner.

What are the potential impacts of this organizing structure on integration practice for individuals with severe mental illness? First, the approach to integration focuses on minimizing the differences between service users and the typical behaviours elicited by members of mainstream society, rather than building the capacity of society to support behavioural diversity. Second, by discouraging external linkages, practitioners are encouraged to accept primary responsibility for the integration of service users, rather than feeling as though they share this responsibility with service users and the community

at large. Third, by linking integration success with concepts of normalization, practitioners inadvertently become gatekeepers for upholding current social standards.

The manual goes on to outline nine core principles associated with the role of the ACT practitioner. These principles include:

- a) capitalizing on client strengths;
 - b) eliciting client feelings and attitudes toward treatment plans;
 - c) tailoring programming to individual needs;
 - d) locating services in the settings in which clients live, work, and socialize;
 - e) relating to clients as responsible citizens;
 - f) utilizing an assertive treatment approach;
 - g) emphasizing clinical assessment; and
 - h) assuming primary responsibility for providing services to meet all client needs
- (Stein & Santos, 1998, p. 71).

These principles highlight, more specifically, the values associated with the continuous care model and are presented as characteristics of practitioner interactions with service users. The principles focus service delivery practices on treating symptoms associated with mental illness (treatment plans, emphasizing clinical assessment) and at the same time, suggest a commitment to maximizing client input (eliciting client feelings and attitudes toward treatment plans), participation (locating services in settings where clients live, work, and socialize), and empowerment (relate to clients as responsible citizens). How will practitioners facilitate input from clients that holds the potential to jeopardize psychiatric stability? More importantly, how does the focus on the individual balance with the need to influence the equitable distribution of resources within society? For example, how does the focus on individual aspects of integration lay the groundwork for socially initiated integration? These questions inevitably form the crux of the tensions examined in the previous chapter. Certainly, these tensions suggest the conceptualization of integration as a health care issue results in a model of integration organized around the

clinical status of individuals. In turn, the extent to which practitioners are able to shape an environment in which individuals with mental illness participate on an equal platform is significantly impaired.

Why is it that a model designed to bring about a new approach to service delivery is limited in the extent to which it promotes a socially-based conceptualization of integration? The following is an excerpt from the Stein and Santos manual, which describes the political and social environment in which the ACT model emerged and fought for sustenance:

In the mid 1960's, the new director, Dr. Arnold Ludwig, was an energetic, creative researcher who was also a skillful administrator. He was successful in getting the hospital to dedicate an entire ward, with a full complement of staff, to research activities. He formed a special treatment unit (STU), a research unit whose primary purpose was to evaluate various psychosocial techniques for the modification of behavior and the rehabilitation of persons with chronic schizophrenia. . . . The operation of the STU was consistent with the traditions, philosophy, and operation of the hospital. The innovations were carried out in an inpatient setting; the roles of the various professional and paraprofessional groups working on the STU were the same as those on the service units. In essence, the innovations were going with the current and thus received the support of the institution. . . . Dr.'s Ludwig, Marx, and Test decided to change the focus of the research from activities in an inpatient setting designed to prepare patients to live in the community to activities in an outpatient setting designed to help patients make a sustained adjustment to community life. . . . From the hospital's point of view, this innovation differed from prior research, in that its operations were not congruent with the customary traditions, philosophy, and practice of the hospital. Thus, rather than going with the current, it was going against the current. This resulted in a change in how the hospital administration related to the research enterprise. Instead of supporting and nurturing the research effort, as it did when the research was carried out in an inpatient setting, the administration was now erecting barriers. Some examples of the administration's concerns were: justification for training time, transportation and liability, who will be watching the aides, can you eat lunch and not have it count as your lunch hour?. . . The administration attempted to deal with [these issues] by putting up enough barriers to influence the innovation that would be more consistent with the institution. . . . Through the researchers' persistence, negotiation efforts, and good will, the administration finally okayed a period of time for staff training and allocated money for the needed transportation (p. 15 - 18).

The movement toward community living was spurred by new advances in psychotropic medications which facilitated greater control over psychiatric symptoms and thus behaviour (Bachrach, 1988). Concurrently, new investigations suggested the positive impact of psychosocial interventions (social, recreational, and vocational participation) on perceptions of mental health and quality of life. The intent of the ACT model was to transfer the focus of service delivery from in-patient psychiatric care to community integration. The objective was both to maintain community living for individuals with severe mental illness and to prevent re-hospitalization. However, despite these intended directions, the model has continually been criticized for the lack of outcomes associated with higher-order aspects of integration, even at the level of the individual (e.g., low number of service users participating in vocational, social, and educational activities). The above excerpt is helpful in providing insight into the ways in which the founders of the model were constrained in structuring services according to new goals and ideals. These constraints offer some explanation as to the current structure of ACT and why it, too, creates barriers for practitioners attempting to carry out community integration practice.

ACT originated and grew under the umbrella of a hospital structure that organized resources, people, and activities for the purpose of supporting inpatient living. Within this setting, interventions were primarily pharmacologic in nature and were implemented for the purpose of stabilizing behaviours. Consequently, the support required to initialize and sustain the ACT model came at a cost. The authors allude to compromises and negotiations that occurred in relation to physical structures, staffing and accountability criteria. These compromises may account for the fact that certain basic assumptions

are consistent between the two approaches. For instance, the approach to intervention remains focused on the individual and her/his illness. Likewise, treatment is considered the primary aspect of service delivery. It can certainly be argued that the need to appease hospital administrators in order to access resources resulted in compromises to the organizing structure of ACT. These compromises led to the development of a parallel structure that continued to uphold many of the assumptions, values, and approaches consistent with psychiatric inpatient care. This would account for the resistance in placing integration at the forefront of service delivery efforts. In fact, any new changes brought about by the ACT structure merely extend the scope of treatment to include social as well as cognitive functioning, but do not actually shift the focus of intervention from one of treatment to one of integration. Had ACT been formed within a different environment, it is conceivable that it might have been based on different assumptions. For example, the model might have been viewed as a social intervention rather than a health intervention with embedded service delivery components that focused on community development. Such an approach, however, would not have been supported within the context of the inpatient hospital from which the founders sought tangible support. As it was, ACT was born with a fundamental conflict: community integration as a health care intervention.

6.2.2 Ontario Program Standards for Assertive Community Treatment Teams

The following is the introductory statement from the most recent Ontario Program Standards of Assertive Community Treatment Teams (OPS-ACT) (Ontario Ministry of Health and Long Term Care, 2004):

Assertive Community Treatment (ACT) is a client-centered, recovery-oriented mental health service delivery model that has received substantial empirical support for facilitating community living, psychosocial rehabilitation, and recovery for persons who have the most serious mental illnesses, have severe symptoms and impairments, and have not benefited from traditional out-patient programs (p. 4).

This description of the ACT model (OPS-ACT, 2004) includes new terms not present in the original description as described in Stein and Santos (1998). Although the term integration is not used specifically to describe the goal of ACT the desired outcomes associated with the model suggest a strong intention toward the facilitation of community living, and fostering meaningful social participation. Psychosocial rehabilitation, recovery, and recovery-oriented services are terms that reflect emergent approaches within the community mental health field. As discussed in Chapter 3, these terms reflect ideologies that emphasize the values associated with individual-level autonomy, participation, and empowerment. These terms have particular implications for how current ACT practitioners interpret their role as facilitators of community integration. A distinctive change from the emphasis on symptom stabilization, it is possible to conclude that these terms were included to emphasize the commitment to higher-order aspects of integration in light of critiques related to the ACT model. Despite the use of these terms, however, the structure presented in the Ontario Ministry of Health and Long-Term Care standards remains relatively unchanged from that of the original model outlined in the Stein and Santos manual. Hence, the everyday practice of ACT practitioners continues, in large part, to be driven by the same conceptualizations of integration that were in use prior to the recent iteration of the standards. The remainder of this section examines key sections of the OPS-ACT in support of this argument.

6.2.2.a ACT Services

The integration of treatment, rehabilitation, and support services is presented in the current guidelines as a formula for facilitating “*community living, psychosocial rehabilitation, and recovery*” (p. 6) for ACT service users:

It is important to ensure that the team can provide a balance of treatment, rehabilitation and support services. Services include: service co-ordination; crisis assessment and intervention; symptom assessment and management; individual counseling and psychotherapy; medication prescription, administration, monitoring and documentation; substance abuse treatment; work-related services; activities of daily living services; social, interpersonal relationship and leisure-time activity services; support services or direct assistance to ensure that clients obtain the basic necessities of daily life; and education, support, and consultation to clients’ families and other major supports (p. 11).

Despite the statement that there must be a balance between treatment, rehabilitation, and support services, this description reflects a hierarchical approach to service delivery practice. Services that involve crisis assessment and intervention, and symptom assessment and management, are located at the top of the list, while those related to social participation, including vocational, social, recreational, and interpersonal functioning are located at the bottom of the list. In fact, it could be interpreted that this hierarchy also reflects an assumption that treatment, rehabilitation, and support services will be provided in a linear fashion, with treatment being addressed prior to rehabilitation and support needs. This is similar to the disordered-person model proposed by Davidson and Strauss (1995). In this model social participation is organized as an accompaniment to the primary task of stabilizing psychiatric illness. Consequently, ACT practitioners carry out everyday practice routines within an environment which considers social participation to be extraneous to treatment needs. If, as suggested in the opening paragraph, the use of the terms ‘PSR’ and ‘recovery’ are the primary ideologies guiding current ACT services, one would expect to see greater emphasis on the role of social

participation and environmental change in promoting wellness. This would be more in keeping with the life context model proposed by Davidson and Strauss (1995). In fact, one would also expect to see new activities included in the guidelines to further promote these new ideals. Such activities might include developing the leadership capacity of service users, performing community assessments and linking with community agencies. Likewise, one might expect to see a reversal of the hierarchical approach presented in earlier structures of the model, in which activities targeting higher-order integration are prioritized and treatment and stabilization activities are placed in a supporting role.

6.2.2b Required Staff

The OPS-ACT (p. 11) presents a description of the minimum professional complement required for urban/full size ACT teams: Team Coordinator (1 FTE), Registered Nurse (3 FTE), Social Worker (1 FTE), Occupational Therapist (1 FTE), Substance Abuse Specialist (1 FTE), Vocational Specialist (1 FTE), Peer Specialist (1 FTE), Other Clinical Staff (2 FTE): Total Multi-disciplinary Clinical Staff, excluding psychiatrist and program assistant, (11 FTE), and Psychiatrist, (0.8 FTE). The inclusion of a broad disciplinary complement is intended to ensure a comprehensive (treatment, rehabilitation, and support) approach to service delivery, which according to the standards, limits the requirement for linking externally. The result is a combination of disciplines, which cut across treatment (psychiatry, nursing, substance abuse specialist), rehabilitation (social work, occupational therapy, vocational rehabilitation) and recovery (peer specialist) philosophies, and specializations. Interestingly, the psychiatrist has been

removed from the team roster (to serve as a consultant to the team). This has possibly been done in response to criticisms that the model is too treatment-oriented.

The guidelines go on to further define individual positions according to professional and non-professional status:

Mental health professionals have: 1) professional degrees in one of the core mental health disciplines; 2) clinical training including internships and other supervised practical experiences in a clinical or rehabilitation setting; and 3) clinical work experience with persons with serious mental illness. They are licensed or certified to practice in Ontario, are regulated under provincial legislation and/or their professional colleges and operate under the code of ethics of their profession. Mental health professionals include persons with master's or doctoral degrees in nursing, social work, rehabilitation counseling, or psychology; diploma and bachelor's degree/level nurses (i.e., registered nurse); registered occupational therapists; and registered/bachelor's level social workers.

Among the clinical staff on an urban/full size team, there is a minimum requirement of 8 FTE mental health professionals. . . . The team coordinator, registered nurses, social worker, occupational therapist, and vocational specialist must be mental health professionals as defined above.

The other clinical staff may be bachelor's level and paraprofessional mental health workers who carry out rehabilitation and clinical support functions. A bachelor's level mental health worker has a bachelor's degree in a behavioural science (other than social work) and work experience with adults with serious mental illness or with individuals with similar human services needs. These paraprofessionals may have related training (e.g., substance abuse worker, social services worker, certified occupational therapy assistant, home health care aide) or work experience (e.g., teaching) and life experience (p.12).

The above description incorporates important terms used to denote differences amongst staff. The terms generalist, specialist, professional, and other clinical staff, stand out in particular. The term generalist is never defined; thus, it is appropriate to apply the dictionary definition: "a person whose knowledge, aptitudes, and skills are applied to a field as a whole or to a variety of different fields (opposed to specialist)" (www.dictionary.com). The generalist role may be interpreted as including common activities, which occur on a frequent basis and may be carried out by all members of the team. The term specialist is used to indicate a particular "specific training and

experience” which enables the person holding this designation to “contribute leadership and expertise” related to their “specialist area.” This leadership is provided to service users in the form of direct service as well as to other team members in the form of education and support. Many roles appear to have a dual generalist and specialist designation; some, however, possess only a generalist designation. For example, nurses, social workers and occupational therapists are generalists while vocational specialists, substance abuse specialists and peer specialists hold specialist designations, yet are also expected to carry out generalist activities. The rationale for designating certain roles as specialist and others as generalist is not clear. The definition of professional roles versus other clinical staff roles relates to the degree of formal training within a mental health discipline. In the case of the peer specialist it is possible to hold a specialist designation but not be designated as professional staff.

Designating certain roles as either “professional staff” or “other clinical staff” implies a hierarchical conceptualization of the various types of knowledge, skill, and experience brought to the table by different members of the team. To be considered “professional staff,” practitioners must possess an advanced university education, and training in a licensed health discipline, as well as clinical training and experience. Practitioners who possess lower levels of education and who are not part of a licensed health discipline, and/or who have been recipients of mental health services, are designated as “other clinical staff.” In total, eight of the positions must be filled by “professional staff”³¹ while three may be filled by “other clinical staff.” A hierarchy exists amongst the three primary elements of practice (treatment, rehabilitation, support)

³¹ Based on the staff requirements for an urban/full-size team.

and thus, among practice disciplines. Consequently, an unbalanced relationship is formed between levels and types of education and personal experience. Ultimately, the heightened requirement for professional staff implies that formal education, in particular education in the health sciences, is of greatest value, whereas education outside of the health services, and personal experience are deemed to be of lesser value. This is reflective of an emphasis on professional knowledge as opposed to the experiential knowledge often highlighted within the recovery approach (Deegan, 1988, 1991, 1996, 1999).

One significant structural change that has occurred since the original iteration of the model is the inclusion of a peer specialist. However, according to the above criteria, individuals who occupy peer specialist positions are not designated as professional staff. This has significant implications for the credibility and value associated with this position. Although the hiring of peer support workers may, on one hand, be promoted as an attempt to move the ACT model in a recovery-oriented direction, in fact, these practitioners are accorded lesser value through lower status. Likewise, practitioners who have been recipients of mental health services and who possess the knowledge and skills to qualify them for a “professional” role (i.e., an occupational therapist or a social worker who have also had experience with the mental health system), may well be disinclined to apply for the position of peer specialist, in turn, diminishing the pool of practitioners representing a recovery approach. Consequently, the division of practitioners into professional and non-professional ideologies according to education, skills, and experience holds the potential for creating a silo effect, wherein professionals from one

group compete with those from other groups for resources and a sense of legitimacy, thus forming a hierarchy of voices that potentially place recovery as a lesser priority.

6.2.2c Staff Roles

The OPS-ACT (p. 13 – 15) outlines the specific roles of the various ACT team members thus:

- *Team Coordinator:* The team coordinator has a master's or bachelor's degree and is a professional regulated under the Regulated Health Professions Act (e.g., nursing, psychology or occupational therapy) or is a regulated social worker.
- *Psychiatrist:* The psychiatrist provides clinical services to all ACT clients; works with the team coordinator to monitor each client's clinical status and response to treatment; supervises staff delivery of services; and directs psychopharmacologic, medical services and other clinical care.
- *Registered Nurses:* On an urban/full size team, a minimum of 3 FTE mental health professional registered nurses are required.
- *Social Worker:* Social workers lead the team in the engagement and partnership with family members of clients and/or their natural supports in the treatment/service planning process and in individual and/or multiple family support and therapy. Social workers may also provide leadership to the team with respect to entitlements, (e.g., financial, housing), advocacy and "working the system".
- *Occupational Therapists:* Occupational therapists act as fully integrated team members functioning in the team's generalist role, and also provide discipline-specific client-centred rehabilitative expertise.
- *Vocational Specialist:* Vocational specialist contribute leadership and expertise to the ACT team in providing vocational program elements within the team and/or in collaboration with other community resources.
- *Substance Abuse Specialist:* The ACT team provides most of the substance abuse treatment services for clients with serious mental illness and co-existing substance abuse disorders. The most effective assessment and treatment approaches employ an integrated treatment model in which mental health and substance abuse treatment are provided simultaneously.

- *Peer Specialist:* Because of life experience with mental illness and mental health services, the peer specialist provides expertise that professional training cannot replicate. Peer specialists are fully integrated team members functioning in the team's generalist role, who also provide highly individualized services and promote client self-determination and decision-making. Peer specialists also provide essential expertise and consultation to the entire team to promote a culture in which each client's point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation, and community self-help activities.

The way in which specialist activities and leadership roles are organized has implications for the conceptualization of community integration within day-to-day practice. The above excerpt indicates that the team coordinator and the psychiatrist supervise the delivery of services. The regulation that the team coordinator position be filled by a mental health professional ensures that peer specialists will be unable to influence the team from a leadership stance, thus decreasing the influence of the peer experience on the community integration practice of other practitioners. By designating the psychiatrist position as a leadership role (particularly in light of the fact that the psychiatrist is not counted as part of the team complement), the team strongly associates itself with the expertise and approach associated with psychiatric treatment. This alignment of roles and responsibilities is in contrast to the objectives espoused at the beginning of the document.

The specification of roles allocates certain positions the responsibility for the assessment and treatment of psychiatric issues. The psychiatrist, for example, "*directs operation of the medication and medical services,*" while nurses are responsible for providing "*medical assessment and services as well as treatment and rehabilitation services*" and substance abuse specialists are described as providing "*most of the substance abuse treatment services for clients with serious mental illness and co-existing*

substance abuse disorders.” Clearly, the role of assessment and treatment (psychiatry, nursing) is highly valued on the team. The psychiatrist role, for example, involves “*clinical supervisory responsibilities for clients and staff.*” In addition to designating a key supervisory role to the psychiatrist, the OPS-ACT also states that

Registered nurses are invaluable on ACT teams because they provide medical assessment and services as well as treatment and rehabilitation services. It is important to have sufficient numbers in order to have nurses to work the majority of shifts. It takes 5 FTE registered nurses to have a nurse on every urban/full size shift. . . . In fact, the failure to pay adequate salaries highly correlates to poor quality staff and high staff turnover in the mental health system (p. 14).

In this excerpt, psychiatrists (through the designation of a supervisory role) and nurses (through the requirement for higher salaries and multiple positions) are singled out as the disciplines most valuable to the ACT model. The explicit promotion of these two disciplines highlights the emphasis placed on psychiatric assessment and treatment. In fact, the description related to the nursing role suggests that filling an ACT team with a minimum of three nurses is tantamount to poor quality service. However, designating psychiatrists and nurses as the primary leaders of the team compromises the degree that other disciplines and thus, approaches, will influence service delivery practice. Of greatest importance is the fact that the role descriptions for psychiatrists and nurses do not include responsibility for promoting community integration. And although the description of the nurses’ role does include the term rehabilitation, it is difficult from the remainder of the description to glean the nature of the rehabilitation activities for which they are responsible within everyday practice. Given the emphasis on PSR and recovery approaches in the outset of the document, it would seem essential that supervisory positions within ACT hold primary responsibility for educating, overseeing, and influencing team members to promote practices in line with these concepts. Yet the

practitioners most likely to be placed in supervisory positions are not explicitly accountable for promoting these philosophies and approaches.

Through the OPS-ACT, occupational therapists, vocational specialists, social workers, and peer specialists are accorded the primary role of facilitating rehabilitation, partnership, and recovery activities. Occupational therapists, for example, are singled out as experts in facilitating meaningful activity; social workers are designated as leaders in engaging and facilitating partnerships with family members as well as building natural supports and providing access to entitlements; vocational specialists are considered experts in vocational program elements within the team and/or in collaboration with other community resources. Peer specialists are touted as recovery facilitators who use their *“essential expertise and consultation . . . to promote a culture in which each client’s point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation, and community self-help activities.”*

The designation of certain disciplines as specialists in community integration and recovery-oriented activities may undermine the extent to which community integration principles become embedded across ACT services. For example, although practitioners are responsible for increasing the capacity of other team members in their respective areas of specialty, only the individual specialist is held accountable for carrying out the actual activities associated with her/his role. An added implication of organizing services in this way is that the responsibility for carrying out community integration activities falls to select team members (those who hold specialist responsibilities) and does not become shared across all team members. The term generalist used throughout this section of the ACT standards suggests a set of basic activities that appear to be separate from specialist

activities. Yet these activities are not specifically defined. Certain members of the team are specifically noted to have generalist duties (occupational therapist, peer support worker) while others are not. Although difficult to interpret given the lack of description around the term, it could be interpreted that the occupational therapy and peer support positions (most noted for their association with PSR and recovery philosophies) are expected to operate primarily at a basic level of integration. It seems obvious that despite their strong integration orientation, attempts by these professions to forward higher-order integration will be eroded.

6.2.2d Comprehensive Assessment and Individualized Treatment/Service Plans

The OPS-ACT stresses that the comprehensive assessment and individualized treatment/service plans must be developed in conjunction with service users. The OPS-ACT states:

The purpose of the entire ACT client-centred assessment and individualized treatment/service planning process is to “put the story together” side-by-side with the service user. Mutually reviewing and learning the client’s psychosocial history leads to a client-centred plan (p. 19).

The Ontario Program Standards for ACT teams state the purpose of the comprehensive assessment as follows

The purpose [of the psychiatric history, mental status, and diagnosis] is to effectively plan with the client and family the best treatment approach to eliminate or reduce symptomatology and to ensure accuracy of the diagnosis. . . . The purpose of the physical assessment is to thoroughly assess health status and any medical conditions. . . . The purpose of the use of drugs or alcohol assessment is to collect information to assess and diagnose if the client has a substance abuse disorder and to develop appropriate treatment interventions. . . . The purpose of the education and employment assessment is to determine with the client: how he or she is currently structuring time; current school or employment status; interests and preferences regarding school and employment; and how symptomatology has

affected previous and current school and employment performance. . . . [The social development and functioning assessment] allows the ACT team to evaluate how symptomatology has interrupted or affected personal and social development. It also includes information regarding any client involvement with the criminal system. . . . The purpose of the activities of daily living (ADL) assessment is to evaluate: the individual's current ability to meet basic needs (e.g., personal hygiene, adequate nutrition, medical care); the quality and safety of the client's financial resources; the effect that symptoms and impairments of mental illness have had on self-care; the client's ability to maintain an independent living situation; and the client's desires and individual preferences. . . . The purpose of the family structure and relationships assessment is to obtain information from the client's family and other significant people about their perspective on the client's mental illness, to determine their level of understanding about mental illness and their expectations of ACT services (p. 20).

The following is a description of the process involved in developing an individualized treatment/service plan for each ACT service user:

Together the ACT team and the client shall assess the client's needs, strengths, and preferences and develop an individualized treatment/services plan. The treatment/service plan shall: 1) identify individual issues/problems; 2) set specific measurable long and short-term goals for each issue/problem; and 3) establish the specific approaches and interventions necessary for the client to meet his or her goals, improve his or her capacity to function as independently as possible in the community, and achieve the maximum level of recovery possible (i.e., a meaningful, satisfying, and productive life). (p. 22).

Similar to the description of team activities, the areas of assessment follow a particular order in which those related to establishing psychiatric status (psychiatric history, mental status and diagnosis, physical health, and use of drugs and alcohol), are followed by those more closely related to integration (education and employment, social development and functioning, activities of daily living, family structure, and relationships). Suggesting an embedded theory of stability before integration, the document states that each area of the assessment plan is to be filled out by the designated specialist (i.e., social worker is responsible for completing the section related to the assessment of social development and functioning, etc.). Hence, although the OPS-ACT

emphasizes the need to include service users in the treatment plan, the service user is not considered a specialist who oversees the development of the actual plan. As well, practitioners are constrained in their ability to explore areas that are relevant to service users, but which do not appear on the form (i.e., financial security, access to valued resources). In terms of community integration, then, service users appear to have little input into how integration is conceptualized, categorized or prioritized within official comprehensive assessments and individual treatment/services plans. Ultimately, the goals are set in response to the health and biomedical problems of individuals, which in turn, depend upon change in the individual as opposed to change in the community. In fact, many community-focused assessments do exist. Kretzman and McKnight's (1993) capacity-focused development assessments are a key example of community-focused assessment tools. Given the stated rehabilitation and recovery focus of the model it would not be unrealistic to expect to see the use of assessments that examine the community environment surrounding the individual. The fact that these tools do exist and have not been adopted suggests that the non-individual aspects of rehabilitation and recovery philosophy have not been operationalized within the clinical planning of ACT services.

6.2.2e Evaluation

The OPS-ACT also outlines the necessity for evaluation:

Program evaluation is critical in order to know if clients are realizing the expected and desired outcomes from ACT. It is also important to know if the program is adhering to the ACT model. Each program is expected to evaluate: 1) client outcomes; 2) client and family satisfaction with the services; and 3) fidelity to the ACT model. Program evaluation should be used by the ACT team, the Ministry of Health and Long-Term Care and community advisory bodies to evaluate

program performance and to establish program improvement/performance goals. (p. 32).

The focus of evaluation appears to be on admissions, treatment plans, discharge practices, and the effective use of program resources. However, with the emphasis placed on PSR and recovery approaches, one would expect to see the inclusion of evaluation criteria to measure aspects of higher-order integration such as the number of linkages with community partners or the number of opportunities created for community participation. The powerful nature of evaluation data in determining funding makes it a particularly important tool for shaping everyday practice. The lack of measurement associated with social aspects of integration limits the degree to which ACT practitioners will be supported in practices aimed at higher-order integration. The expectations surrounding evaluation are often established external to the organization (particularly those that are publicly funded). Hence, what is being and not being measured in relation to ACT services is most likely a reflection of what larger society is interested in. The expectation around basic level integration then is more likely to become absorbed by ACT practitioners as a primary responsibility.

6.3 Analysis Summary

The opening paragraph of the OPS-ACT suggests a potentially different conceptualization of ACT practice than that presented in Stein and Santos' influential manual. The inclusion of the terms 'PSR' and 'recovery,' the inclusion of a peer specialist role, and the designation of the psychiatrist as a consultant to the team, suggest that the activities of ACT will shift away from a focus on treatment to a focus on higher-order aspects of integration. However, the priorities, roles, and responsibilities outlined

in the document continue to organize the everyday activities of practitioners in ways that are highly congruent with the original assumptions contained in the Stein and Santos manual. This section of the analysis demonstrates how texts construct practice that is carried out on an everyday basis by ACT practitioners, as well as the extent to which new ideology is able to permeate this level of organization without corresponding change in organizational structure. The following analysis chapter will examine how the organizing structures contained within these texts determine practitioner-to-practitioner, practitioner-to-service-user, and practitioner-to-community member interactions.

CHAPTER 7: SOCIAL RELATIONS

Power is mobile and contingent. (Danaher et al., 2000, p. 71)

7.1 Background and Chapter Overview

Texts contain the organizing structures that shape everyday practice. The impact of these organizing texts can be seen in the social relations enacted between individuals in the course of carrying out everyday activities. Campbell and Gregor (2002) suggest that social relations “arise in people’s activities and through the ongoing and purposeful concerting and coordination of those activities” (p. 27). It is through this “concerting and coordination” of activities that individuals engage in the social relations that shape their everyday lives:

People participate in social relations, often unknowingly, as they act competently and knowledgeably to concert and coordinate their own actions with professional standards or family expectations or organizational rules. We draw on what we know. This is how we are able to move competently through our days in workplaces or at home, taking up one action after another, in a more or less unselfconscious manner. . . . The social relations of this series of actions are invisible, and being part of them does not require the exercise of much, if any, conscious thought (Campbell & Gregor, 2002, p. 27).

The routine activities and interactions of individuals reflect the accepted knowledge and assumptions that are communicated through official texts such as those examined in the previous chapter. Consequently, texts serve as a conduit for transferring knowledge and assumptions into routine activities (e.g., degree of compensation, autonomy, responsibility in relation to others). This chapter will examine the ways in which social relations engaged in by ACT practitioners reflect the organization of knowledge and

assumptions contained in ACT texts, and the subsequent impact on community integration practice.

7.2 Analysis

The language used by ACT practitioners illustrates that the most common terms used amongst study participants to describe the ideological premise of their work is ‘PSR’ or ‘recovery’. PSR seems to be most prominent³², possibly due to the still relatively new emergence of the recovery approach within the field. Interestingly, the various disciplines attempt to make a case for their value on the team in relation to their association with PSR and recovery ideologies, including those disciplines traditionally associated with a bio-medical approach. The following field note provides a glimpse into the way in which the various disciplines claim association with PSR and recovery concepts:

Observation: Members of all disciplines claim some aspect of the PSR / recovery ideology. Disciplines such as social work, occupational therapy and vocational recreation argue that the principles of PSR and recovery are embedded in their professional training. Interestingly, many practitioners from these disciplines will offer that practitioners with nursing, psychiatry and addictions backgrounds are the least PSR / recovery oriented because their professional training is not consistent with these principles. On the other hand, one nurse told me she believes nurses are the most suited profession for ACT because they learn about PSR in their courses and are also able to dispense medications and give injections. As she points out, other disciplines are only trained in PSR but are not licensed to provide medication related services.

Although PSR and recovery are the stated ideologies of ACT, the following quote by a vocational specialist suggests the existence of an underlying, competing ideology that more powerfully influences how everyday activities are actually enacted:

³² This is evidenced not only in the language and terms used by participants both also in program mission and vision statements and the predominant use of the PSR Toolkit as a primary measurement tool.

We (often) talk about PSR visits, but I'm like, how can you have a PSR visit? Like, it just doesn't fit. Because it is an ideology, it's a way of thinking. And so, I don't think of it as necessarily an activity in and of itself. I think it should be reflected in everything I do, whether it's giving medication or not. But I think the everyday sees the team as being too split (between these two ideological perspectives).

The organization of activities as either associated with a PSR or, in this case, a bio-medical approach, certainly suggests that PSR and recovery ideologies do not guide all components of ACT service delivery even though these are the approaches around which practitioners most identify. Consequently, this individual is forced to think of everyday ACT practice as divided into distinct categories (PSR or non-PSR) depending upon the type of activity in which she/he is engaged (e.g., delivering medication or supporting vocation) and her/his scope of practice. Organizing practice in ways that allocate certain activities as exempt from PSR and recovery approaches creates a disconnect in how practitioners perceive the purpose of their role and the actual activities they carry out on an everyday basis. The remainder of this chapter will explore how the prioritization of activities, not classified as PSR activities (e.g., symptom monitoring and medication delivery) in fact dictates the practitioner-to-practitioner, practitioner-to-service user, and practitioner-to-community member relations that comprise community integration practice.

7.2.1 Prioritizing Psychiatric and Social Stability

The previous chapter contained many examples of how activities and disciplines associated with psychiatric treatment and assessment were given higher status and priority than those associated with rehabilitation and support. The following excerpts demonstrate how, as a consequence of organizing practice in this way, practitioners are

forced to a) devote a majority of their practice time to activities that support psychiatric and social stability; b) limit active participation to preserve stability; and c) support choices that do not detract from stability.

In the following quote, a psychiatrist discusses his thoughts on facilitating the rehabilitation goals of service users:

(Choice,) well that's a fairly crucial area there, whose life is it, uh, (if our approach is client centered) then we help people achieve what they want to achieve, not what we think they should achieve. And, um, do you need to put ideas in vulnerable minds, and create their schedule for them and create their goals for them, and suggest to them that this would be better than that. So it's quite easy to say that they're independent vulnerable people with mental illness, and (therefore) suggest certain things, activities, and that's what you see, a lot of people agreeing to all sorts of things. (Clients will) take on four or five groups and quickly get stressed and can't handle it, because we know, especially with schizophrenia, you can't, they have difficulty screening out all the information, background noise and distractions. That's one of the features of the illness, so what is our, when you say appropriate behaviour, act appropriately, well then that's a value, you know, what's appropriate? . . . and we don't know if (that is what clients) want a lot of the time . . . we think they should brush their teeth and comb their hair and have a bath and clean their apartment and have cleaner clothes and do their laundry, and all middle class values . . . and maybe this isn't what they want to do. So with the individual client, you know, every engagement is (focused on determining) what they want, how they feel about what they have got, is there anything else they would like to achieve or attain, is there anything they think we could do . . . (the role becomes one of) advocating for them, exploring with them, looking at options that might be possible, and (all the while) trying not to bias the situation by suggesting (activities and goals) that reflect our (own values and assumptions).

On the surface, it appears as if the practitioner espouses the values of self-determination and that this forms the basis for advising practitioners not to push service users to participate in multiple activities. Upon deeper analysis, however, it becomes apparent that an alternative set of values may underlie this rationale. For instance, the comment "*do you need to put ideas into vulnerable minds*" suggests a belief that service users are easily manipulated and in need of protection. Likewise, the comment "*Clients*

will take on four or five groups and quickly get stressed out and can't handle it ...

[stress] is one of the features of the illness" suggests a belief that social participation is a potential source of psychiatric instability. These assumptions are closely tied to those that underlie the organizational structure presented in the Stein and Santos (1998) manual. Consequently, the message from this psychiatrist is one of exercising caution when promoting participation based on a fear of invoking psychiatric instability. The organizational structures of ACT then create social relations in which practitioners feel compromised in promoting active participation in the community and feel uncertain about the legitimacy of choices expressed by service users.

Field observations of daily team meetings reveal another area in which social relations are impacted by the focus on psychiatric treatment, medication monitoring, and social stability:

Observation: Each morning the team goes through the list of service users, simultaneously assigning duties to team members. This exercise ultimately forms the primary means through which the daily, weekly and monthly needs of service users are met. During these meetings the majority of discussion and scheduling of activities centres on medication and housing issues (e.g., medication injections, medication drop-off, symptom assessment, avoiding eviction, transportation to and from psychiatrist, lab and housing appointments). Clients usually receive one long (30-45 min) visit per week but may receive smaller (10 min.) visits for med drop-offs (service practitioner brings a pre-packaged regimen of medications for approx. one week – prepared by nursing member of the team as prescribed by team psychiatrist³³). During visits for medication drop-offs, packs are dropped off with the service user. Usually a bit of small talk may accompany the visit. The practitioner usually comments that the “prime” worker will be back later in the week to do a “regular” visit (meaning longer visit).

The scheduling of home visits to address issues related to social, recreational, employment and educational activities occurs less often (e.g., taking someone to an art museum because art is of interest to them). There appears to be less immediacy to ensuring that psychosocial activities take place and they are rarely the primary focus of daily visits. Instead, they are left to be dealt with by the prime worker during a “regular” visit. For example, if the prime worker is on

³³ Two of the three participating ACT teams provided medication drop-offs on a regular basis.

vacation, other members of the team will take over medication delivery or even a housing appointment, but discussions exploring interest in employment will be re-scheduled until the prime returns.

The number of visits seems to increase when a person is identified as possibly decompensating (e.g., from once per week to every other day). Visits are short but frequent and all members of the team will do visits. Effort is aimed at keeping an eye on them, making certain they are taking their medications as prescribed and decreasing stress by discouraging active participation. Visits are increased, all members of the team will volunteer to participate – visits are short but frequent. Often discussion will occur around decreasing stressful activities usually around employment, socialization and recreation.

By placing an emphasis on activities such as medication drop-offs, symptom assessment, housing stability, and transportation on the list of daily services, the *team* becomes responsible for facilitating psychiatric treatment and stability. The daily team meetings themselves become a structural constraint to ensuring attention is paid to activities which foster higher-level integration. The prime worker, on the other hand, remains solely responsible for facilitating higher-order aspects of integration through the specialist role. Generic activities, then, become the focus of everyday practice rather than specialist activities, which hold most potential for facilitating higher-order integration. The increased frequency and limited focus of visits which occur when a service user experiences psychiatric and social instability also limits the ability of practitioners to engage in integration activities with individuals who are not currently in psychiatric crisis. The tendency to pursue integration once psychiatric and social stability have been established causes higher-order aspects of integration to be enacted as a series of unassertive activities (this is opposed to the assertive approach to medication and symptom assessment). There also appears to be a presumption that these activities will halt at the next sign of social or psychiatric instability. Therefore, the day-to-day activities of ACT practitioners involve the assertive maintenance of psychiatric and social

stability, and the largely unfocused and passive promotion of higher-order aspects of integration.

The following quote by an ACT team manager provides an example of how practitioners become constrained in their ability to facilitate choice when service users choose not to take psychiatric medications:

So, if the client says I'm not taking medications and that's their goal, um, that's okay, that's the goal. We would still document it, I would think, you would write it down in the client's language. However, let's say that person was working, okay, the risk management plan might be that well we need to monitor this, if disturbances are occurring at work, how are we going to mediate that when the symptoms are interfering? Or, how to continue to provide support despite the fact they're not taking medications so they don't fail at the job. You can imagine, in a work environment for example, a client's goal is to work at Swiss Chalet . . . Well, okay, they're not taking medication. So that's the whole risk management plan, supporting that person at work when they're not taking medication. . . . You might be doing behind the scenes things to manage the risk. Another piece of it might be trying to use the consequences that come out of it as a motivational strategy to demonstrate to the client how in fact maybe it wasn't successful because there's conflict [due to psychiatric symptoms]. And using [the experience] as a learning strategy. I mean those are some of the things that might be documented behind the scenes.

A degree of uncertainty emanates from the statement "*we would still document it, I would think.*" The practitioner is uncertain of how to address choices on the part of service users to refuse psychiatric medication. Interestingly, this practitioner struggles with whose words should be used to document the choice (service user or practitioner). Alternatively, the choice to take medications would be written in the words of the practitioner. At the end of the quote the practitioner speculates that the service user will ultimately fail to maintain employment due to his refusal to take medication. This indicates again the association between "decent" or "quality" integration and effective practice. In the face of a refusal to take psychiatric medications, then, the role of the ACT practitioner becomes one of distancing her/himself (and the onus of responsibility)

from such a choice and preparing to help the service user make an alternate (better) choice in the future. Hence, the role becomes one of managing the risks associated with a potential decline in stability rather than facilitating autonomous choice on the part of service users.

The following field note relates to a home visit carried out by a nurse for the purpose of delivering medication.

Observation: I accompany L on a home visit to drop off medication with F. It is 9:00 a.m. F is agitated – upset that we are early. L enters the hallway, remains standing, and asks how he is. She tells him she passed on his message re: wanting to work, to M (his prime worker) and that M will talk to him about this when she sees him next. F nods his head a lot, I ask F what kind of work he wants to do. He states that he does not know. L asks him if he's been eating well. F seems to get agitated after she poses this question. He looks around – responds “yes” in a gruff tone and says rather hurriedly that he is fine (he looks as though he wants us to leave). L responds that she is sorry we woke him and we won't stay long. F says he wishes the team would come after 12:00. He goes on to state that P, another ACT worker, tends to come in the a.m. “even though I tell him not to and it really pisses me off.” L responds that she will let the team know that F doesn't want people to come before 12:00. F smiles then and seems to become less agitated.

In this scenario the ACT practitioner arrives at the service user's door without pre-arranging the appointment and wakes the service user. This scenario demonstrates the limited degree of control extended to service users around their medications. Non-medication related visits are more likely to be scheduled in advance and at the convenience of service users. The prioritization of psychiatric and social stability promotes service delivery patterns that can overrule the amount of control that service users exercise over their daily schedule.

7.2.2 Defining Quality of Life

The key texts that influence the everyday practice of ACT practitioners suggest that quality of life occurs as a result of engagement in socially acceptable behaviours and activities (e.g., non-criminal activity, socially approved housing, abstinence from substance abuse, and compliance with psychiatric medications). This concept of quality of life impacts the concerting and coordinating of service activities by encouraging practitioners to a) be less assertive in their facilitation of choice when the goals of service users conflict with social ideals, b) remove individuals from society rather than lose access to valued resources, and c) accept professional responsibility for repercussions resulting from psychiatric instability.

The following quote from a team manager demonstrates how community integration practice is shaped when choices made by service users involve what are considered to be socially unacceptable behaviours:

The only examples where I can think about people that [we might] protect [from the impact of their choices], we have one client who's always wanted to go travel to South America and wants to go get her passport. Nobody's played too active a role in helping her get the paperwork done, fearing that she wants to go to Columbia, and she's a heavy substance user to begin with, like that just doesn't seem like a good idea. She's also the same client who wants to get her papers to be um, a stripper. Now people have helped her, though, helped her figure out how you would do that and whatever, but no one ever really goes out of their way to accompany her [to submit her application]. It's not that they hold her back but it's not something that they jump to go accompany someone to do.

Conflicts arise for this practitioner between the intent to promote higher-order integration on the one hand, and an awareness of society's views of substance use and sexual exploitation on the other. Normalized concepts of what determines quality of life shape how this team manager attempts to facilitate these choices. Ultimately, the conflict

between the desired choices of the service user and socially accepted behaviours causes this practitioner to be less assertive in the promotion of choice.

Concepts of normalization are also integral in shaping what is viewed as the immediate priority/responsibility of the team. For instance, the assumption that ACT practitioners are responsible for ensuring a quality of life as defined by psychiatric and social stability influences which situations constitute a crisis. The following field observation of a crisis incident exposes the rationale used to determine both the nature of crisis and the subsequent decision-making evoked in these situations.

Observation: During a morning case conference ACT team practitioners expressed concern that a 31-year old male service user had been demonstrating increased psychiatric symptoms over a period of 2-3 weeks. Various team members reported that the individual had been drinking alcohol, taking illegal drugs, was not taking his psychiatric medications as prescribed, and had been inviting prostitutes into his apartment. One practitioner reported that the individual's keys had gone missing several times in the past week, and expressed concern that the service user may be loaning his keys to the prostitutes.

A subsequent meeting was arranged between the service user and the psychiatrist. The purpose of the meeting was to convince the service user to enter the hospital voluntarily. Members of the team rationalized that a period of time spent in the hospital would stabilize psychiatric symptoms which would lessen this individual's engagement in inappropriate social behaviours. The concern with this individual's behaviour also seemed to be tied to observations that the client was no longer 'engaging with the team' and that he was "at risk of losing his housing." One team member commented "we know his pattern and it will only get worse."

Two other team members were also present for the visit with the psychiatrist (medication manager, peer specialist). The service user appeared to become increasingly irritated over the course of the meeting. At one point he left the room, arms crossed, carrying his belongings as though intending to leave the premises. The psychiatrist and one of the ACT practitioners asked him where he was going. In response, he mumbled, "you said I am going to the hospital, so I guess I am going to the hospital." The service user then proceeded to leave the building. Unbeknownst to the service user the psychiatrist subsequently signed a Form 1³⁴ and the team arranged to have police (along with a team member) pick

³⁴ A Form 1 is a form signed by the attending psychiatrist that provides legal authority to involuntarily admit a person to hospital. A person can be "formed" based on a psychiatrist's clinical determination that she/he is not mentally competent.

him up at his apartment the following morning to take him to hospital. The following day the team discussed the situation commenting that they believed they would be able to maintain the service user's housing while he was in hospital. They intended to have the locks changed so as to protect his belongings. Several members of the team expressed concern over the amount of work ahead of them to re-establish a relationship of trust once this individual returned from hospital.

The decision to classify this incident as a crisis is influenced by assumptions that individuals with mental illness will lose access to valued resources (such as housing) if they engage in socially unacceptable behaviors, and that it is the responsibility of ACT practitioners to ensure that service users do not jeopardize this access. The perceived possibility that the service user might lose his housing due to his engagement in socially inappropriate behaviours (presumed to be caused by psychiatric instability) guided the practitioners in the above account to temporarily override a service user's autonomy. Would an alternative perception of the behaviours from a community integration perspective have altered the proposed intervention? For example, would community integration theory suggest a graduated intervention approach that began with looking for alternate environmental placements before determining the need for hospitalization? Importantly, in all of the field observations and personal interviews conducted for this study, the potential for the loss of employment or the de-compensation of a close relationship was never classified as a crisis. Rather, crisis situations tend to emerge primarily when the ACT team determines that they cannot maintain psychiatric and social stability.

The following quote from a team manager illustrates how everyday practice is organized around the assumption that ACT practitioners will take on full responsibility for ensuring normalization on the part of service users.

As a manager, even as much as I'd like to say that I don't put [responsibility for crises] upon my team members, but I know that I do. So, and I think that's been true for me as a worker too. As much as, you know, whenever you have a crisis and something's gone wrong, um, if you're the last person to see the client, you're the one that has to answer the questions. And usually some person might have done something different. So, in the report you might come and the psychiatrist might ask you, you know, well did you ask them about their medication, or did they seem paranoid at that time, and it's just, if you were already feeling that time had come [to recommend the person be admitted to hospital, but had not acted on it], then you're very prone to feeling that you're the cause [of the crisis].

The moral and legal responsibility placed on practitioners for the psychiatric and social stability of service users makes them vulnerable when things go "wrong". Hence, a tremendous effort is put into ensuring that things go "right" - potentially to the detriment of facilitating service user participation and empowerment. The following quote from a vocational specialist provides an example of how members of society hold practitioners responsible for the behaviours elicited by service users:

One of our clients was very distressed, he called the police, and then the police did a finger pointing thing, [saying] what are you guys doing for this guy? Like why is he living here, why isn't he in an institution? Like he, you know, you're not helping him function here, um, and I felt like [I was being] blamed. . . . He told me all people [with psychiatric disabilities] should be shipped up to a funny farm up north. You know, comments like that, while he was interacting with one of our clients, like how do you juggle that? You know yourself and your beliefs and [you're] trying to hold back at lashing out at this policeman. But he's a police officer who holds power in your society, and he has my client in the back seat of his cruiser. It's like we're trying to bridge you know, between, okay what we're doing, integrating people into the community, knowing that there's a lot of resistance to that out there, and dealing with those pressures and ideas everyday.

In the above account, a police constable suggests, not so subtly, that the job of the ACT practitioner is to ensure that service users maintain proper social behaviour within the community, and if that fails, to remove the individual from the community. In response, the practitioner assumes a passive role "*[you're] trying to hold back at lashing*

out at this policeman. But he's a police officer who holds power in your society, and he has my client in the back seat of his cruiser" so as not to aggravate the situation.

The assumption that ACT practitioners are responsible for the appropriate behaviour of service users is linked to the assumptions of normalization and responsibility detected in the Stein and Santos manual and again in the OPS-ACT. It appears that the organizing structures that exist at societal levels are consistent with those contained in key ACT texts. Thus, this practitioner is unable to counter the constable's argument yet clearly experiences personal tensions as to what she/he personally believes *ought* to be the role of the ACT practitioner. This scenario also clearly illustrates the tension between societal perceptions and expectations surrounding the role of ACT practitioners in relation to community integration and the professional concept of integration held by many practitioners.

7.2.3 Licensing Treatment

The act of licensing legitimizes and validates certain activities and professions over others. The following excerpt from an interview with a team psychiatrist reflects how leadership capacity is bestowed upon individuals licensed to carry out treatment activities.

I'm the part that has to do with all the legal part of, medical legal part of [the service], [clients] become my patients, and the prescribing of the medications is my responsibility, and so that comes to me. [It] can't go to anyone else. So that part of the treatment, whereas others may do recreation or help with family work, well I can also do that as well, but the specific function [of prescribing medication] is mine.... Once they become my patients, I have a responsibility to [the clients] to make sure that I think they get the best care or treatment. Using a biopsychosocial model, which is what I use in the formulation of the treatment plan, [I try to provide the] best biological treatment: best medication, [identify] possible interactions with other medications, side effect profiles, watching and monitoring their physical health, any

interactions of their medications for their mental illness that impacts on their medications of physical health, and promoting the physical health, um, linking to other physicians, um, you know, [making clients] aware of the effects of their mental illness on their physical health and their physical health on their mental illness. . . . so that's the biological areas and then there are the psychological areas. [In terms of best psychological treatment], I am trained in the psychoanalytic approach, so individual therapy, supportive-expressive group therapy. I teach group therapy to other team members. In terms of the social sphere, we look at the social, housing, family relationships, um, friendships, um, financial productivity, creativity, and try to decrease isolation [in these areas].

This individual links the power of the psychiatrist position to the legal responsibility associated with prescribing psychiatric medications. For these reasons the discipline of psychiatry assumes greater legitimacy and power than other disciplines. The power and responsibility of this role are directly connected to the license to carry out treatment activities, not to activities associated with social participation. Hence, it is not unfounded to anticipate that psychiatrists may emphasize treatment in their leadership role with the team and minimize the time and importance attributed to the promotion of social participation. In fact, the above quote provides a detailed description of treatment-related activities for which the psychiatrist is responsible, but the description becomes both generalized and depersonalized when describing activities which fall under the 'social sphere.'

The following field note demonstrates the link between professional licensing and reimbursement of team members.

Observation: Pay scale seems to correlate with hierarchy associated with licensed activities. Highest pay – psychiatrist, nurse; middle pay – professional staff (OT, SW, addictions, Voc Rehab); lowest pay - non-professional staff (mental health worker, peer support). Note psychiatrist is paid more (per hour) than team leader.

Psychiatrists and nurses are considered the most valuable members of the team from a compensation perspective. Psychiatrists and nurses are also the only members of the

team who hold professional licenses related to medication. That these licenses are associated with psychiatric treatment (psychiatrists for diagnosing and prescribing medications and nurses for dispensing medications) suggests again the priority of ACT to function as a vehicle for psychiatric stability. The social relations that directly arise from the value placed on treatment licenses include the allocation of pay, responsibility, and flexibility.

In practice, the activities of psychiatrists deviate from the prescribed role of the typical ACT practitioner. The OPS-ACT states that the ACT team is “*mobile and delivers services in community locations ... rather than expecting the client to come to the program*”³⁵ (p. 6). The following field note highlights how the power bestowed upon those who are licensed to treat shapes their everyday practice in a different way from other team members.

Observation: A psychiatrist on one of the participating ACT teams preferred to visit with service users at the ACT office rather than go to their homes. To accommodate this preference, daily schedules were often coordinated to provide transportation or make arrangements for the service users to meet with the psychiatrist. At times the psychiatrist would visit with clients in the community but would do so only if transported by another ACT practitioner.

The activities described above suggest that the psychiatrist is exempted from contributing to the requirement that 75% of services be based in the community. Additionally, other team members spend a portion of their time providing and arranging transportation to and from visits with the psychiatrist. In particular, many of the day-to-day activities of team members are performed in relation to the work of the psychiatrist.

³⁵ The following description demonstrates how the emphasis on psychiatric treatment can influence how community integration practice is carried out by the ACT team. It is important to note that this description is not necessarily indicative of the practice of psychiatrists across all ACT teams. However, office visits for psychiatric treatment occurred routinely within two of the three participating teams in this study.

As the psychiatrist is not required to do home visits or deliver medications, other team members often assume responsibility for providing transportation either for the psychiatrist or for the service users, and therefore have less time available to devote to specialist activities. Given the lack of description earlier in relation to the generalist role, one wonders if these activities are also considered part and parcel of this function.

A key informant interview with a program coordinator sheds light on the rationale behind the practice of allotting different rules for psychiatrists.

We need [psychiatrists] in order to exist. When we first started the team [in 1998] we couldn't get a psychiatrist to work with us. We were lucky to get [the person we have now]. Most psychiatrists see ACT teams as being community-work that they feel is beneath them.

Fear of being unable to attract psychiatrists to ACT in light of the fact that they are the only ones licensed to prescribe medication, results in a pattern of social relations that permeates the everyday community integration practice of ACT practitioners. Members of this discipline are in a position to demand exemption from certain rules and regulations in exchange for their services. Certainly not all members of the psychiatric profession do so, yet the fact remains that licensing is at the crux of these rather common social relations. Contained within the above quote is also a reference to community work as possibly “beneath” the profession of psychiatry. This may suggest that the association between professional licenses and treatment creates social relations at systemic levels as well, whereby certain professions and care models may be considered to be less valuable due to their non-medical approach. Does the lack of perceived expertise in non-licensed professions reflect an overarching perception that the activities performed by these professions are not integral to health? The prioritization of practice activities in relation

to this presumption obscures both knowledge and tools that link participation with increased health and wellness.

7.2.4 Working in Isolation

The requirement for ACT staff to limit the degree to which they link with external services constrains their ability to facilitate community pathways for service users.

The following field note demonstrates the conflicts that can emerge when practitioners are isolated from individuals and organizations within the community.

Observation: N, a vocational specialist, commented that at present, she was able to provide service users with options for education and employment in the following settings: sheltered employment, day programs, transitional employment, adult/learning program, and a community art class. Although these options offer a range of opportunities they do not include a regular community-based employment setting. She states that she has a desire to connect with community employers such as Wal-Mart, but that finding the time to do so is an issue. “You need one full day a week to do that type of thing, but there just isn’t the time between covering for other team members who are sick or on vacation and just general support.”

In this account the practitioner directly attributes the lack of time available to create community partnerships to the amount spent providing general support and covering for absent team members. The distribution of practitioner time overrules attempts to establish new contacts in the community and hinders the ability of practitioners to build opportunities for higher-order integration.

The following field note is another example of how organizing structures come to shape the daily activities of practitioners:

Observation: We visit S & L to drop off medications. G, the medication manager whom I have come with, asks S & L if they will be going to the Pope’s vigil that takes place today. S & L reply that they would like to go but transportation is an issue – buses set up to go to the vigil leave from a place that is inaccessible to

them by foot. G agrees that this is indeed disappointing and comments that the extra traffic, caused by the event has made it difficult for staff to do home visits.

The above scenario contrasts the legitimacy attached to an activity such as driving to a service user's home to deliver medications, and driving service users to independently attend a community event. Likewise, working with the local taxi/bus company to aid service users in attending a community event (i.e., arranging for subsidies for service users or arranging for special pick-up) also is not seen as a legitimate use of practitioners' time. Making arrangements for similar services to attend clinical appointments, however, is.

Alternatively, the following field note illustrates the reliance upon maintaining connections with the mental health system:

Observation: J, a team leader, discusses how his background working in a psychiatric hospital aids him in his role as a team leader. He states that, "agencies with anti-hospital philosophies can't get access to beds." He expresses concern (possibly even anxiety) around ensuring that there is access to hospital beds for those service users who must return to hospital. This anxiety stems from assumptions that practitioners will act as enforcers of psychiatric stability.

The concern over ensuring an ongoing relationship with the hospital system coupled with the lack of concern over building community partnerships is indicative of the priority placed on ensuring psychiatric and social stability over that of integration.

Finally, the following field note describes a social drop-in run by a community mental health organization housing one of the participating ACT teams.

Observation: One of the participating community mental health agencies³⁶ runs their own social drop-in centre. L, a nurse, tells me there is a long waiting list for getting ACT service users into the drop-in. It is designed for all service users of the community mental health agency. L tells that few ACT clients are attendees "because they tend to not show up or become disinterested". The drop-in operates

³⁶ This community mental health agency operates several mental health programs including an ACT team.

one day per week and sessions are unstructured. Unstructured activities include such activities as watching television and playing cards. Group activities take place once a month – go out as a group into the community (i.e., ball game). Go as a group into the community rather than focusing on generating relationships between those with and those without mental illness.

The social drop-in centre is conceptualized as an internal entity in that it is located on the site of a community mental health agency. The program is designed only for service users of that agency. Outings are done as a group, and staff work directly with service users to engage them in activities such as movies, puzzles, and crafts. Thus, structures that isolate practitioners from working with mainstream society result in the creation of a parallel social world contained within the mental health system. This provides opportunities for physical participation and presence within the community, but does not foster participation and responsibility sharing within the community. Ultimately, no formal structure exists for ACT practitioners to establish opportunities outside of the mental health system.

7.3 Analysis Summary

Social relations constitute the interrelationships that occur as part of everyday practice. These relations occur at individual (service user with practitioner), organizational (discipline with discipline), system (ACT practitioner/team with Ontario Disability Pension/psychiatric hospital) and social (ACT practitioner with community organization/police) levels. The organizing structures contained in key texts orchestrate these interrelationships according to embedded values and assumptions, which then become translated into everyday practice. Practitioners may commit to the values of promoting higher-order aspects of integration but, because of these organizing structures, continue to enact practices incongruent with these values.

The social relations demonstrated by participants on an everyday basis are affected by the emphasis placed on psychiatric and social stability, normalized behaviours, professional licenses, and working in isolation from community partners. Ultimately, individual practitioners are often unaware of the extent to which their everyday practice shifts away from the goals of integration. Unfortunately, the promotion of integration of individuals with severe mental illness requires a decreased emphasis on risk and practitioner responsibility and an increased emphasis on opportunity and service user responsibility as links to wellness.

The following chapter demonstrates the ways in which ACT practitioners, through the enactment of agency (instrumental behaviour taken in order to reach desired ends), attempt to combat these organizing structures in order to bring their everyday activities into closer alignment with their personal and professional intentions.

CHAPTER 8: AGENCY

We cannot escape the regulatory institutions and discourses in which we are produced. But we can identify them and identify our own practices of the self, and from this basis of knowledge, formulate tactics by which we can live in the world (Danaher et al., 2000, p. 131).

8.1 Background and Chapter Overview

Certain camps of structural theorists assert that individuals are active both in their submission to, and resistance of, ideologically determined ways of thinking and behaving (Scott, 2000). Following from this theory is the assumption that individuals become knowledgeable of accepted (socially constructed) ways of thinking and doing by actively familiarizing themselves with official texts (i.e., legal texts, government policies, disciplinary texts) and subsequently engaging in the everyday social operations and relationships of power associated with them. Consequently, individuals come to make sense of their world in ways that are consistent with the reasoning that underlies the organizing structures of a particular society. It is in this way that “thoughts and actions are influenced, regulated, and to some extent controlled by [organizing structures]” (Danaher et al., 2000, p. 33). Thus, individuals unknowingly become a part of the processes that sustain the particular ideological and power apparatus in which they live and work. These theorists do not believe, however, that individuals are entirely helpless in the face of organizing powers of external structures. To the contrary, they argue that individuals can “*choose to respond to, or resist,*” the ways in which these structures shape their everyday activities (Danaher et al., 2003, p. 120). For example, individuals can act to develop an awareness of the structures that organize their everyday practice. Individuals may use an ethic to guide them in responding to powerful organizing

structures. This requires a process of self-reflection and subsequent action commonly referred to as agency (Scott, 2000). Agency refers to the engagement in, and use of, self-reflective processes to consciously devise, plan, and implement actions in keeping with personal values, beliefs, and intentions (Scott, 2000). Previous analysis chapters explored the everyday tensions experienced by practitioners (Chapter 4), traced the impetus for these tensions to conflicting values and assumptions embedded in key texts (Chapter 5) and then linked the organizing power of these texts to the way social relations (practitioner-to-practitioner, practitioner-to-service user, practitioner-to-community member) become shaped on an everyday basis (Chapter 6). The current chapter explores actual examples of agency employed by individual practitioners to resist the influence of organizing structures that systematically overrule opportunities for higher-order integration.

8.2 Analysis

The following observation demonstrates the attempt by a team manager to re-organize aspects of the program structure to bolster the influence of the peer support position over service delivery practice:

Observation: The ACT team has invested resources to make the peer support worker³⁷ position full-time. The ACT standards state that the position is to be filled on a half-time basis only. Hence, teams are only provided the funds for a half-time position. The team commissioned a long-term study of the peer support worker role across the province. A follow-up study is about to begin soon. The team manager believes the position should be equal to that of other ACT staff. The team manager states that “it is what I need to run my team and I feel that it is a statement of values.” However, as the results of their study show, peer support

³⁷ When this observation took place Peer Specialists were referred to as Peer Support Workers and the position was designated as half-time. The 2004 guidelines now designate the role as a full-time position and have changed the name to Peer Specialist.

workers receive less pay (on a per hour basis) and enact fewer responsibilities than other team members. The team manager is currently looking to revise the job description to include shift work (evening – on call) and crisis intervention. The team manager would also like to title the position as a “mental health worker” to decrease the stigma associated with the title.

The manager demonstrates agency by attempting to change the peer support position from a half-time to a full-time position and by strengthening the roles and responsibilities associated with the position. The impetus for this decision appears to stem from a personal and professional belief that the knowledge, skills, and experience of peer support workers ought to be allocated a presence and level of responsibility equal to that of other team members. Thus, the traditional way of structuring the position³⁸ (funding, roles, and responsibilities) does not reflect the values of the team manager.

We felt that the peer support position was an important one and should be equal with the rest of [the positions]. That it should be full-time with full responsibilities and that it should not be identified [as a peer position] because that is segregating. It identifies the person as a consumer [of mental health services]. But if other members of the team experience mental health problems like a nurse or a social worker, they would not be identified [as having experienced mental health issues] through their job title. So, our Peer Support person actually holds the position of Mental Health Worker. However, because we chose to create the peer support worker position differently (full-time instead of part-time) than what was laid out in the ACT Standards we had to find the resources to support the additional pay that comes with additional hours and increased responsibility. We literally had to rob Peter to pay Paul.

The manager’s attempt to reorganize the position required the re-distribution of resources from other areas of the organization. In the end, hardships inherent in following through with this re-organization (e.g., potentially losing a position elsewhere in the organization, or fewer funds for professional development) could have resulted in an abandoned

³⁸ This observation took place 6 months prior to the enactment of the current ACT guidelines when the Peer Support positions were only funded on a part-time basis.

attempt to expand the role. The dedication to an ethic, however, seems to have been integral in sustaining the re-organization effort.

Similarly, the following quote provides an example of an executive director who consciously decides not to place individuals from treatment-oriented disciplines (e.g., nursing, addictions) in the role of team manager. Rather, only professionals from psychosocial backgrounds (social work, occupational therapy, vocational rehabilitation) are placed in this position as a way to strengthen the rehabilitation (and thus, integration), and orientation of everyday activities.

Treatment is always going to be there, no matter what. Rehabilitation as a guiding philosophy is important to us as the agency is based on a PSR model. Therefore, leadership must come from those trained in a rehabilitation approach or else [ACT] will just become a vehicle for medication.

In a further attempt to strengthen the rehabilitation-orientation of the team, this same executive director also implemented a policy wherein the psychiatrist role would be filled by two part-time psychiatrists rather than one. Like the team manager position, it was believed that by splitting this role, the leadership presence associated with the psychiatrist would be minimized. The goal was to provide more opportunity for leadership stemming from a rehabilitation approach. The agency demonstrated in this scenario is the attempt to change the ideological influence guiding everyday activities through powerful leadership positions.

A final example of agency is demonstrated by an ACT team that chose to interpret requisition forms for transportation funds (taxi chits, bus subsidies) in a way that supported service users to independently access community-based resources:

Observation: The system under which taxi chits and bus tickets are provided to ACT service users free of charge requires that transportation be for medical appointments only (lab work, psychiatrist). All other transportation needs must

be funded by the service users themselves or transportation must be provided by the ACT team. Hence, due to the limited finances of service users, activities such as grocery shopping or leisure activities require the direct assistance of ACT practitioners for transportation, thus limiting the degree that service users can independently engage in the community. To counter this discrepancy, this ACT team chose to “fudge the paper work” in order to access money for transportation to and from social activities based in the community.

In the above account, practitioners were aware of a conflict that existed between goals of integration and the mechanics of obtaining financial support for transportation. They believed that community integration would be better supported if subsidies were used to enable service users to access community-based venues such as the grocery store. Within the current organizing of funds for transportation service, users are encouraged to be independent in attending treatment appointments but discouraged from independently traveling to get their own groceries. Through their demonstrations of agency, the ACT practitioners were able to resolve the tensions they experienced when trying to aid service users to independently integrate into society. They were prepared, to some extent, to challenge the system in order to remain in keeping with their professional vision. However, their attempts at agency could be short-lived if the system were to challenge their interpretation of how to complete the requisition forms.

These examples of agency demonstrate that individual practitioners, particularly those in managerial positions, are, to a certain degree, able to impact the organizing structures in ways that better reflect personal and professional commitments to integration. These examples also demonstrate, though, that agency does not alter practice in a systematic manner across sites. Agency may translate into a consistent practice for a particular individual or even a particular team (i.e., a team consistently places non-medical professions in the team manager role). Agency does not translate into systematic

change and often produces inconsistent change only at the level of the individual or program. Acts of agency are random due to the fact that organizing structures systematically drive practice in the direction of the ruling apparatus. Any attempt to counter this direction through agency is subject to resistance from powerful organizing structures. By not shifting the organizational structure to match integration goals, activities associated with agency do not become automatic tasks, but rather require additional effort, added time, and focused mental commitment. Hence, despite acts of agency, it remains easier to drive service users to the grocery store than to ‘re-work’ the paperwork to access funding. In other words, within the existing structure, driving a service user to the grocery store is still the most legitimate way of enacting transportation for community integration purposes despite the negative impact on independence.

A final observation emphasizes how agency, though essential for instigating structural change is, on its own, unable to consistently re-shape everyday practice:

Observation: Although the Executive Director put forth great effort in re-organizing the administration of the team leader and psychiatrist positions, the relationship seems to continue to be characterized by the staff and team manager enacting activities to accommodate treatment-related activities (e.g., team provides transportation for psychiatrist, team brings service users to appointments with the psychiatrist, team accompanies the psychiatrist on home visits, team provides symptom assessments for the psychiatrist during daily team meetings). Thus, despite the purposeful attempt to minimize the role and influence of a treatment-orientation, it becomes obvious that this discipline doesn’t have to interact with the team on a frequent basis to continue to function as the team expert. Indeed, the influence of the psychiatrist position is supported by the organization of the multidisciplinary team itself.

8.3 Analysis Summary

Agency refers to an individual’s intentional and conscious altering of her/his everyday practice, to better reflect personal and professional values. This study did not

uncover many examples of agency. This is consistent with the theory that organizing structures are, more so than individual intentions, the primary factor determining everyday practice. However, the examples of agency observed across the three participating ACT teams demonstrate the level of commitment of ACT practitioners to the notion of facilitating higher-order aspects of integration. These acts of agency serve as a catalyst for broadening the movement to re-organize the structures that shape community integration practice.

Ultimately, acts of agency require an awareness of how organizing structures account for the everyday overruling of personal and professional values. Through the process of reflecting on these values and assumptions and identifying the ways in which organizing structures re-shape everyday activities, agency is enacted and becomes a catalyst for sustainable change. A real shift in service delivery directions, however, requires consistent changes in everyday practice across multiple sites of ACT. Agency is a statement of needed change and indeed, demonstrates that an alternate way is possible. It is from here, though, that structures must be altered across sites to facilitate systematic change. For example, the role of the peer support worker was, at the time of this study, designated as a part-time position. However, largely as a result of demonstrations of agency on the part of individual ACT teams, (e.g., conducting studies on how the peer support worker role compares to other roles, finding ways to classify the peer support worker position as full-time), the standards have now been changed and currently classify the position as full-time. Agency, then, is the seed for change but re-alignment of organizing structures is required for ensuring sustainable shifts in everyday practice.

CHAPTER 9: SYNTHESIS

9.1 Background and Chapter Overview

Organizing structures shape everyday practice through obscure means. As a result of this, practitioners are often not fully conscious of the ways in which these structures influence their everyday practice decisions and activities. The tensions experienced by practitioners within the context of everyday practice, then, are often assumed to be the result of personal characteristics particular to the practitioner. This study supports the idea that, in fact, these tensions most often reflect structurally orchestrated tensions common to practitioners working across program sites. Because the direction set forth by organizing structures is not obvious within the context of everyday practice, the ways in which these structures shape everyday practice are rarely examined, questioned, or resisted. Therefore, they become powerful organizers of practice, and important factors influencing practice outcomes. Additionally, the tensions that arise as a result of conflicts between organizational structures and professional values manifest themselves within the everyday practice experiences of practitioners and service users. Chapters 5 through 8 analyzed the tensions, textual constructions, social relations, and

agency associated with the community integration practice of ACT practitioners. This final analysis chapter presents a synthesis of the primary ways in which organizing structures come to shape community integration practice.

9.2 Analysis

The current chapter identifies three central tensions involved in the community integration practice of ACT practitioners. These tensions relate to the systematic overruling of a) cohesive integration by the fragmented organization of roles and responsibilities, b) social-level interventions by the organization of practice around an individual model of disability, and c) empowerment practices by the organizing of practice according to a protectionist mandate (illustrated in Figure 3, p.130).

9.2.1 Goals: Protection Versus Empowerment

The prioritization of treatment and support over rehabilitation activities within ACT demonstrates a lack of understanding of integration as a social issue. Likewise, the perception of the relationship between these elements as somehow detached, demonstrates a lack of understanding of the interdependent relationship that social and economic security has with inclusion, cohesion, and empowerment. Without this understanding, protection rather than empowerment becomes central to everyday practice and consequently organizing structures focus on ensuring the social, economic, and health security of the individual.

As explored in the previous section, a social model approach to integration aims to improve the lives of individuals by aiding the collective to regain control over living and working conditions. A focus on protection to the exclusion of empowerment can

lead, unconscious though it may be, to the oppression of the service user. If there is no attempt to improve the living and working conditions of the collective, then community integration practice merely functions as a tool for helping service users to manage the existing conditions in which they currently operate and does not address barriers to social security, inclusion, cohesion, or empowerment for this population

Empowerment conveys both a psychological sense of personal control over influences and a concern with actual social influence, political power, and legal rights. It is a multilevel construct applicable to individual citizens as well as to organizations and neighbourhoods (Rappaport, 1987, p. 121).

Community integration, as proposed by Berman and Phillips (2000), is a concept comprised of multiple interdependent layers each contributing to a whole greater than the sum of its individual parts. Empowerment forms the final layer of the model and refers to social, cultural, political, and economic influence. Certainly, empowerment cannot be reached if there is not first a sound foundation of security. However, security provided solely by, and under the responsibility of health care practitioners, does not create an adequate foundation for building social, cultural, economic, and political influence. It stands to reason that security, within the context of the model, refers to social security. Thus, interventions would include activities that sought to ensure the social and economic security of all individuals with severe mental illness (e.g., waivers on bank account fees for individuals receiving government subsidies and the creation of efforts to increase the capacity of family doctors and pharmacists to address the unique treatment needs of individuals with severe mental illness). Ultimately, efforts to build the capacity of the community to provide a secure social, economic, and health environment for individuals with severe mental illness will naturally begin to facilitate opportunities for social inclusion, social cohesion, and social empowerment. However, by isolating practitioners

from their community partners and by expecting practitioners to take full responsibility for the social, economic, and health security of individuals with severe mental illness, both practitioners and service users become debilitated in their attempts to genuinely pursue community integration. Although chronologically security / stability should come first, the primary goal must go beyond that if one wants to achieve integration. Thus, everyday activities cannot be prioritized according to basic-level integration alone.

9.2.2 Focus: Individual Versus Social-Level Integration

Opportunities for integration are not created in isolation of the interests, perspectives, and priorities of the social environment. Service users and practitioners must interact with members of the community in order to ensure social influence, and encourage mutual responsibility. According to Priestly (1998) research and practice are based on models that stress a materialist explanation of disability and are primarily concerned with the biological state of the individual:

[Individual models of disability] suggest that social phenomena have no ‘real’ existence beyond our perceptions and interpretations of them. They are simply an aggregation of individual phenomena (p. 76).

Priestly (1998) argues that an individual model of disability may also be based on an idealist explanation which concerns the notion of self-expression, personal experience, and social roles. Individual-level interventions (based on either a materialist or an idealist explanation) tend to focus on the treatment, rehabilitation, and support needs of the individual and the interaction of the individual within a social context, whereas social models of disability (based on either a materialist or an idealist explanation) focus on the needs of the collective. Priestly (1998) comments:

[Social models of disability] suggest that social phenomena do have some ‘real’ existence beyond our observation and interpretations – that they exist independently of the individuals who experience them.

Social-materialist models focus on structure, whereas social-idealist models focus on culture and local understandings of mental illness. Social models of disability facilitate integration by focusing on the treatment, rehabilitation, and support needs of the collective and the interaction of the collective within society.

The findings of the current study demonstrate that the main organizing structures of ACT shape community integration practice according to individual, rather than social-based interventions. The organization of ACT integration practice appears to reflect both materialist and idealist explanations of individual-level interventions. In other words, a tension plays out between whether ACT is primarily concerned with the biomedical characteristics of service users, or their personal experience and social roles. The larger unexposed tension, however, is associated with whether ACT is organized in a way that enables higher-order integration for individuals with severe mental illness. Such integration requires a focus on the collective and its interaction with society. This study did not detect organizing structures that lend themselves to a social model of integration.

Individual-level interventions place responsibility and resources in areas related to the everyday health care of individual service users (e.g., providing service users with opportunities to enhance work skills and to have input into their treatment/rehabilitation goals). However, without an explicit social model of intervention, practitioners are unable to actualize their work in terms of creating pathways for the population of individuals with severe mental illness to enjoy security, inclusion, cohesion, and empowerment within mainstream society.

Social-level interventions require that practitioners engage in a certain number of activities that directly involve community members as opposed to service users. Thus, practitioners must work not only with individual service users, but also with community partners on behalf of the population of individuals with severe mental illness. Specific social-level interventions may include a meeting with the human resources department of local stores (e.g., Wal-Mart) to discuss options for creating flexible work environments for individuals with severe mental illness or, engaging a community stakeholder group to plan community-based strategies for the population of individuals with severe mental illness. However, as long as the organizational structures of ACT promote an individual model of disability (whether this model is based on materialist or idealist interventions) higher-level aspects of integration will remain limited and unfulfilled responsibility for integration will continue to be placed on practitioners and service users.

9.2.3 Practice: Fragmented Versus Holistic

Within the current structure of ACT services, community integration practice is conceptualized as comprised of three distinct, discontinuous elements: treatment, rehabilitation, and support. Every activity in which practitioners engage is categorized according to one of these service elements (e.g., a treatment visit, a support visit, a PSR visit). Each element differs structurally in terms of its prioritization, resources, time allotment, and philosophical approach. Hence, the fit between elements becomes “structurally uncomfortable”³⁹. Examples of this structural discomfort are seen in the priority differential between treatment, rehabilitation, and support activities in terms of

This term is introduced in Scott, 2001 p. 43.

staffing, role responsibility, and pay. Less emphasis is placed on choice, participation, and autonomy in both treatment and support activities as compared to rehabilitation activities.

Tensions arise when practitioners who value ACT work because of the association with service user choice, participation and autonomy, discover that in actuality, these approaches are reserved for specific activities only (e.g., vocational visits rather than medication visits). Tensions also arise when the time to engage in activities associated with integration (e.g., vocation) are consistently eroded by the priority placed upon treatment (e.g., medication, crisis). These personal tensions of practitioners are experienced systematically across sites and reflect a fragmented organization of everyday practice. By organizing practice according to discordant categories of activity and by prioritizing particular practice categories over others, a form of integration practice has emerged which fosters basic-level integration; higher-order integration is consistently undermined.

A practice approach, which had as its basis the theory of integration (security, participation, autonomy, cohesion and empowerment) would emphasize the interdependence among elements of practice. For example, interventions involving medication would not only take into consideration the purpose of facilitating social and health security, but would also emphasize participation, choice, and autonomy. Alternatively, rehabilitation interventions would emphasize security as well as higher-level integration. In all cases the focus would be on social security, inclusion, cohesion, and empowerment which would necessitate the creation of social-level interventions as opposed to individual-level interventions. For example, practitioners would seek to work

with the community to develop sustainable and secure opportunities for both medication and employment for the population of individuals with severe mental illness. All practitioners (regardless of professional background) would be tasked with the promotion of community integration practice and higher-order integration. In particular, those practitioners occupying leadership roles on the team would be tasked with providing leadership related to the promotion of higher-order integration. Overall, intervention activities would seek to facilitate linkages between service users and community partners and would begin to shift the onus of responsibility from practitioners to service users and the community (e.g., working with ODSP to ensure sustainable livelihoods for individuals with severe mental illness). An integrated approach would view the interconnected elements of community integration as a seamless whole, focused on all aspects of integration, thus disabling the current fragmentary structure, that now undermines attempts to facilitate higher-order aspects of integration.

9.3 Analysis Summary

Community integration is a complex, multi-dimensional conceptualization of how an individual is positioned within society. Hence, the focus of practice ought to be the community life of the service user. The structures organizing ACT services focus practice on the health and security of service users, to the exclusion of higher-order aspects of integration. The tensions that result can be accounted for by the systematic overruling of a) cohesive integration by the fragmented organization of roles and responsibilities; b) social-level interventions by the organization of practice around an individual model of disability; and c) empowerment practices by the organizing of

practice according to a protectionist mandate. These tensions are at odds with what is necessary to achieve full integration for individuals with severe mental illness.

The current structuring of ACT services is such that community integration becomes conceptualized as three distinct and often disparate elements: treatment, rehabilitation, and support (Figure 3). This organization of services into discrete categories reflects a materialist emphasis which links to an individual model of disability that, in turn, endeavours to enact interventions which target the properties of individuals. To the extent that the properties of individuals with severe mental illness are the target of service delivery interventions, service delivery holds the health of the individual as its primary goal and only a basic level of integration is pursued. Alternatively, were the structure organized in relation to an understanding of the role of social interventions in the promotion of integration, everyday practice would aim to develop the interrelationship between individuals with severe mental illness and mainstream society.

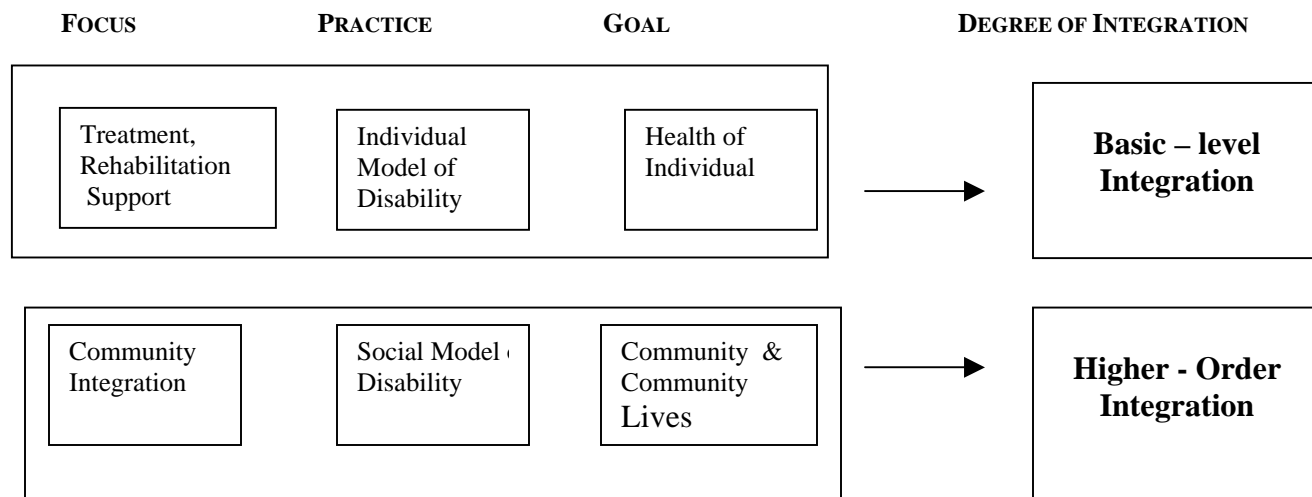


Figure 3: Level of Integration Based on Service Delivery Approach

CHAPTER 10: DISCUSSION

To be sure it does not supply the solution to the riddle, but I believe it is again possible to march forward. Wolfgang Pauli re: quantum theory in matrix mechanics (Kronig, 1960 cited in Thomas Kuhn, 1996, p. 85).

The ACT model, as originally conceptualized by its founders at Mendota State Hospital 35 years ago, was a vehicle for integrating former patients of the psychiatric hospital into the community. Thirty-five years later, ideas about the degree to which individuals with severe mental illness should participate in, contribute to, and hold influence over our communities have evolved; social empowerment, rather than social security, is now viewed by many within the field as a primary goal of integration efforts. This shift can largely be attributed to the integration gains made by individuals with severe mental illness in recent decades; gains for which ACT served as an integral vehicle. Individuals with severe mental illness have established a physical presence in their communities and have sustained livelihoods in the community despite occasional returns to hospital for focused periods of treatment. With such significant gains in basic level integration, it is clear that there is room to conceptualize integration for this population in higher-order terms. To continue to advance the levels of integration engaged in by individuals with severe mental illness, models of service delivery, such as ACT, will need to evolve; integration services must facilitate the present and future realities of community life for this population. Hence, the organizing structures that at one time focused the practices of ACT practitioners on basic-level integration (institutional-medical, PSR and even recovery) may not fit with re-conceptualizations of integration that stress social inclusion, cohesion and empowerment. The current study used the method of institutional ethnography to examine *how* the everyday practice

activities of ACT practitioners become organized by factors external to the individuals who enact them. The merits of this study lie primarily in the potential to heighten the awareness around the impact of organizing structures on everyday practice activities. By examining the meta-level organization of community integration practice, the study identifies structural barriers that impede the development of higher-order concepts of integration. Ultimately, an understanding of the link between organizing structures and everyday practice will provide ACT managers and policy planners with an enhanced knowledge base from which to develop structures that better enable practitioners to facilitate higher-order integration.

10.1 Study Limitations and Strengths

This study does not explore all aspects of ACT structure at organizational, systemic, and social levels. The intent of an institutional ethnography is not to present an exhaustive account of organizing structures but rather to demonstrate *how* these structures shape everyday experience. Additionally, the study does not identify the degree of influence of individual factors (job descriptions, accountability frameworks, clinical licensing, funding policies) on community integration practice. Rather, the method employed stresses the compounding impact that arises as a result of the interrelationships that exist amongst various factors across multiple levels of structure. The study also does not allow for generalization in the traditional sense. The findings of this study are generalizeable to the extent that similar structures shape practice in a generally consistent pattern across sites. The specific ways in which individuals enact everyday practice differ across individual and environmental contexts. Finally, this study does not provide an answer to the question, “what is the structural formula required to

produce outcomes associated with higher-order integration?” Rather, this study presents a model of the central tensions involved in the community integration practice of ACT practitioners and traces these tensions to the systematic overruling of activities which attempt to facilitate higher-order aspects of integration.

The goal of the study is both to create an awareness amongst ACT practitioners of the influence of organizing structures over day-to-day practice decisions, as well as to inform policy and practice efforts aimed at enhancing the community integration practice of ACT practitioners. The results of this study have implications for how the field of community mental health as a whole thinks about, structures and practices community integration. Finally, the study encourages continued investigation into the impact of organizing structures on everyday service delivery activities in general.

10.2 On Taking a Critical Stance

The explication in an institutional ethnography describes critically how and why experiences of tension are invisibly organized by conceptual practices of power that regulate what people know and do in the everyday world. ...In essence, the research questions addressed by institutional ethnography are about common experiences of powerlessness that persists without the use of force, and without full awareness of the sources of tension (Townsend, Langille, & Ripley, 2003, p. 18).

Arguments against undertaking a study of this sort often focus on the difficulty (what some even term the idealism) inherent in attempting to change social, organizational, and systemic structures. The counter argument, however, centers on the fact that structures and systems cannot exist without the willing participation of the individuals who function within them. In other words, individuals and their activities contribute to the power wielded by organizing structures. It is important that these same individuals are made aware of how these organizing structures affect their everyday

practice; their actions work to sustain and strengthen the very same structures that conflict with their personal and professional values. Resolution of the tensions experienced by ACT practitioners in the course of enacting community integration practice is the ultimate reason for pursuing this study. Practitioners believe that their role is to strive beyond a level of community integration characterized primarily by psychiatric and social stability. This perception originates from professional training as well as from the concepts and language associated with both ACT and mental health reform as well as advances made by other marginalized groups (e.g., physical and developmental disability fields). Thus, practitioners come to experience systematically organized tensions within the course of carrying out community integration practice. Ultimately, these tensions will not be placated until organizing structures better reflect the values and practices associated with current conceptualizations of community integration.

10.3 Study Findings

The use of PSR and recovery language within the ACT standards implies that community integration practice will be in keeping with the ideals of higher-order integration. In the reality of everyday practice, however, activities associated with higher-order integration are systematically overruled by organizing structures that focus everyday practice activities on the promotion of psychiatric and social stability.

Data gathered from personal interviews, field observations, and document review suggest that organizing structures shape the everyday activities of ACT practitioners in ways that systematically overrule; a) cohesive integration by the fragmented organization

of roles and responsibilities, b) social-level interventions by the organization of practice around an individual model of disability, and c) empowerment practices by the organizing of practice according to a protectionist mandate. Ultimately, the data suggest that within the current structure of ACT, higher-order integration is largely enabled through acts of individual agency. Agency, though, is not sufficient to promote systematic changes in practice directions.

10.4 Relating Findings to Relevant Schools of Thought

10.4.1 Ideology

Why are biomedical values and assumptions so entrenched in the structure of the ACT model, when the model associates itself with PSR and recovery ideologies? Why are the approaches associated with the empowerment-community integration approach not present despite the theoretical influence this ideology has had on the community mental health field in recent decades? Freeden (2003) asserts that macro-level ideologies which exist at the level of society and government (such as political ideology) impose particular structures on the organization of social and work activities and thus play a significant role in determining the “look” of a particular society. In turn, micro-level institutions such as community mental health, reflect and ingrain the values and assumptions associated with these macro-level ideologies. It is through this process that a unifying ideological link is formed between diverse social institutions (Freeden, 2003).

It can be argued that within North American society there is a long history of social and political thought which views the strength of society as emanating from the productive capacity of individuals (Foucault, 1965; Szaz, 1999). Within such a society,

individuals who are perceived to be limited in their productive capacity due to physical or cognitive functioning become marginalized from mainstream resources such as education, employment, housing and transportation (Bickenbach et al., 1999). The alternate premise that society is strengthened by maximizing the potential for all individuals to participate in the production of society would better facilitate higher-order integration opportunities for individuals with severe mental illness. Unfortunately this premise lies in contrast to long-standing ideological beliefs within North American society and thus stands as a significant barrier to mental health advocates attempting to maximize the community integration of individuals with severe mental illness.

10.4.2 Bio-Power: The Role of Human Science Disciplines

Like Freeden, Foucault asserts that liberal values are highly entrenched within the fabric of North American society and, in particular, the fabric of human science disciplines (Danaher et al., 2000). Foucault theorizes that a body of knowledge based on a liberal ideology (statistical knowledge, rational distribution of populations, normalization) is disseminated through the human science disciplines, and associated human service fields, and functions as a regulatory body for sustaining liberal values and assumptions (Danaher et al., 2000). Biomedical values and assumptions then become embedded within and supported by organizing structures operating at macro-levels. Hence, micro-level ideologies compatible with a socialist ideology conflict with the larger organizing structures that determine governmental, economic, and cultural directions. Thus, the ability to shift everyday practices to reflect a social model of

integration is constricted by beliefs, knowledge, and practices which are deeply embedded within macro-level organizing structures.

Why are biomedical values and assumptions sustained across organizational, systemic, and social levels despite professional intentions to adopt alternative ideologies? The permeation of liberal/biomedical values across organizational, systemic, and social levels of society strengthen the resistance to change. For example, at a social level, legislation around Community Treatment Orders can directly lead to police holding mental health practitioners responsible for the illegal actions of service users, reinforcing the view of practitioners as social gatekeepers. Similarly, at a systems level, policies that entitle service users to subsidized taxi chits require that travel be limited only to medical appointments. At an organizational level, practice standards, which promote psychiatric stability prior to community integration, tie community integration to levels of individual functioning. Clearly, biomedical values and assumptions are embedded in the organizational standards that guide everyday ACT practice.

Similar to the idea of organizational legitimacy, Foucault contends that in order to maintain the popular appeal essential in democratic societies, social institutions often associate themselves with new, socially appealing ideas (e.g., human rights, deinstitutionalization, recovery) (Danaher, et al., 2000). Foucault suggests that human science disciplines, largely controlled by the public sector, are particularly vulnerable to the whims of public appeal (e.g. the continual search for research dollars from government and the private sector) (Danaher et al., 2000). Consequently, it can be anticipated that by associating particular goods and practices with popular ideas the product or service will become sellable to the public. Although there may be an intention

to align the product or service with the new ideas to which it has been associated, the need to reflect macro-level ideologies makes it difficult for the institution to restructure its practices in radically different ways. Consequently, the language of new ideas continues to be associated with the social institution, but the organizational structure determining everyday practice remains consistent with pre-existing macro-level ideologies, a structure that is compatible with the language and goals used to promote it. Hence, the discourse surrounding a particular social institution can be and often is incompatible with the values and assumptions that orchestrate the everyday practice within it. Foucault specifically suggests that the purpose of social institutions is to sustain liberal values and assumptions (Danaher et al., 2000). This can be seen in the agendas of the organizing structures that guide practices within these institutions, which are in line with broad liberal values.

Foucault (1965) states:

Although knowledge and technologies are being used to control and regulate individuals and populations, the official version of things is that they are working in our interest, taking care of us, looking after us and watching over us for our own good (1965, p. 68).

10.4.3 Mental Competence and Responsibility

Findings from the current study suggest that it is in the attempt to facilitate higher-order integration that practitioners become overruled by organizing structures. Why do the values and assumptions associated with a biomedical ideology conflict with higher-order integration?

Szaz (1991) proposed a framework for understanding the relationship between perceived competence and social responsibility that helps to explain the resistance to

facilitating higher-order integration of individuals with severe mental illness from a liberal standpoint. Szaz (1991) contends that the values and assumptions that comprise a biomedical ideology impact the degree of independent choice exercised by individuals with mental illness, and that the ability of service users to exercise independent choice is integral to higher-order integration. A structure based on the ideals of social and psychiatric stability ultimately places decision making power in the hands of professionals, a fact that necessarily decreases the ability of individuals with mental illness to exercise independent choice. The framework suggests that independent choice is contingent upon two conditions. First, the degree of independent choice available to any one individual is contingent upon both internal (self-discipline) and external (social relations) factors. Second, independent choice exercised by one individual axiomatically affects the amount that can be exerted by another. Szaz (1991) argues that when the behaviours engaged in by individuals with mental illness are considered within a biomedical context, these two conditions come together to form a society and related institutions that do not expect individuals with mental illness to take responsibility for their personal conduct. Consequently, social relations operating at social, systemic, and organizational levels reflect an assumption that others (e.g., family members, service practitioners) must take responsibility for the actions of these individuals, thus limiting the degree to which independent choice and engagement in higher-order integration will be pursued.

Like Foucault, Szaz (1991) suggests that language can give the appearance that the mental health field wishes to increase the opportunity for independent choice, when in

reality psychiatry functions as a primary vehicle for shifting responsibility for mental health from service users to mental health professionals. He further argues

Psychiatry cannot be extracted from the purpose of taking responsibility for the decisions and actions of individuals with mental illness so long as the [organizing] structures to which it was born continue to govern and ensure its existence in its present form (Szaz, 1991, p. 240).

According to Szaz, a psychiatric system built on the values and assumptions associated with a biomedical ideology is axiomatically opposed to creating the conditions in which independent choice is an option for those with mental illness. The assumption that the psychiatrist is in a position of authority over those individuals who receive psychiatric services is integral to the legitimacy of the profession. The accuracy of this statement is exemplified in the establishment of community treatment orders.

10.4.4 Paradigm Shift

The current study captured some examples of agency in which practitioners consciously resisted the impact of organizing structures. Despite these accounts, however, the study supports the theory that structure is a more powerful determinant of how everyday practice is consistently carried out across sites. Kuhn's (1996) theory of scientific paradigms⁴⁰ offers insight into why it is so difficult to shift the ideological emphasis of organizing structures simply through acts of agency.

Kuhn (1996) suggests that once an ideology becomes integrated into the organizing structure of a field (becoming the dominant paradigm), the values and assumptions of that field are no longer overtly stated. Hence, they become obscure and,

⁴⁰ Although his theory is derived for the pure sciences, Kuhn suggests that his theory can also be applied to "corresponding communities in other fields" including the social sciences (p. 209).

over time, difficult to detect. The values and assumptions of the dominant ideology determine the activities of a particular field. Thus, individuals operating within the field engage in activities that disseminate knowledge and skills compatible with the underlying values and assumptions of the dominant paradigm (in this case liberalism and the biomedical model). Knowledge and practices based on the dominant paradigm are then proliferated, strengthened, and sustained through this process of dissemination. Likewise, professionals within the field become committed to a set of core rules, tools, areas of investigation, and forms of intervention, which are again connected to the underlying values espoused by the dominant paradigm. Funding, too, will show preference for those practices that reflect these core rules, tools, areas of investigation, and forms of investigation.

Kuhn (1996) contends that ultimately new ideas, theories, and events emerge to explain some aspect of the field that was previously unexplained by the dominant paradigm (e.g., why did the introduction of psychotropic medications fail to maintain people with mental illness in community settings?). However, for the reasons indicated above, it is common for new ideas and approaches (e.g., ACT) to become subsumed by the dominant paradigm rather than actually cause a paradigm shift. He explains that the dominant paradigm will attempt to assimilate the conflicting rules of the new theory with the result that the dominant paradigm will claim the theory as its own and re-shape it to adhere to the rules, tools, investigations, and interventions to which it subscribes “so that what exists after is no longer associated in any way with what came before” (Kuhn, 1996, p. 65). Ball (2004) points out that the concept of paradigm shifts is equally applicable to

scientific thought as it is to political and social thought. Examples of this process can be seen in the mental health field through adoption of PSR and recovery philosophies. The terms PSR and recovery are stated prominently in the most recent ACT documents. As predicted in Kuhn's theory, the terms have been associated with ACT practice; however, the ideologies behind these terms have not been made explicit. Nor is there a re-examination of ACT practice standards to ensure that activities, resources, and organizing structures reflect the values and assumptions that underlie these new terms. In fact, the structure of ACT shifts just enough to include specialists associated with PSR and recovery goals, but the prioritization of their activities still centers on the biomedical principle of achieving and maintaining psychiatric and social stability. In line with Kuhn's theory the concept of recovery, after originating within consumer/survivor literature was assimilated into the mental health services literature. Anthony (2000), a former proponent of PSR⁴¹ began writing about recovery-oriented services and soon became a noted expert on recovery. From this perspective recovery-oriented services are added to the existing lexicon of PSR activities, which include crisis and treatment (Anthony, 2000). Eventually, a series of objective measures for recovery were proposed to objectively measure what was originally conceptualized as a subjective experience. The idea that PSR and recovery ideologies have been assimilated into a mental health and larger societal structure that supports and maintains core elements of a biomedical ideology (rather than creating their own paradigm shift) may ultimately explain why ACT is accused of being a "hospital in the community" (Gomory, 1998, 1999, 2005; Nugent &

⁴¹ PSR itself went through many iterations of assimilation from societal rehabilitation (Anthony, 1972), to psychological rehabilitation (Anthony, 1977) and finally to psychiatric rehabilitation (Anthony, 1979).

Spindel, 1998). This may also explain why randomized controlled trials of ACT do not consider psychosocial variables as viable measures of the model.

ACT proponents have attempted in recent years to develop variations of the model which incorporate adaptations aimed at maximizing community integration for specific sub populations including homeless persons (Morse et al., 1992), veterans (Rosenheck & Neale, 1998), individuals with co-occurring substance use disorders (Bond, McDonel, Miller et al., 1991), and those individuals with mental illness involved in the criminal justice system (Lamberti, Weisman, & Faden, 2004). There has also been a call for combining ACT services with other best practice models such as supported housing (Nelson, Aubry & Lafrance, 2007), and supported employment (Gold, Meisler, Santos, Carnemolla, Williams & Keleher, 2006). A randomized controlled trial conducted on a hybrid ACT / vocational support program (Gold, et al., 2006) suggests that such adaptation may well lead to better outcomes associated with higher-order integration. What we do not know, however, is whether these models lessen the tensions experienced by practitioners in carrying out everyday community integration practice. This would be an important area for further exploration of the organizing structures that impact community practice. The fact that these ACT teams, though structurally different in their inclusion of new practice technologies and focus on specific sub-populations, are still bound by the same funding and practice standards as traditional ACT teams suggests that the prioritization of biomedical principles most likely continue to shape the distribution of time, resources and expertise in ways that compromise the ability of practitioners to facilitate higher-order integration.

According to Kuhn (1996) the only way for a paradigm shift to occur is to cease assimilating and altering new information into the dominant paradigm and instead to devise a new theory – with new rules, tools, investigations, and interventions. He contends that the emergence of a new paradigm is not an extension of the old; rather it is

A reconstruction of the field from new fundamentals, a reconstruction that changes some of the field's most elementary theoretical generalizations as well as many of its paradigm methods and application. When the transition is complete, the profession will have changed its views of the field, its methods, and its goals (1996, p. 85).

10.5 Making the Connection

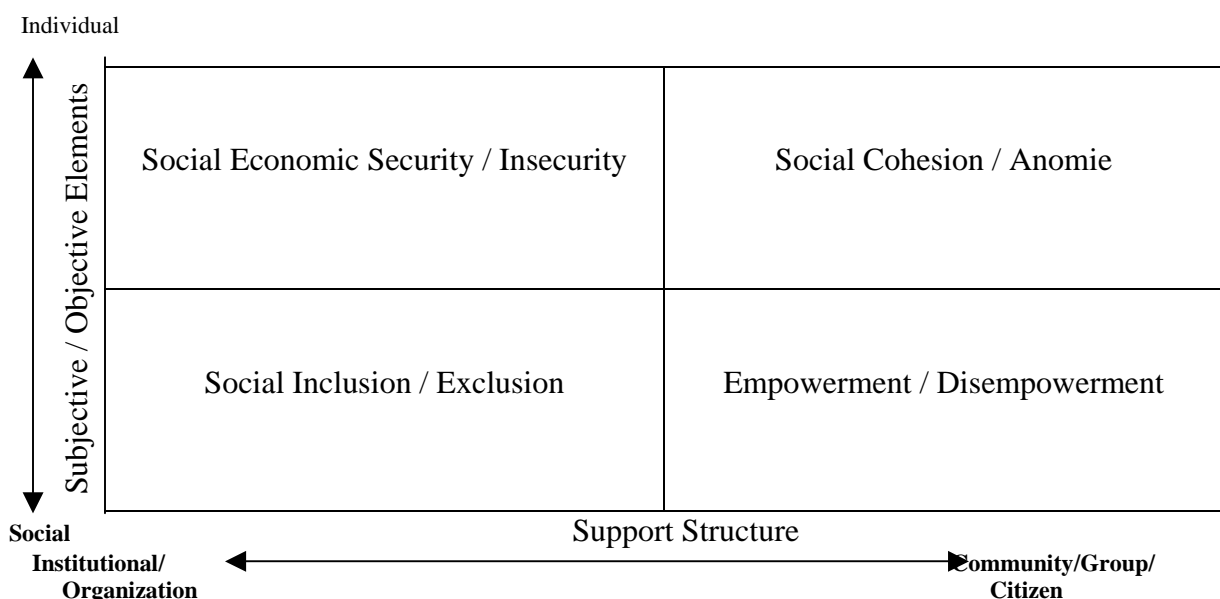
Organizing structures existing at organizational, systemic, and social levels operate concurrently in time and place and are often mutually supportive and reinforcing. These structures are thought to “signal purposefulness and rationality both internally and to external audiences, demonstrating the organizations connections to and congruence with wider belief systems” (Scott, 2000, p. 9). A social constructionist view argues that organizing structures constitute the rules, define the players, and frame the situations that occur in the context of everyday practice. Organizing structures, then, are perceived as pervasive and powerful in their influence over the everyday activities of individual actors. The method of institutional ethnography attempts to explicate the linkages between these organizing structures and the common rules, players, and situations that characterize everyday activities and which are often perceived to be randomly occurring.

10.5.1. Ideology and Integration

Berman and Phillips (2000) present a model of integration that constitutes a continuum from social exclusion to social inclusion. Viewing integration in this manner

highlights the role which social order plays in facilitating or constraining integration. Berman and Phillips (2000) suggest that their model of integration can be divided by a vertical and horizontal axis (Table 4). The vertical axis constitutes subjective and objective elements that delineate individual versus social aspects of integration and exclusion. The horizontal axis indicates prevalent support structures and is divided into institutional /organizational supports and community /group /citizen supports. Social quality comes as a result of “citizens participating in the social and economic life of their communities” (Berman & Phillips, p.340), whereas, social exclusion is a reflection of detachment from social order. McMillan and Chavis (1986) suggest that to be a member of a community demands an investment and active participation within the community framework. To do so requires support from both institutional/organizational as well as community/group/citizen elements to foster both objectively as well as subjectively meaningful integration.

Table 4: The Social Quality Quadrant (derived from Berman & Phillips, 2000, p.338)



The processes and resources required to promote social economic security (which refers to the way in which the essential needs of individuals, with respect to their everyday existence, are addressed by different systems and structures) and social inclusion (which refers to a basic level of inclusion with help of supportive infrastructures / labour conditions) are controlled by organizing structural features embedded in institutions and organizations. The processes and resources required to promote social cohesion (which refers to the processes which create and defend inclusive social networks) and empowerment (which refers to the realization of human competencies and capabilities in order to fully participate in social, political and cultural processes), on the other hand, are controlled by the structural features which are embedded in communities, groups, and citizens.

Social economic security is both supported by institutional/organizational supports and is objectively measured. The results of the current study suggest that social economic security and social influence are the most common indicators of success cited in relation to ACT. Both are reliant upon institutional / organizational supports. Given the ideological influence on organizing structures it is not surprising that within the structure of North American society, social economic security and basic social influence would be the simplest form of integration to support and sustain.

Social cohesion and empowerment are presented in this study as higher-order aspects of integration and are linked with community /group /citizen supports. These supports tend to be limited within liberal-based societies given the contrast with the focus on the individual as the social unit and the encouragement of competition between groups. It is not surprising then that empowerment, the community integration approach

which requires subjective measurement as well as community /group /citizen support, becomes incompatible with the organizing structures guiding everyday community integration practice within our society. The structures which prevail over North American society promote, foster and sustain social-economic security and to a partial extent social inclusion for individuals with severe mental illness but are at odds with the structural organization required to foster social cohesion and empowerment. Consequently, the organizing structures which dominate our society and seep through to our mental health system, and even further into our community mental health programs, systematically limit the extent to which ACT practitioners are able to foster higher-order integration for individuals with severe mental illness within the context of their everyday practice routines (see Table 5, p. 164).

Table 5: Social Quality Vs. Levels of Integration

The diagram illustrates a conceptual framework for social integration and support structure. It is organized into a 2x2 grid with axes representing different levels of analysis.

Vertical Axis (Left): Labeled "Subjective / Objective Elements". The top arrow points up towards "Individual", and the bottom arrow points down.

Horizontal Axis (Bottom): Labeled "Support Structure". The left side is "Social Institutional/ Organization" (with an arrow pointing left), and the right side is "Community/Group/ Citizen" (with an arrow pointing right).

Grid Content:

	Basic-Level Integration	Higher Order Integration
Subjective / Objective Elements (Top)	Social Economic Security / Insecurity	Social Cohesion / Anomie
Subjective / Objective Elements (Bottom)	Social Inclusion / Exclusion	Empowerment / Disempowerment

10.5.2. Macro-level Ideologies Versus Micro-level Approaches

An integral connection exists between mainstream social values, preferences and power and the degree of social integration and exclusion promoted within community mental health programs. The tendency for micro-level approaches (PSR, recovery, empowerment) to incorporate macro-level ideals (liberal ideology) can result in the unintended transformation of approaches. The absorption of macro-level values into micro-level approaches and program structure explains how approaches such as PSR, recovery and empowerment never seem to become forefront drivers of the field (in practice terms) despite enjoying theoretical prominence. This phenomenon also fits with Kuhn's theory of a paradigm shift: until society is ready, what is likely to occur is assimilation rather than real change. The result of infusing practices with conflicting macro-level ideologies under the guise of alternative micro-level ideologies is the practitioners' lack of ability to facilitate the necessary interplay between the individual and the mainstream social environment. Practitioners are also limited in their view of the systematic overruling of their professional practice intentions to ensure that individuals with severe mental illness have access to full integration opportunities.

10.5.3 Normative, Regulative, and Cognitive Influences

Macro-level ideologies seep into micro-level structures and approaches through normative, regulative and cognitive elements. Despite intentions of the field to place a greater emphasis on higher-order aspects of integration, the normative structures that guide everyday practice are shaped by the prescriptive and proscriptive signals of mainstream society. These signals are often aligned with values and assumptions that

emphasize the need for symptom and behavioural management in relation to individuals with severe mental illness. Another aspect of normalization is also at play in that individual practitioners are ultimately a part of the wider society and are thus highly likely to internalize these same assumptions and apply them to their work, largely unconsciously. Such normative pressures explain how Foucault's theory of bio-power can so easily exist within human science disciplines. The mandate to "help" those who are less capable (cognitively, socially, physically) is one that originates with society and is operationalized through a system of government. Normative pressures are therefore part and parcel of the "caring" professions. The professions themselves, however, are influenced as well through academic research and advances, as well as the consumer and human rights movements. As a result, professional intentions for new directions may come to clash with the normative pressures extolled upon them, but professionals may be unable – both for reasons of maintaining social legitimacy as well as personal legitimacy – to wholly abandon these practices.

Regulative processes such as acts of law, funding regulations, and professional credentialing influence organizations to structure themselves in certain ways in order to maintain legal and economic support. In the case of ACT, such regulative elements as Community Treatment Orders, team complement standards, and professional responsibility and remuneration, are in line with the expectations of symptom and behavioural control prescribed by normative elements. Consequently, these regulative elements serve as a mechanism for legitimizing practices aligned with wider liberal values. For example, the intention of the ACT founders was to "go against the current" (Stein & Santos, 1998, p.16) and promote community integration for individuals with

severe mental illness. Yet from the outset the founders were constrained by regulative structures, which required them to compromise in certain areas – largely those related to the perceived competence of individuals with severe mental illness and associated levels of social responsibility. Again regulative elements serve to maintain and strengthen organizing structures reflective of a largely liberal ideology. These same elements support liberal assumptions related to the appropriate level of responsibility.

Likewise, cognitive processes are at play in the attempt by individual practitioners to negotiate the tensions that arise from situations wherein personal and professional values and intentions contrast with everyday activities. As the field of community mental health moved ideologically forward (from the institutional-medical approach and community-treatment rehabilitation approach to the recovery approach and empowerment – community integration approach), tensions arose within the actual practice environment that constrained the shift in priorities. In an attempt to maintain personal legitimacy, practitioners tend to follow social scripts, routines and performances because they are accepted as “the way things are done by a person like me in situations like this” (Campbell & Gregor, 2002, p. 31). When tensions surface as a result of contradictions between activities and deep seeded ideological stances they are rationalized, by the individual and others, as being temporary or due to personal characteristics of the individual. These tensions are rarely thought of as reflections of a systematic overruling of everyday practice intentions. Consequently, an ambiguous environment surfaced wherein certain activities, particularly those most in line with conventional social norms, such as medication dispensing and symptom management, remained, and new approaches

became altered in their appearance – as though assimilated to some degree by the existing institutional-medical approach.

Normative, regulative, and cognitive elements provide a basis for legitimacy (i.e., normative = social legitimacy, regulative = systems legitimacy, cognitive = personal legitimacy) and act to maintain the status quo by powerfully shaping the structures which guide everyday practice. As a result of the influence exerted by these elements, organizing structures become powerful forces against change and in the case of ACT, against the empowerment of individuals with mental illness. It is due to these powerful forces, more so than the intention and skills of individual practitioners, that everyday community integration practice becomes re-shaped in ways that limit higher-order integration for this population.

10.6 Potential New Directions

Agency occurs when a critical point is achieved which causes the individual practitioner to reject a stable state of acceptance and compels her/him to accept a period of disorder in which she/he comes to reject common scripts and attempts to better align her/his day-to-day activities with personal intentions and values (Ball, 2000). Acts of agency tend to go against the prescriptive and proscriptive, and can bring legitimacy into question. Such acts can only come as a result of a conscious examination of the disconnect between organizing structures and personal values and beliefs. And it is through cumulative awareness that a critical mass may emerge and impact wider knowledge and rule systems.

Transformative change “relies on an intricate network of mutual nudges which come together at a given point and energize a radically new steady state” (Ball, 2004, p.

109). The most useful approach to transforming integration for individuals with severe mental illness is to foster such a networked awareness of the linkage between organizing structures, everyday community integration practice and limited higher-order integration. Pods of awareness must exist across the multi-layered, interconnected system of support including policy makers, funders, researchers, practitioners, service users and family members. It is only through the mobilization of a critical mass that significant transformation can occur. To what model/approach will such mobilization lead? In the true sense of change theory, mass mobilization will constitute a shift in thought and conceptualization so as to be unrecognizable from our current standpoint. It is not the intention of this study to propose a new model for ACT or for community integration generally. The purpose of the method employed in this study is to explicate obscure linkages between everyday practice and organizing structures operating not only at organizational levels but also at social and systemic levels. The objective of the study is to create a deeper understanding of a critical element that has often been overlooked in the attempt to explain discrepancies between basic and higher-order outcomes relating to the integration of individuals with severe mental illness.

The findings from this study lend themselves primarily to awareness raising. However, in an attempt to offer something tangible for the present – structurally a place to begin to cast our eyes – an obvious suggestion is for ACT and the community mental health field generally, to consider which rules, tools, investigations, and interventions best support the facilitation of higher-order integration for individuals with severe mental illness. To do so, the field will need to return to its philosophical roots; a debate will need to occur regarding the current values and assumptions upon which organizing

structures are based and to assess their relation to desired future directions. ACT proponents may wish to prepare the model to function as a catalyst for paradigm change. The first step in orienting ACT as a catalyst for change is to recognize that it has not shifted from a biomedical model to a PSR/recovery model. Rather, it has assimilated these ideas into the existing organizing structure based on biomedical assumptions of the roles and responsibilities of both practitioners and service users. The second step is to make explicit the values and assumptions that underlie not only PSR and recovery concepts, but more importantly, a social model of disability. The third is to examine existing organizing structures for their congruency with these espoused ideologies. Finally, the ACT model must begin to demonstrate what a shift looks like in concrete terms, and be prepared to negotiate challenges and produce an evidence base associated with higher-order integration.

It is important to state that in order for practitioners to facilitate higher-order integration they must receive organizational, system and social support to

1. Focus interventions on the community in order to build relevant relationships and create effective pathways for service users.
2. View social inclusion, cohesion, and empowerment as essential components of community integration practice.
3. Place greater responsibility on service users for their social actions, and on communities to provide opportunities/supports for integration.
4. Integrate the principles of community integration into all ACT activities, including medication and symptom monitoring.

To support the community integration practice of ACT practitioners, the following structural elements must be considered:

- a) With whom does the intervention occur?
- b) How is time legitimized?
- c) Who is accountable?
- d) Are measurements of accountability consistent with community integration theory (for what are practitioners held accountable)?
- e) Are day-to-day processes consistent with the role of facilitator?
- f) What constitutes an emergency, what doesn't?
- g) Is resource distribution consistent with guiding principles (job descriptions, leadership)?
- h) Is training consistent with guiding principles (capacity building, community development)?
- i) Have indicators of integration been developed (focus on reciprocity between community members, investment and action)?

Ultimately, the argument here is not that mental illness (and even severe mental illness) does not exist. Nor is the argument that the act of supporting integration for this population is not challenging, regardless of ideology. Rather, the argument presented in this study is that current organizational structures, in obscure and seamless ways, shut down alternate discourses for thinking about, structuring and practicing community integration for this population. As a result such structures may serve as a significant factor contributing to limited outcomes in areas of higher-order integration.

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APPENDIX A:_ LETTER OF INTENT/CONSENT FORM - ACT PROGRAMS

Salinda Horgan
School of Rehabilitation Therapy
Queen's University, Kingston, Ontario, K7L 3N6
Date

Dear ,

My name is Salinda Horgan. I am conducting a research project as part of the requirements for my doctoral degree in Rehabilitation Science at Queen's University. I am interested in examining how ACT services facilitate participation and community integration for those who use the program. I am also interested in understanding how these services enable users of the program to access resources that are important for them to be equal citizens within our society.

In order to explore this question I am proposing to conduct an institutional ethnography with three ACT teams. The [name of ACT team] is one of the three ACT teams that I am interested in pursuing for this research. As I will be employing an ethnographic methodology, I am proposing to conduct a document analysis that would include reviewing documents such as program mission statements, client activity calendars, and staff activity forms. There would also be a participant observation component in which I would observe staff activities and interactions with clients (where permissible). Finally, I am proposing to conduct personal interviews with one or more staff from each program. Each interview session would last approximately 45 minutes and would take place at a time and place convenient for the participants.

I recognize that in order to pursue many of these avenues, specific coordination of events and issues of confidentiality would need to be further discussed. At this point I am requesting your participation in this study. If you are interested in participating in this study please sign the attached participant statement and we will set up a time to further discuss the details involved in implementation.

I would be happy to provide any further information that you may wish at this time, my phone number is (613)533-6000 ext.74756 and my e-mail address is sh37@post.queensu.ca . You may also feel free to contact my thesis supervisor, Dr. Terry Krupa by phone (613)533-6236 or by e-mail krupat@post.queensu.ca.

Sincerely,

Salinda Horgan, Ph.D. Candidate

Risks

No risks are expected from taking part in this study. The document analysis will not require any interaction with team members. The participant observation aspect of the study will involve limited interaction between the researcher and members of the ACT team. However, as the observation process is passive rather than active the interaction will be minimal and no risk is anticipated on the part of ACT team members (staff or clients). The in-depth interviews conducted with staff and clients of the ACT teams and with key informants will be taped. Some individuals may feel nervous during the interview. If anyone feels uncomfortable during the interview they are asked to let the researcher know. Participants are also informed that she/he may request a break during the interview, or request to continue the interview at another time.

Benefits

ACT teams will not benefit directly from this study. Indirect benefits include contributing to the knowledge regarding ACT and increasing the understanding of how clients participate as citizens in our society.

Confidentiality

Any information that is gathered for this study will remain confidential. A code number will be used to identify all information provided. The information will be kept in a locked storage space at Queen's University. Any research reports that come from this study will not identify your program in any way. The reports will be written about all teams that participate in the study, as a group.

Voluntary Participation

It is the program's decision to take part in this study. If at any point the program as a whole decides that it does not wish to complete the data collected up until that point will be destroyed and no data from the program will be used in this study.

Feedback

A presentation of the final analysis will be provided to each program at the end of the project. A more in depth report of the background of the research, how the information was gathered and what the findings were will also be provided.

Participant Statement

I, _____ (print name of program coordinator), program coordinator of _____ (print name of program) have read and understand what is involved in the study. My questions have all been answered. I have had enough time to think about whether I want to take part. I am signing this form voluntarily on behalf of _____ (name of program). The members of the _____ (name of program) are aware that they can collectively change their minds and not take part at any time. If I have more questions I will call: Salinda Horgan at (613)533-6000 ext.74756 (researcher) or Dr. Terry Krupa at (613)533-6236 (thesis supervisor). If I have

any questions about my participation or rights in this research, I can contact [name] who is chair of the Research Ethics Board at Queen's University [number].

Signature of Participant

Date

Signature of Researcher

Date

APPENDIX B: CONSENT FORM – INDIVIDUAL INTERVIEWS (STAFF)

Informed Consent

Details of the study

My name is Salinda Horgan. I am conducting a research project with [name of program] as part of the requirements for my doctoral degree in Rehabilitation Science at Queen's University. I am interested in examining how ACT clients participate and integrate both within the ACT program and in society. I am also interested in understanding how ACT clients access resources that are important for them to be equal citizens within our society. As you are currently a [staff member] with [name of program], I would like to ask you to participate in this study.

What is involved?

The researcher will conduct a personal interview with you. The interview will ask you to describe your daily routine as a [staff member] of an Assertive Community Treatment Team. Primarily the interview will center around questions related to how [the facilitation of citizenship fits into your everyday routine of providing ACT services]. A specific definition of citizenship will be given at the time of the interview. The interview will be taped. Only myself and the person who transcribes the interview will hear the tape. The tape will be erased as soon as the interview has been transcribed. It is expected that the interview can be completed in one visit for a total time of 45 minutes. A break will be built into the interviews, but you can have additional breaks if you feel that you need them.

Participation in this study should not cost you anything. You will be given the money to cover any travel costs that you may incur as a result of participating.

Risks

No risks are expected from taking part in this study. The interview will be taped and this may make you feel nervous during the interview. If you feel uncomfortable during the interview please let the researcher know. You can take a break, or meet at another time. You can decide to end your participation in the study. If there is any question you do not wish to answer, just tell the researcher to skip it.

Benefits

You may not benefit directly from this study, however, a secondary benefit for you is the chance to talk to someone about things that are important to you.

Confidentiality

Any information that you give for this study is confidential. Your [program manager and colleagues] will not be informed about the information that you provide. Instead of your name, a code number will be used to identify the information that you give. The information will be kept in a locked storage space at Queen's University. Any research reports that come from this study will not identify you in any way. The reports will be written about everyone who takes part in the study, as a group.

Voluntary Participation

It is your decision if you want to take part in this study. You can change your mind and leave the interview at any time. This will in no way affect [your position with] the [name of program]. If at any point you decide that you do not wish to complete the interview the tape will be erased and nothing that you have said will be used as data for this project.

Feedback

You will receive a copy of the transcribed interview one or two weeks after the completion of the interview so that you can review it and provide me with suggestions for adjustments prior to data analysis. You will also receive a more in depth report of the background of the research, how the information was gathered and what the findings were once the data have been analyzed.

Participant Statement

I, _____ (print name of participant) have read and understand what is involved in the study. My questions have all been answered. I have had enough time to think about whether I want to take part. I am signing this form voluntarily (on my own). I know that I can change my mind and not take part at any time. If I have more questions I will call: Salinda Horgan at (613)533-6000 ext.74756 (researcher) or Dr. Terry Krupa at (613)533-6236 (thesis supervisor). If I have any questions about my participation or rights in this research, I can contact [name] who is chair of the Research Ethics Board at Queen's University [number].

Signature of Participant

Date

Signature of Researcher

Date

APPENDIX C: LETTER OF INTENT/CONSENT FORM – KEY INFORMANTS

Salinda Horgan
Queen's University
Kingston, Ontario, K7L 3N6

Date
Participant Address
Dear,

My name is Salinda Horgan. I am conducting a research project as part of the requirements for my doctoral degree in Rehabilitation Science at Queen's University. I am interested in examining how ACT clients participate and integrate both within the ACT program and in society.

Participation would include an interview of approximately one hour during which I would ask you to answer the question, From a systems perspective, in what way does ACT promote and /or demote the experience of integration for clients?

Approximately four individuals representing several perspectives on the issue of citizenship will also be asked to participate in the same manner. Following completion of the interview, a transcription of the interview will be compiled. I will send you a copy of the transcription so that you have an opportunity to review it and make suggestions for changes before the data is analysed. There is a possibility that this information may be published in the future as well. Please be assured that your name will in no way be associated with your story unless that is your wish.

The interviews may be conducted either in person or by telephone. I will contact you in approximately one week to inquire about your willingness to participate and I would be happy to answer any questions at that time. The interview would be held at a time and place that is convenient for you. With your permission, we will tape-record the interview. I will be the only person who will have access to the tapes and they will be destroyed following the completion of the study. Please be aware that your participation in this research project is completely voluntary.

I ask that you sign and return to me the attached consent form. This form indicates that you understand the purposes and conditions of participation in the research and agree to participate. I can answer any questions you may have about this form before you sign it. If there is anything that you do not feel comfortable talking about, just let me know and I will go on to something else. You can refuse to answer any questions. If at any time you'd like to end the interview, just tell me and I will stop at that point. Everything you say during the interview will be held in the strictest confidence, and you will be identified by code number only. Your name will not be associated with anything you say and the tape of your interview will be securely stored in the office of one of the researchers.

If you have any questions, you may contact me at (613) 533-6000, ext. 74756. You may also feel free to contact my thesis supervisor, Dr. Terry Krupa at (613)533-6236. Also, please be aware that this research has been reviewed and approved by the Research Ethics Committee at Queen's University. If you have any concerns about this research, you may contact [name] at [number]. Thank you for your consideration of my request.

Sincerely,

Salinda Horgan, Ph.D. Candidate

Risks

No risks are expected from taking part in this study. The interview will be taped and this may make you feel nervous during the interview. If you feel uncomfortable during the interview please let the researcher know. You can take a break, or meet at another time. You can decide to end your participation in the study. If there is any question you do not wish to answer, just tell the researcher to skip it.

Benefits

You may not benefit directly from this study. A possible benefit for you is the chance to talk to someone about things that are important to you regarding the ACT model.

Confidentiality

Any information that you give for this study is confidential. No one will be informed about the specific information that you provide. Instead of your name, a code number will be used to identify the information that you give. The information will be kept in a locked storage space at Queen's University. Any research reports that come from this study will not identify you in any way.

Voluntary Participation

It is your decision if you want to take part in this study. You can change your mind and leave the interview at any time. If at any point you decide that you do not wish to complete the interview the tape will be erased and nothing that you have said will be used as data for this project.

Feedback

You will receive a copy of the transcribed interview one or two weeks after the completion of the interview so that you can review it and provide me with suggestions for adjustments prior to data analysis. You will also receive a more in depth report of the background of the research, how the information was gathered and what the findings were once the data have been analyzed.

Participant Statement

I, _____ (print name of participant) have read and understand what is involved in the study. My questions have all been answered. I have had enough time to

think about whether I want to take part. I am signing this form voluntarily (on my own). I know that I can change my mind and not take part at any time. If I have more questions I will call: Salinda Horgan at (613)533-6000 ext.74756 (researcher) or Dr. Terry Krupa at (613)533-6236 (thesis supervisor). If I have any questions about my participation or rights in this research, I can contact [name] who is chair of the Research Ethics Board at Queen's University [number].

Signature of Participant

Date

Signature of Researcher

Date

APPENDIX D – INTERVIEW GUIDE

1. Tell me about your [position with ACT/the services you receive from ACT].
2. Tell me about daily successes and frustrations that occur in your job.
3. Are there things that you thought you would be doing in your job that you are not (or not as much as you would like?)
4. Are there things that you thought you would not be doing in your job that you are doing (or doing more than you thought you would?)
5. What sources of information tell you what you should be doing in your job?
6. Tell me the best thing that you like about working in ACT.
7. Tell me what disappoints you about working in ACT.
8. Tell me about citizenship and how this relates to your job.