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Article abstract

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Recovery Compromised : Tracing the Structural Conditions that Perpetuate and Maintain Social Exclusion in Assertive Community Treatment¹

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Abstract

Concerns have been raised regarding the extent to which the services provided through the Assertive Community Treatment (ACT) model are based on an understanding of recovery as primarily a clinical phenomenon rather than a journey that is fundamentally about self-determination, social inclusion, citizenship and civil rights. Until recently, the limited degree of social inclusion experienced by users of ACT has been assumed to result from individual functioning or inadequate practitioner training. These explanations negate the role of organizing conditions in shaping a systematic approach to everyday practice that diminishes opportunities for inclusion. The current study identifies key areas where practices consistent with the current recovery vision and theories of social inclusion are superseded by accepted and legitimized forms of practice that are aligned with a medical model approach. The study explicates both how and why this happens in the course of everyday practice.

Keywords : social inclusion, recovery, paradigm shift, service planning and organization, Assertive Community Treatment, institutional ethnography

Résumé

Des inquiétudes ont été soulevées à savoir si les services fournis par le modèle de traitement communautaire intensif sont basés sur une compréhension du rétablissement en tant que phénomène principalement clinique plutôt qu'une progression fondamentalement liée à l'autodétermination, à l'inclusion sociale, à la citoyenneté et aux droits civiques. Jusqu'à récemment, on a présumé que le niveau limité d'inclusion sociale, dont les utilisateurs de traitement communautaire intensif faisaient l'expérience, résultait du travail individuel ou de la formation insuffisante des praticiens. Ces explications nient le rôle qu'ont les conditions organisationnelles dans l'adoption de pratiques quotidiennes diminuant systématiquement les opportunités d'inclusion. La présente étude identifie des domaines clés où des pratiques compatibles à la vision actuelle du rétablissement et aux théories courantes d'inclusion sociale sont remplacées par des pratiques acceptées et légitimées par une approche reposant sur le modèle médical. L'étude démontre comment et pourquoi cela se produit dans le cadre de la pratique quotidienne des praticiens.

Mots-clés : inclusion sociale, rétablissement, changement de paradigme, planification et organisation des services, équipes communautaires de traitement intensif, ethnographie institutionnelle

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Introduction

The recovery approach is currently considered the guiding vision for mental health policy and practice in Canada (Davidson, Harding, & Spaniol, 2005; Kidd, George, O'Connell, Sylvestre, Kirkpatrick, Browne et al., 2010; Kidd, George, O'Connell, Sylvestre, Kirkpatrick, Browne et al., 2011; Salyers & Tsemberis, 2007). Recovery has been described as "a redefinition of one's illness as only one aspect of a multidimensional sense of self capable of identifying, choosing, and pursuing personally meaningful goals and aspirations despite continuing to suffer the effects of mental illness" (Davidson et al., 2005, p. 483). A core assumption underlying the recovery concept is the assumption that active involvement in care processes and community life are essential to the health and well being of individuals with mental illness (Kidd et al., 2011). The key dimensions of recovery include "overcoming the effects of discrimination, assuming control, becoming empowered and exercising citizenship, managing symptoms, and being supported by others" (Kidd et al., 2011, p. 95).

Individuals with mental illness who are engaged in recovery come to assume ownership and responsibility over the health care process and adopt roles with greater significance within their communities. In turn the health system and broader society enable recovery by offering enhanced opportunity for individuals to manage their own illness and to integrate more fully into community life. The recovery vision represents a significant and difficult shift from traditional mental health service delivery which has largely been dominated by a medical model perspective and individual approach to service delivery. Concerns have been raised about the extent to which the mental health system remains oriented to understanding recovery, particularly in relation to individuals with serious mental illness, as primarily a clinical phenomenon, as opposed to a journey that is fundamentally about self-determination, social inclusion, citizenship and civil rights (Davidson, Drake, Schmutte, Dinzeo, & Andres-Hyman, 2009; Davidson, Rakfelt, & Strauss, 2010).

Davidson and colleagues (2009) point out that the latter "represents a personal, social, and political reality as much as it does a medical one" (p. 325).

Until recently explanations regarding the limited levels of recovery that have been achieved by individuals with more serious forms of mental illness have centered on suggestions that such individuals are unable to achieve full social inclusion or that service practitioners are inadequately trained in the competencies required to foster inclusion. Largely absent from this discussion, though is a recognition of the role of organizing conditions in shaping how service delivery practices are carried out on everyday basis. That is, the rules and regulations contained in policy and procedure manuals, government standards, job descriptions, and disciplinary regulations create an overarching structure that systematically controls and coordinates an unquestioned approach to practice (Smith, 2006). To resolve the discrepancy between new expectations associated with current views of recovery and the reality of mental health service delivery for individuals with serious mental illness, it is necessary to identify where practices consistent with recovery may be superseded by overarching organizing structures and conditions aligned with a traditional individual/medical model approach.

The current study concerns itself primarily with how organizing structures and processes work in concert to potentially subordinate social inclusion dimensions of recovery within Assertive Community Treatment (ACT). ACT is a particular model of service delivery for people with serious mental illness that has gained prominence as an evidence-based model in community mental health and has been widely disseminated internationally. In some jurisdictions, such as Ontario, Canada, the implementation of Assertive Community Treatment has been conceived as a key policy response to the need for community mental health services for this population.



- *Recovery as Social Inclusion*

Social inclusion refers to equitable and reciprocal interpersonal, economic and political exchange between marginalized groups and mainstream society. The results of this exchange are of mutual benefit to both the individual and society (Berman & Phillips, 2000; Ware, Hopper, Tugenberg, Dickey, & Fisher, 2007). The individual gains access to community resources and is able to make a contribution to social, economic and political life (Ignatieff, 2004). Likewise, society increases the breadth of social contribution, improving overall growth (Beck, Van der Maesen, & Walker, 1997; Berman & Phillips, 2000). This concept represents an important ideological shift with respect to individuals with serious mental illness. The degree of inclusion experienced by members of this group has historically been assumed to be contingent upon the actions and capacities of each individual. The current recovery perspective however emphasizes the role of society in either activating or restricting opportunities for individuals with mental illness to become actively and meaningfully engaged in society (Berman & Phillips, 2000; Raphael, 2004; Topor, Borg, DiGirolamo, & Davidson, 2011).

Berman and Phillips (2000) propose a continuum of social inclusion along which are positioned critical points of interchange between individuals and society. These points of interchange include social economic security (e.g., shelter, health care, financial assistance); social participation (e.g., employment, education and recreation); social cohesion (e.g., occupying membership and ownership roles in mainstream society); and empowerment (e.g., representation and influence) (Berman & Phillips, 2000; Milner & Kelly, 2009; Ware, Hopper, Tugenberg, Dickey, & Fisher, 2008). To foster full social inclusion exchange must occur between the person and society at each point (Berman & Phillips, 2000). Although the dimensions are described as discrete, they are highly interrelated and encapsulate both basic and higher-order elements of inclusion. Basic elements such as social economic security and social participation represent rudimentary

forms of exchange, and foster the physical presence of individuals within society. Higher-order elements foster the conceptual and intellectual presence of the person through an intricate cross-pollination of idea and activity sharing, ultimately opening the door for social transformation. Where opportunities for exchange are not present (i.e., at either basic or higher-order levels) dimensions of social exclusion are likely to develop (Berman & Phillips, 2000) and suppress the physical and/or intellectual presence of the person in society. If social inclusion is an integral element of recovery, then consideration must be given as to how to foster both basic and higher-order elements of inclusion to ensure that members of this group become active participants within society.

A particular challenge in enabling recovery for this group will be to shift the broader conceptualization of the nature of disability as it pertains to mental illness (Leonardi, Bickenbach, Ustun, Kostanjsek, & Chatterji, 2006). New policy trends in health care generally consider impairment as operational within a broader economic, social and political reality (Breen, Green, Roarty, & Saggars, 2008; Davidson et al., 2005; Scullion, 2009). This recognition of the interchange between physical illness and social and environmental conditions however, is radically unaligned with the roles and functions of mental health practice as it is applied to individuals with serious mental illness (Novella, 2010). The medical model of disability that has largely shaped current mental health practice, targets correction of the underlying illness process and/or the individual's ability to manage with their health condition. Interventions focus on changing behaviours to comply with social norms (WHO, 2002). Where this is not possible there is an assertion that true inclusion may not be achievable given lower levels of functioning for this group (Gabel & Peters, 2004; Kawachi & Berkman, 2001; Oliver, 1998). Alternatively, the social model of disability focuses on the extent to which underlying social processes of exclusion, marginalize people who do not function according to social norms (WHO, 2002). Interventions associated with this model attempt to build community capacity by enabling full participation and community membership

(Ochocka, Nelson, & Lord, 1999; Ware et al., 2008). Because of its emphasis on the relationship between the individual and broader society, the social model of disability is most consistent with producing outcomes in line with a recovery-orientation. Although recent interventions in community mental health are increasingly recovery oriented, these have not been routinely developed and applied in services to individuals with serious mental illness. In recent high profile efforts to develop practice and system guidelines to advance the recovery vision (Davidson, Rakfelt, & Strauss, 2010) a specific focus has been to identify the tensions surrounding the delivery of recovery oriented services in practice situations where the medical model is prominent, including acute care settings (Chen, Krupa, Lysaght, McCay, & Piat, 2011).

- Recovery and Assertive Community Treatment: Ideological and Practice Divide

Despite the increasing alignment of mental health policy with social model ideals (Davidson et al., 2009; Hopper, 2007) the values and principles associated with the medical model continue to dominate community-based practice for individuals with serious mental illness (Ware et al., 2007). Concerns have been expressed regarding the degree to which current practices are aligned with the values and assumptions of the medical model. Assertive Community Treatment (ACT) is considered the best practices service delivery model for individuals with serious mental illness and is one such model over which concerns have been expressed (Kidd et al., 2011; Mueser, Bond, Drake, & Resnick, 1998; Salyers, McGuire, Rollins, Bond, Mueser, & Macy, 2010). ACT is a multi-disciplinary community based service that provides continuous treatment, rehabilitation, and social support to enable individuals with serious mental illness to become integrated into community life (Huxley & Thornicroft, 2003; Stein & Santos, 1998). ACT has been critiqued for placing an unbalanced focus on the physical presence of the individual in society (i.e., basic-level inclusion), compromising attention to higher-order levels of inclusion that rely upon reciprocal economic, political and

cultural exchange (Gomory, 2005; Marshall, Crowe, Oades, Deane, & Kavanagh, 2007). Reviews of randomized controlled trials, for example have shown ACT to be an effective approach for reducing hospital admissions, and supporting independent living in the community (Marshall & Lockwood, 2009; Mueser et al., 1998). However, variables associated with more complex levels of inclusion such as, vocational functioning, social functioning and quality of life have demonstrated fewer outcomes and have been less likely to be included as areas of investigation (Bond, Drake, Mueser, & Latimer, 2001; Mueser et al., 1998).

Salyers et al., (2010) and many others (Anthony, 2004; Drake & Deegan, 2008; Kidd et al., 2010; Kidd et al., 2011; Salyers & Tsemberis, 2007) contend that by virtue of its mandate to “keep consumers in the community” (p. 320) and its position as a best practice model it is inherent upon ACT to demonstrate outcomes consistent with recovery. Over the past ten years several recovery-oriented initiatives have been incorporated into existing ACT services including peer support workers, supported housing, and supported employment programs. However, a discrepancy continues to persist between the overall outcomes associated with the model and recovery principles. For example, in their examination of the association between key recovery domains and ACT outcomes, Kidd et al. (2010) report that only modest indications of recovery-oriented service provision were found amongst ACT teams in the province of Ontario. In a related paper, Kidd et al. (2011) identified points of divergence between ACT standards of practice and ideal recovery-oriented care. The authors found that the standards that determine diversity in treatment options, consumer involvement in service provision, recovery education, and individually tailored services, contrast with an ideal conceptualization of recovery. Similarly, Salyers and Tsemberis (2007) found ACT fidelity measures to be only minimally linked to the key tenets of recovery (Salyers & Tsemberis, 2007). The authors conclude that, “ongoing work is needed [beyond training in recovery competencies, the adoption of recovery-oriented language and the inclusion of consum-



ers-survivors as service practitioners] to operationalize recovery-oriented practices and clinical functional outcomes” (Kidd et al., 2011, p. 200). They further suggest that the fidelity measures that guide ACT practice may be misaligned with recovery-oriented principles and may be a factor in limiting the extent to which recovery outcomes can be measured. In particular, they note that the more social elements of recovery are not being measured through traditional outcome measures (Kidd et al., 2011). All three of the above studies recommend interventions to enhance the recovery-orientation of ACT including: on-going training in recovery principles, monitoring of recovery processes and strategies, new measurement tools to assess recovery outcomes (Kidd et al., 2010; Kidd et al., 2011), and involving consumers in decision-making processes (Salyers & Tsemberis, 2007).

Several theorists suggest that the limited uptake of the social model in mental health services may stem from a lack of understanding of how to practically apply it in practice and reconcile the inevitable tensions (Davidson, Ridgway, Wieland, & O’Connell, 2009; Krupa & Clark, 2009). These theorists suggest that re-thinking practice from the perspective of the social model may require a fundamental shift in viewing practitioners as “social mediators” rather than “case managers” (Breen et al., 2008; Davidson et al., 2010; Davidson, Ridgway et al., 2009) wherein the focus of service provision becomes one of:

“Facilitating the process of development... [by] invest[ing] in, creat[ing], engage[ing], and making more flexible and responsive, the policies and opportunity sets available, expand[ing] the range of accessible and valued options and choices, and improve[ing] access to resources and supports so that people have the means necessary to engage in the activities they value” (Davidson, Ridgway et al., 2009, p. 44).

Although ACT fidelity scales have helped to facilitate a uniform structure ensuring consistent service delivery across sites and have helped to establish a strong research base

(Kidd et al., 2010; Kidd et al., 2011; Salyers & Tsemberis, 2007), studies examining the association between ACT and recovery suggest that these scales may in fact entrench a medical model approach to service delivery (Kidd et al., 2010). Kidd et al. (2010) further suggests that ACT may be responding to two conflicting mandates, the first, to reduce hospital admissions and ensure medication compliance (Watts & Priebe, 2002) and the second, to increase participation in the community” (Kidd et al., 2010, p. 343). To understand the role of organizing conditions such as the ACT fidelity scales in accounting for the discrepancy between recovery and current practice approaches, it is necessary to trace the alignment between overarching organizing conditions, assumptions of disability, and everyday practice.

- Organizing Social Integration Practice

Shifting the roles and responsibilities of ACT to enable outcomes aligned with recovery requires a re-examination of the organizing conditions that shape everyday practice (Scott, 2000). The system of organizing conditions (e.g., policy and procedure manuals, government standards, job descriptions, disciplinary regulations) that control and coordinate practice across sites (Smith, 2006; Townsend, 1998) create routine ways of thinking about, and acting out practice. These organizing conditions are most obviously reflected in official texts, which then serve as a key mechanism through which common ways of thinking about, and carrying out practice are communicated (Smith, 1996, 2006). The worldviews expressed in these texts along with associated rewards and consequences, come to constitute the conditions that ultimately shape social integration everyday practice (Campbell & Gregor, 2002). The knowledge and assumptions contained in these texts is then reflected in the social relations that occur between practitioners as well as between practitioners and service users. Hence, practitioners come to make sense of their practice in ways that are consistent with the embedded reasoning in these texts. The ways in which texts shape practice become legitimate and approved over other forms of practice. Individual practitioners may

be unaware of the extent to which their approach to practice is universally orchestrated through a system of organizing conditions (Smith, 1996, 2006). When and if practitioners do become aware of the impact of organizing conditions on their work, they may “choose to respond to, or resist” the ways in which their practice is being shaped (Danaher, Schirato, & Webb, 2000, p. 120). This process is referred to as agency and may involve practitioners and administrators, purposely implementing novel and innovative practice components to counteract the ways in which their work is organized. Kuhn (1996) contends that it is common for new ideas and approaches to become subsumed by dominant paradigms rather than cause a paradigm shift. He explains that the dominant paradigm will attempt to assimilate the conflicting rules of the new theory and reshape it to adhere to the rules, tools, investigations and interventions to which it subscribes. Many theorists suggest that the logic and rationale of the medical model continues to coordinate and concert ACT practice through a relatively unchanged system of organizing conditions (Drake & Deegan, 2008). Although recovery concepts have been added to the existing structure of ACT through, for example, the addition of peer support roles, supported employment, and illness management and recovery (IMR) programs, they have been subsumed under a larger structure of organization that reflects medical model ideals. Thus, rendering a weak implementation of their recovery orientation, and in turn, lessening the likelihood that they will produce strong recovery-oriented outcomes. In other words, while fidelity criteria are meant to promote consistency and quality in research and evaluation, the extent to which they are themselves institutionalized, and therefore closed from critique and debate, may impact the potential for moving forward using a true recovery approach.

- The Current Study

The current study employed an institutional ethnography to trace the link between overarching organizing conditions and the ways in which knowledge and behaviour come to form a structured, legitimized approach to social

integration within ACT. The study identifies key areas where practices consistent with the current recovery vision and theories of social inclusion are superseded by accepted and legitimized forms of practice aligned with the medical model and explicates both how and why this happens in the course of everyday practice.

Method

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. This methodology attempts to make clear the complex field of organizational, systemic, and social coordination that accounts for and is reinforced by, everyday activities (Smith, 2006; Campbell & Gregor, 2002). The method involves observing what individuals do within a particular setting and identifying common responses across sites. Subsequently, interviews are conducted with individuals operating within these settings to understand the “logic” behind their daily practice. A review of the texts that appear in people’s talk is performed to explicate the organizational priorities of everyday practice and the compatibility of these with theoretical proclamations of practice, aim and purpose. Finally, social relations are examined to trace how organizational priorities contained within texts directly and systematically affect decision-making and social practices that account for everyday tensions.

Three ACT teams in central, eastern and southeastern Ontario, Canada participated in the current study. These teams were developed following the provincial program standards for Assertive Community Treatment Teams in Ontario, Canada (Ontario Ministry of Health and Long-Term Care, 2004). ACT teams were chosen for the study based on their designation as an internationally recognized best practice model for the integration of individuals with serious mental illness and who are frequent users of intensive health and social services (Mueser et al., 1998; Stein & Santos, 1998). Data collection for the current study



consisted of 22 full days of field observation, 26 in-depth personal interviews with ACT administrators, staff and service users, and review of 30 ACT program and policy documents. An institutional ethnographic approach was used to guide the data collection and analysis processes. Key texts were examined to identify the material organization of practice activities and to verify the association with broader ideological positions. Personal interviews were conducted to uncover the “logic” used to justify particular approaches to everyday practice and finally, social relations were observed to trace how organizational priorities directly and systematically affect decision-making and social influence processes. The data were analyzed using a back-and-forth method of exploration to trace connections between the everyday activities of individuals and the documentation and other processes that organize this work. Through this process, the data were examined with the intent of revealing the influence of entrenched ideological and structural influences in the production of everyday social integration practice, and to make visible the points of connection that create and sustain these practice processes (Campbell & Gregor, 2002; Smith, 2006).

Findings

The findings of this study suggest that although practitioners are aware of and consciously embrace the values of social inclusion as defined within a recovery or social model approach, actual everyday practice is more likely to be organized according to a medical or individual approach to care. This accounts for the tension between expected outcomes from a theoretical standpoint and actual outcomes associated with service user functioning and experience. Specifically, the patterns of priority setting, resource distribution and intervention approaches facilitate the physical presence of the individual in society, and compromise attention to recovery goals that relate to higher-order aspects of social inclusion. The analysis revealed three central structural and practice tensions concerning the goal, focus and approach to social integration practice. The following quotes, observations and excerpts from texts trace the

rather complex path from organizing conditions to everyday practice that shape and define these tensions.

- Goals

The rationale surrounding the overall goal of ACT practice assumes a link between community living and overall health. However, the actual operationalization of integration practice is disposed towards protection, controlling the interactions of individuals within the larger social environment. A crucial contradiction between current integration theory that stresses integration as a form of voice and community interchange and everyday practice routines is created.

The everyday experiences of practitioners reflect a particularly heightened concern regarding protection from illness relapse. This comes primarily in the form of managing and reducing susceptibility to features of mental illness. This quote by an ACT practitioner highlights the tension between protection and a social model ideology:

“[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. I say job one is staying well, taking medications, taking care of yourself, living as healthy as you can, having friendships and relationships, um, kind of like retirement. So, I, you know really try not to put that pressure on them to be productive”

If the overriding integration goal is understood to be the avoidance of mental illness then introducing unpredictable social interactions into the service support repertoire becomes suspect as potentially damaging risk-taking. This protectionist stance results in an emphasis on basic levels of social inclusion and questions of the relevance of higher-order integration for this population. Pressures emanating from the mental health system to assume responsibility for ensuring symptom stability only serve to further entrench this stance. This has far reach-

ing implications for practitioners, impacting how their competencies are evaluated and even whether they will be held liable for the actions taken by service users. The preference not to “pressure” individuals to be “productive” may equally reflect the “pressure” that is perceived by practitioners in instances where mental health symptoms may become exacerbated. Social inclusion, particularly when involving elements of social exchange, can be seen as a potential source of conflict for practitioners and a situation to be avoided rather than an opportunity to be considered.

Evident in the above discussion is an implicit assumption about what constitutes wellness. This assumption is linked to a particular way of thinking about and enacting social inclusion. Practitioners are hesitant to embark on a path that encourages opportunities for heightened social exchange as it necessitates engaging with perspectives and skill sets uncommon to traditional practice. Ultimately, the protectionist stance illustrated in the above dialogue compromises the extent to which opportunities for meaningful social, political and economic inclusion are prioritized and further developed within everyday integration practice.

This protectionist perspective is further demonstrated in the designation of psychiatrists as the clinical leaders on ACT teams. The “logic” behind this designation is described by one ACT psychiatrist in the following manner:

“I’m the part that has to do with all the legal part of, medical legal part of [the service], [service users] become my patients and the prescribing of 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 medications] is mine... Once they become my patients, I have a responsibility to [the service users] to make sure that I think they get the best care or treatment.”

In operational terms ACT teams are unable to function without filling the psychiatrist position. The placement of the psychiatrist (the only professional licensed to prescribe medication) as the clinical lead is a testament to the high priority placed on the role of medically oriented treatment, and the extended value associated with psychiatric stability. Even when the training or professional licensing of other ACT practitioners (e.g., occupational therapy, social work, peer support) is not directly in the area of clinical treatment and assessment, their activities also become organized around the “medical and legal responsibility” associated with psychiatric stability:

“As a team manager, even as much as I’d like to say that I don’t put [responsibility for a psychiatric crises] upon my team members, I know that I do. As much as, you know, whenever you have a [psychiatric] 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].”

Ultimately, the responsibility placed on the psychiatric and social stability of service recipients creates a vulnerable environment for service practitioners when things “go wrong”. As part and parcel of the objective to ensure stability, everyday practice gives priority to ensuring that the conditions for basic-level social inclusion are met. These activities become a fundamental part of the generic work and responsibility of all ACT providers regardless of whether their primary specialization falls into this area of service delivery. Thus, assurance of psychiatric and social stability becomes central to the organization and distribution of time for practition-



ers charged with specializations in other areas. For example, the following observation of the organization of daily activities was common across ACT sites:

Field observation: Daily scheduling centers primarily on medication and housing issues. Clients receive several shorter visits per week for medication and symptom assessment and one extended visit per week to address issues related to social, recreational, employment and/or educational activities. If the prime worker is on vacation, other members of the team take over medication delivery and housing appointments, but activities related to employment or recreation will be re-scheduled until the prime worker returns. If a service user is identified as experiencing a decompensation in symptoms all members of the team will participate in frequent short visits focusing on symptom assessment and medication management. Often the team will encourage the individual to decrease participation in employment, socialization and recreation activities until such time as symptoms have become stabilized.

When social integration practice is operationalized according to a goal of individual and social protection, integration practice becomes centrally organized around illness, as opposed to integrated exchange. The distribution of activities around preventing destabilization and crisis mediation (e.g., medication delivery, symptom monitoring) across team members is seen as legitimate given an overarching objective to ensure stabilized community living. Yet, similar levels of legitimacy do not present themselves with regard to activities that promote personal and social growth. Social, recreational, educational and employment activities are not maintained with the same frequency or continuity as medication related activities. Were the distribution of activities to reflect an understanding of illness as an ever-present part of life for service users, the distribution of activities to prioritize personal and social growth would be anticipated. In this context, social integration practice

becomes structured as a physical presence but ultimately disadvantages higher-order social inclusion.

- Focus

While a focus on the social world external to the team is critical for developing key pathways to mainstream society, the focus of everyday practice is largely internal. Observations of practitioners reveal frustrations that arise in response to the lack of allocated time and resources to create linkages necessary for social inclusion:

Observation: The vocational specialist commented that at present she was able to provide service users with options for education and employment in sheltered employment settings, day programs, transitional employment programs and a community art class. She stated 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 [doing] general support".

This tension can be traced back to organizing texts, which are fundamental to the reasoning processes that practitioners apply to routine practice. In their seminal description of the ACT program, Stein and Santos (1998) describe ACT as the "fixed point of responsibility for service delivery" and state that "by being the provider of most services (brokering only a few), the continuous care team assures that the services are integrated and provided in the context of the [service users] current needs" (p. 71).

Establishing ACT as the "point of responsibility" was originally intended to ensure continuity in response to service failures that left people with serious mental illness highly vulnerable to poor quality and disjointed services. Yet, the actual practice of this responsibility contrasts with the idea of creating viable pathways for

social inclusion to support political, economic and cultural exchange with members of broader society. Emerging from this textual discourse are constrained integration practices. The only consistently supported arena available in which to create opportunities for higher-order social inclusion is within the mental health system itself. The following comment from an ACT service practitioner offers an example of this phenomenon:

“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 five 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”.

In this situation, the practitioner asks, “How, within the context of my service, can I help the individual to manage and maximize money” and, with reservations, arrives at an explanation for the internally constructed response to the issue. A focus external to the team might generate alternate questions such as “How can we work with the local bank to ensure service recipients get access to resources in a way that best meets their needs?” Ultimately, a solution is found internal to the system rather than working to influence socially constructed restrictions that limit interchange within the community.

A focus that discourages the development of external linkages leads to missed opportunities for facilitating social inclusion, and obscures from everyday consciousness, the significant potential of such opportunities:

Observation: We visit S & L to drop off medication. The case manager with whom I have come asks S & L if they will be going to the Pope’s vigil which takes place today. S replies 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. The case manager agrees that it is indeed disappointing and comments that the extra traffic, caused by the event, has made it difficult for staff to do home visits but does not offer to assist S & L with transportation to the event.

In this observation the intentions of the ACT practitioner to support participation in a meaningful function is evident. These intentions, however, do not translate into activities to assist with accessing the community event. It is notable as well that extra effort is extended to ensure access to medication delivery.

The internalized focus of everyday practice operationalizes integration practice in ways that require practitioners to create a parallel community, rather than work with the community to address barriers to social inclusion. The latter requires a conscious recognition of the long-term value inherent in building relationships between mainstream society, individuals with serious mental illness, and the mental health system itself. This value unfortunately becomes obscured by a structure that focuses practice within the walls of the mental health system.

- Discrete Versus Synergistic Practice Approach

Although the synergistic delivery of basic and higher-order integration practice is desired for facilitating highly interrelated dimensions of inclusion, day-to-day practice in ACT becomes divided into discrete, often disconnected areas of activity. This quote by an ACT practitioner reflects the sense of confusion engendered by this separation:

“ We often talk about [rehabilitation] visits, but I’m like, how can you have a [rehabilitation] visit? 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 its giving medication or not. But I think the every day [work] sees the team as being too split [between separate types of activities].

The routine separation of social integration practice is likewise reflected in official textual discourse:

ACT teams are best conceptualized as ...vehicles to provide whatever service or practical need a [service user] requires. Services that address these needs fall into three broad categories: treatment, rehabilitation and support (Stein & Santos, 1998, p. 71)

While the original intent of conceptualizing treatment, rehabilitation and support as discrete entities was to ensure a comprehensive range of services to support community living, operationally the result has been a differential prioritization of different activity areas. For example, the following ACT text specifies the standards for the composition of 11.8 full time equivalent positions giving priority to those professions associated with clinical treatment:

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. (Ontario Ministry of Health and Long-Term Care, 2004, p. 14)

Service practitioners are compensated differently according to their association with one or another of these categories of activity. In general, those associated with clinical treatment are at the top of the pay scale, while peer support providers and non-regulated mental health workers reside at the bottom.

The activities of practitioners (with the exception of psychiatry and nursing) are constructed to consist of dual generalist/specialist functions. Specialist functions, relate to those activities most closely associated with practitioner training and expertise. The specialist functions operationalize the "multi" in the multi-disciplinary team concept and are most aligned with facilitating higher-order areas of social inclusion (e.g., recreation, education, vocation, peer-coaching, family engagement). Generic functions are meant to ensure that every ACT staff will address the emerging day-to-day needs and issues of service users. They are, however, also heavily weighted towards the challenges of avoiding illness and crisis and carrying out practical tasks and resources of daily living. Given that an ACT team consists of between 10 and 12 staff, approximately 75% of team resources are structured to carry out generic tasks including symptom stability, while only 25% of team resources are structured to carry out specialist activities. The prioritization of illness-focused activities emphasizes basic inclusion and erodes resources distributed to facilitate higher-order aspects of social inclusion. Thus, undermining the very human resources put in place to do this work:

ACT service practitioner: It's interesting because I am the [vocational specialist] role, but [practitioners in] other [specialist] roles have certainly said the same thing as me, 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 is it they're supposed to be doing. So that's my biggest frustration, is that it's very hard to, you know, to perform the [vocational specialist] role plus the generic part.

Perspectives on social inclusion engender the view of an interconnected whole, a circular phenomenon in which an individual's ability to experience inclusion at one level is determined in large part by their inclusion experiences at other levels. Social integration practice in ACT, however, is operationalized by contingent parts (treatment, rehabilitation, support), which are differentially resourced and prioritized within the context of everyday practice, thus, posing a

distinct challenge to the ability of ACT to attend to aspects of higher-order inclusion such as, social cohesion and empowerment.

Discussion

Depending on their orientation, organizing conditions may or may not support the alignment of practice with new emerging ideologies. The findings of this study suggest that ideas and beliefs associated with an individual model of disability flow fluidly through the myriad structural channels that comprise the policies and standards of the ACT model. This medical model foundation shapes an approach to service that impedes the facilitation of higher-order social inclusion for individuals with serious mental illness. Key structures such as pay distribution, team compliment, supervisory and reporting channels, daily activity schedules and identified service priorities are organized to reduce hospital admissions and ensuring medication compliance. These organizing structures then condition the activities that comprise everyday practice and ultimately suppress emerging values, knowledge and priorities that are connected with a recovery approach. The degree to which recovery-oriented activities are prioritized, resourced and funded to a lesser extent than those that directly address medical model outcomes contribute to an overall perception of recovery as a less legitimate form of practice. Although practitioners experience tensions between recovery principles and the way in which they are directed to carry out their activities, they remain largely unaware of the extent to which these tensions are orchestrated by socially constructed organizing conditions (Smith, 2006; Townsend, 1998).

The current study supports the argument advanced by Salyers and Tsemberis (2007) that the ACT structure directly challenges recovery goals such as self-direction, person-centeredness, non-linearity, holistic care, self-responsibility and social interdependence. The study further suggests that the tensions inherent in social integration work within ACT stem from the dichotomy in values, attitudes and structural processes associated with the individual and social models of disability (Bryers, 2010).

Drake and Deegan (2008) in a seminal paper on ACT and recovery question the “long-term viability of the fundamental ACT model” and ask whether we should “continue to modify ACT to address multifarious community mental health needs” (p. 76). As the ACT model emerged “earlier and largely independently from the recovery movement” (Kidd et al., 2010, p. 343), structures and processes consistent with a recovery philosophy have been mapped onto an existing medical model framework. The lexicon of recovery, for example is featured prominently in recent ACT standards for Ontario ACT Teams and peer support practitioners have been added to the repertoire of disciplines, however the foundational components of the model remain unaltered. In essence, a full re-examination of ACT practice standards to ensure an alignment of activities, resources, and priorities with recovery values and assumptions has not occurred. Rather, the structure of ACT has shifted just enough to include recovery interventions but, continues to align ACT practice primarily with medical model roles and priorities. The idea that recovery ideology has been assimilated into a larger structure that supports practices aligned with an alternative ideology, may ultimately explain why recovery-oriented outcomes have failed to meet expectations. Potentially, the only way, for a true paradigm shift to occur is to cease assimilating recovery knowledge and approaches into the existing ACT structure and to instead devise a new structure (rules, tools, investigations and interventions) better aligned with producing recovery-oriented outcomes.

Scullion (2009) suggests that a “firmly medicalized notion of disability retains dominance in health care [generally, and that] there is a growing interest in the possibility of using a social model of disability in developing a social model of mental health” (p. 699). By doing so, disability is “taken out of the private medical arena and placed in public and political spheres, giving prominence to the notion of rights and responsibilities” (Beresford, 2004, p. 701). Ideas related to recovery and social inclusion, however, are emerging within a health system that has long assumed social stability to be the marker of quality care struc-



turing practice accordingly. Challenging assumptions about why and how to enact social integration practice is a difficult task given the system of interconnected regulative elements that hold in place these traditional ways of thinking and doing. Similar to the idea of the adoption of a facilitator or mediator role raised by Davidson et al. (2005), Scullion (2009) recommends adopting the role of “equalities champion” to enable practices aligned with the social model. Within this role, practitioners would directly engage in solution finding around social inequity, expand their conceptualization of disability and operate as social change agents. She argues that advocacy as a practice must occur both at the individual level, impacting the relationships and activities that occur within healthcare walls and at a social-systems level, that attempts to impact conditions within larger society (Scullion, 2009).

Certainly, flexibility in social model thinking is required to be responsive to the critical interaction between biology and society, and to balance tensions between the need for individual self-determination and group cohesion and justice (Gabel & Peters, 2004). However, in its current context, social integration practice, as it relates to individuals with serious mental illness, serves merely as a vehicle for managing, rather than transforming marginalizing social conditions. Consequently mainstream society remains unaffected by and unresponsive to the needs of these individuals. For a shift to be achieved we must suspend our attachment to what we “think” we know, our certainty in our methods and our conceptualization of the problem to allow new forms of “knowing” and “doing” to emerge both structurally and in practice (Davidson et al., 2009; Hopper, 2007; Ware et al., 2008). We must be open to enacting social integration practice in ways that may at first appear to be counterintuitive to how things are “normally” done, and to attempt to address problems that may at first seem unsolvable (Ford, 1999) in order to forge a different social reality for individuals with serious mental illness. This includes the strategic transformation of the structures that define and determine how integration practice is constructed on an everyday basis within ACT.

The purpose of the current study was to uncover organizing structures and processes that could account for discrepancies between medical (hospital recidivism and symptom stability) and recovery-oriented (meaningful activity, social integration and employment) outcomes in ACT. The study traces tensions in integration practice back to an orchestrated imbalance in the system of organization between medical and recovery-oriented priorities. Through this method the study explicates *how* everyday practice becomes conditioned in ways that inevitably contribute to diminished recovery outcomes. The “look” of everyday practice that is attributable to overarching organizing structures can be a more powerful factor in determining practice outcomes than even levels of individual functioning or practitioner training. Institutional ethnographies make explicit the connections between the activities that individuals engage in and the organizing conditions that operate in the background (often obscurely) to coordinate and shape these activities in ways that may conflict with the intentions and values of the individuals who carry them out. It is not the intention of an institutional ethnography, however, to account for all incidents of tension related to a specific phenomenon. Consequently, the current study does not provide a comprehensive listing of all activities within ACT that cause tensions specific to social inclusion work. This lack of completeness could be construed as a limitation of the study and constitutes an area for further research. Another limitation specific to institutional ethnography is the over emphasis on actions that *do not* reflect a recovery-orientation, and an under-emphasis on those that do. This is an inherent limitation in using institutional ethnography given that the purpose of the methodology to focus on areas of tension rather than congruence.

Acknowledging that existing organizing conditions continue to orchestrate everyday practice according to an individual model of disability will enable critical discussion regarding the alignment of practice with contemporary perspectives on social inclusion. A key area for future research includes investigating the effects of structural and process change on re-

covery-oriented outcomes in ACT. To continue to advance higher-order levels of integration the following assumptions must be engrained into attempts to re-construct practice. First, organizing conditions must be re-organized to better enable practitioners to foster working and social relationships between service users and members of the community. Second, the conceptualization of social inclusion must go beyond safe housing and symptom stability to include conceptual and intellectual exchange within broader society (Crow, Zlatunich, & Fulfroost, 2009); third, the community mental health field must target interventions to develop both individual and social capacities for inclusion (Hopper, 2007); and fourth there must be an acceptance that “success and failure, trial and error [rather than stability] are expected parts of the process” (Ware et al., 2008, p. 31). These suggestions in no way deny the importance of attending to illness management and individual needs, nor are they meant to under represent the complexities of addressing issues of social inclusion in the context of serious mental illness. They do, suggest that in its present form, ACT practice compromises the development and delivery of higher-order forms of inclusion and as such deviates away from the values and beliefs inherent in contemporary health care directions.

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